

**Cultural Variables Affecting Client / Therapist Consonance:**

**The Perception of Efficacy in Arts Therapies Groups**

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**Cultural variables affecting client / therapist consonance: the perception of efficacy in arts therapies group treatment**

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**Abstract**

This thesis addresses the hypothesis

“ Intragroup cultural differences between client and therapist will adversely affect client – therapist consonance in their perception of arts therapies group treatment”

The literature review of intercultural psychotherapy, arts therapies and congruence research is contextualised in a discussion of the arts therapies in the UK, in particular group therapy in psychiatry. The discussion of the evolution of a multi modal research design incorporates an ethnographic perspective. The researcher shows how the setting and two pilot studies as well as the Evidence Based Practice initiative influenced the design. The main concepts in the research question are defined and the sample analysed within its local context.

Helping and hindering factors in arts therapies group sessions are identified through cluster analysis of questionnaires and focus groups. The next stage of the analysis examines which client, therapist and treatment variables are shown to affect dissonance. Five case studies show the interaction of these variables for individual clients.

The concluding chapter discusses the findings and critiques the methodology, as well as providing recommendations for further research. The hypothesis of the research is found invalid; cultural background variables alone do not create client-therapist dissonance. The findings show that client, therapist and treatment variables interact to

create dissonance. Client diagnosis, stage of treatment and cultural background interact with their experience of the arts therapies medium. In an arts therapy group context the structuring of the group and the interpretation of the arts expression as symbol or index, will interact with client and therapist cultural background variables. The intragroup variations are migration history, nationality, religious orientation and first language spoken. Cultural difference with the therapist affecting dissonance was evident for those clients who were third generation English / British and who had grown up and were still resident in an non-urban area (small town or village in a predominantly agricultural region) with little cultural diversity. Intergroup difference affected attrition for one client, influenced more by peer than therapist dissonance. Treatment interruptions, the theoretical orientation of the therapists and peer dissonance interact with the client-therapist dissonance.

Recommendations for practice are formulated from these findings. These concern adjusting practice to allow for a greater emphasis on expression and play, differing client perceptions about symbolism and the establishing of an early therapeutic alliance.

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**All client names are pseudonyms, setting and location details are anonymised to protect confidentiality.**

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# Chapter 1 Personal and professional journey to the research

## 1.0 Chapter Overview

In this Chapter I outline the personal and professional journey that enabled me to formulate the research question and design.

### **1.1 Background; personal and professional journey**

Over the past ten years I researched the effectiveness of the arts therapies across-cultural and ethnic borders. Although I say ten years, that only shows the formal period of time, from taking a MSc in social anthropology including a thesis on the cultural complexity of the application of arts therapies across different European nations (Dokter, 1993) to my PhD research. However, the personal aspect of the research started in the early eighties, when I migrated as a young single adult to Britain to study Dramatherapy. At the time I understood drama as expression through word and movement. I trained in developmental play, dance (jazz, folk) and clowning. My first degree was in youth welfare work, which emphasized 'ludic' play (Huizinga 1985). I had done some work within the deaf community in the Netherlands and was interested in exploring this possibility of drama. For someone of my Calvinist working class background, theatre was rather alien territory. I became conscious of issues around cultural form, class and religion regarding their effect on expectations, cultural identity and power relationships.

At the end of the eighties, this was reinforced, when I facilitated a weeklong workshop on therapeutic laughter as part of a theatre festival in Grenoble, France. I found myself working with a French group, while I had expected an international multilingual one. My French is not fluent, so a process of negotiation needed to take place where tolerance for difference, for time to translate and for not finding the right words, was developed. I was taken back to my first experience of operating in an English language group. This time, however, I was trying to facilitate it. Acknowledging difference and negotiating how to work with it was a key. The issue of linguistic difference and the power relationship between a first and second language speaker, even with additional expression through the artistic medium, became more conscious. In the intervening years I had settled with a British partner

and had a child. Personally, being in an intercultural partnership and trying to raise a bi-cultural child reinforced my awareness of the intergenerational effects of migration on cultural identity (McGoldrick et al 1996, Schutzenberger 1999).

In the meantime I had joined the staff of a dramatherapy training course and facilitated dramatherapy training groups for students who came on a European Union grant to study dramatherapy in the UK and then returned to their country of origin to practice. Expectations linking age, gender and authority provided important issues for a young female facilitator in a male majority Greek/ Irish group. Issues of power and cultural difference were closely interwoven. The additional factor of people training to be therapists in one cultural context, then applying this training to practice in another made me aware of the potential conflicts in this two way migration process. My MSc Social anthropology thesis was a first attempt at identifying these conflicts (Dokter 1993)

The interesting aspect for me was the fact that here I was working with all-white adult groups, that showed a remarkable degree of cultural diversity. Most of the debate around intercultural practice at that time tended to focus on 'racial' black/white differences. I worked in Islington as a group work co-ordinator with multi-ethnic and multi-cultural groups. Sue (1991) states that ethnicity involves shared social and cultural characteristics that bear on psychological functioning. I distinguish ethnicity and culture in the following ways:

- Ethnic groups are those who conceive of themselves as alike by virtue of common ancestry, real or fictitious, and who are so recognised by others (McGoldrick, 1996).
- Culture is a system of social institutions, ideologies and values that characterise a particular social domain in its adaptation to the environment. It is also important that these traditions and beliefs are systematically transmitted to succeeding generations (Landau, 1982).

During the group work in London I encountered issues of race, ethnicity and racism. How others regard you in the 'host' society and their continuing response can be a

very different issue for white and black migrants. The focused multicultural approach of the time tended to address the visible racial and ethnic minorities (Bradt, 1997).

During the nineties my professional identity as an arts therapies practitioner and trainer evolved. As a dramatherapist, dance movement therapist and group analytic psychotherapist, I was interested to study group therapy approaches across the arts therapies in particular. My practice with refugees was mainly individual (Dokter 1998, 2000, 2003), but the descriptions of other arts therapists about their group practice (Case 1998, Orth 1998, Callaghan 1996) had made me wonder about intercultural aspects of group work. My own experiences in the Black-White group at the Institute of Group analysis and the European Association for Transcultural group analysis meant that I was predisposed to think of groups as a useful forum for intercultural exchange in therapy. I wondered whether the differences between Eurocentric individualism and Afrocentric (Boston & Short 1998) and Asian (Orth 1998, Sue 1991) communality could be better addressed in group than in individual therapy. My religious and political values made me aware of potential conflicts between individualism and interdependence within the white majority population too, as Waller identified in Italy (Waller 1992). My professional training and personal therapy experiences (group analysis and Jungian analysis) connected me to the psychodynamic orientation within the arts therapies (see 2.1).

These personal and professional experiences and musings led me to undertake the PhD inquiry, from literature search to the identification of one specific question and the appropriate methodology to attempt to answer it.

## **1.2 Starting out: the first steps in my research journey**

In chapter 2 I will look at the overlapping of arts therapies and intercultural psychotherapy / counselling literature (case studies and research) with that of sociology and anthropology. Here I first want to sketch the broad connections between migration, mental health and arts / psychotherapy in the UK.

There are over two and a half million people in Great Britain with their origins in the new commonwealth, a mainly twentieth century migration. Together with migrants from the Irish republic and mainland Europe, and their children, they comprise approximately ten percent of the UK population. The popular perception is that all immigrants are black. In reality, half of all black people are British born. The majority of recent immigrants have been white, partly due to immigration policies, the war in the ex-Yugoslavia and the widening of the European Union to include former Eastern bloc countries. Other migrant streams have been identified historically (Winder, 2004).

Racism has always been a part of the experience of immigration. For some time it has been known that to be black in Britain is to be exposed to a variety of adverse stimuli, which can add up to a serious mental health hazard (Littlewood and Lipsedge 1997, Mental Health NSF 1999). The mental health problems are not simply a consequence of geographical and cultural dislocation, the adjustments and inevitable stresses of migration (Dokter 1998 b). An important issue is the ongoing response of and to the white host society, its values and institutions (Kareem and Littlewood 1992). Refugees and asylum seekers come with their own particular set of problems and needs (Dokter 1998, 2000 a and b, 2003, Papadopoulos 2002, Blackwell 2004).

For most immigrants the poor social conditions and loss of cultural identity have a detrimental effect on psychological health. If this results in psychiatric illness the psychosocial problems can easily be lost sight of. The experience of migration and discrimination in housing, employment and everyday life are frequently expressed by patients not as conscious complaints, but symbolically, in the structure of their illness (Littlewood & Lipsedge 1997). The way people express their disease is also strongly influenced by their cultural background. This background is not a static, given entity, but a changing interactive one, depending on individual and family circumstances. For example, someone's distress may be connected to a lack of a sense of belonging, not feeling at home anywhere, de-culturation as opposed to acculturation.

In a recent dramatherapy group, a client, who migrated to the UK from Nigeria as a child, drew two masks. One represented the tribal scarring marks as worn by the men

of his tribe. The other showed a face without the marks. He reflected at first that his face was not marked, but that he was still recognisable as a member of his tribe. When working with the masks later, the unmarked mask became a woman. He reflected that the women of his tribe did not carry the marking, but was unsure of what this might mean about him. An additional problem about identity for him was that his family was upper middle class, while he, due to severe mental health problems, tried to survive on benefits. A fellow patient, born in Jamaica, also a long standing UK citizen, used his masks to reflect on the part of him that wanted to stay separate, an individual, and the part of him that wanted to belong. He said the two masks reflected himself and his fellow black patient. He saw himself as the one who stayed separate, kept his hair long and wore 'ethnic' dress, while his fellow patient had succumbed to the unit male haircut of a shorn head, giving up his dreadlocks. He also discussed the difficulties in assuming either stance and swinging between the two.

Black researchers have identified various stages black people go through in identifying their identity (Cross 1991; Helms 1992, 1995). The above case example shows two ways in which clients identified their black identity in a white group. Black researchers have critiqued ethnocentric assumptions about identity. Rattansi posits a continuum between *racism* and *ethnocentrism*. The former defines groups of human populations into 'races' on the basis of some biological signifier, each race being regarded as having essential characteristics, or a certain essential character. The inferiorisation of 'races' may or may not be present. In *ethnocentrism* ethnic groups are primarily defined in cultural terms and are recognised as having essential traits. There is a tendency to view cultures from within the framework of one ethnic group (Rattansi 1992).

On page 2 I discussed the definitions of culture and ethnicity I use. It is important to be able to see them in their complexity. Culture is not a bag of memories and survival techniques, but a dynamic recreation by each succeeding generation. It is a complex and shifting set of accommodations, resistances and re-workings (Kareem & Littlewood 1992). Ethnicity describes a sense of commonality transmitted over generations by the family and is reinforced by the surrounding community. It is more

than race, religion or national and geographic origin (which is not to minimise the effects of race and racism). It involves conscious and unconscious processes that fulfil a deep psychological need for identity and historical continuity. Ethnicity patterns our thinking, feelings and behaviour. It plays a major role in determining what we eat, how we work and relax, how we celebrate holidays and rituals, how we feel about life, death and illness. Many cultural values and assumptions are outside our awareness; we see the world and each other through our own cultural filters.

The subject of ethnicity evokes deep feelings; discussion frequently becomes polarised and judgemental. Levine (1981) equates ethnicity with sex and death as a subject that touches on deep unconscious feelings in most people. Looking at difference can evoke a deep sense of threat, 'ethnic cleansing' is both a modern and historical reality, but colour blindness is no virtue if it means a denial of difference in experience, culture and psychology (Acton 2001). Differences do not represent a hierarchy of inferior and superior qualities. Deficit theorists have pathologised differences and seen them as a deficit, a disadvantage. Re-framing may mean that a deficit can be strength, i.e. a lack of a clear definition of role can mean role flexibility (Rattansi 1992).

Black ethnic redefinition is a redefinition against the assumptions of white society. Redefinition gives a positive value to or plays with the stereotypes, challenging white society with a mirror of its prejudices. Sometimes the reaction can be a reassertion of the original culture, rather than the creation of a new identity. The aspects of the original culture that are most rigorously reasserted are usually those that are considered fundamental to the continuation of boundaries internal and external to the community (Littlewood & Lipsedge 1982).

In the course of my therapeutic work I realised that achieving a dialogue across-cultural filters, whilst sensitively acknowledging difference, is of major importance in the relationship between therapist and client. In order for this dialogue to be made possible, both therapist and client need to become aware of their ethnic roots. As a migrant I had become part of an ethnic minority in this country. I wanted to study what this meant as a therapist in my relationships with clients from both the 'majority'

and 'minority' cultures. I have commented on the implications of the language and terms used elsewhere (Dokter 2000 b).

Traditionally arts therapies have been presented as a therapy of choice in intercultural therapeutic practice (Wong 1981, Wolff and Hall 1971). They were seen as a useful alternative to verbal therapies, as they allowed emotional expression when language difficulties were prevalent. Arts therapists have also used the arts in healing in different cultural contexts as a way of validating their use in the UK (Jennings 1987, Grainger 1991). This complements those arts therapists who trained in one cultural context, before leaving to practice in another, drawing on both to validate their use (Mereri 1996, 1997). Arts therapies publications so far consist mainly of case studies. There are only a few that comment on the ethnic and cultural identity of the therapist and the effect of the interaction between client / therapist differences. This is a more general reflection of the lack of transparency of the therapist, critiqued by, for example, social constructionism (see chapter 2)

A critique of the lack of therapist reflexivity (Pajaczkowska and Young 1992) articulates the absent centre of white identity. White cultural identity is absent in a number of senses, both political and subjective. Within European history descriptions of whiteness are absent due to a denial of imperialism. This leaves a blank in the place of knowledge of the destructive effects of wielding power. An identity based on power never has to develop a consciousness as responsible. It has no sense of its limits, except as these are perceived in opposition to others. The blankness of the identity of empire covers an ambivalence which is often unconscious and which can be more easily noticed in the representations it makes of the colonial 'others'. Arts therapists easily refer to anthropological notions of the ancient healing roots of the arts and borrow cultural forms to show intercultural awareness. The western use of non-western performance forms can have a hidden agenda of imperialism. The fundamental principle of cultural exchange depends on translation taking place. Positive interculturalism comes from the drama of immigrants in which an oversimplification of cultural identity becomes impossible. The cultural representation of unfamiliar things risks a reproduction of stereotypes. Cultural stereotypes tend to fix power relations (Stone Peters 1995). Lack of therapist

reflexivity on the effect of their cultural identity in interaction with that of the client can reinforce this (Tuckwell 2002).

This interwoven personal and professional experience and orienting, combined with my reading of the available literature led me to research the influence of cultural identity on the interaction between client and therapist. In the mid 1990's there was little research available in the fields of the arts therapies that focussed on the effect of cultural identity. There was a small body of research available in the field of psychotherapy with culturally diverse populations. Sue, Zane and Young (1994) reviewed the available outcome studies, concluding that intercultural psychotherapy research was necessary. They gave their reasons:

- The rapidly changing nature of the population,
- The evidence that ethnic minority groups are experiencing significant mental health problems,
- The controversy over the effectiveness of psychotherapy for ethnic minority clients
- The relevance for mental health treatment as a whole.

They defined three research questions necessary to be answered in the field of psychotherapy:

- Do ethnic minority clients improve?
- Do they fare as well as other clients?
- Which client, therapist and situational variables are associated with a positive treatment outcome?

These three questions are equally valid in the arts therapies field. In chapter 3 I will discuss how they influenced my formulation of the research question and the development of the methodology to study that question.

Two further questions were formulated in the next edition of the psychotherapy research review (Zane et al 2004):

- whether certain types of treatment are more effective with black and minority ethnic clients
- what conceptual and methodological issues need to be addressed in psychotherapy research on culturally diverse populations

I will return to these latter questions in my concluding chapter, which includes both a methodological critique and recommendations for further research.

## **Chapter 2 Literature review**

### **2.0 Chapter overview**

This chapter reviews the relevant literature related to the cultural background variables affecting client-therapist consonance in their perception of arts therapies group treatment. Chapter 3 will discuss in detail the research road followed to reach the hypothesis and define some of the main concepts related to it, but this chapter aims to review critically the available literature.

In chapter 1 I outlined the personal and professional journey leading to this research. I searched for relevant literature related to the cultural backgrounds of client and therapist influencing the outcome of arts therapy. I found that this was potentially very wide ranging. I considered a variety of perspectives for the research (see chapter 3), but at this stage searched for the most appropriate perspective, the formulation of the research question and the potential research methodology. I realised that intercultural psychiatry and medical anthropology inform more general reflections about cultural understandings of mental health, illness and its treatment. Intercultural psychotherapy research and the research into the influence of client and therapist variables on psychotherapy outcome fits a more evidence based practice framework.

Much psychotherapy research has taken place in the United States. One difference between UK and US practice is that most US research is based on manualised (using protocols) psychotherapy treatment. Humanistic psychotherapy research on therapist-client congruence is closer to UK arts therapies practice (non-manualised). I decided to include this. Arts therapies research in the area is scarce, but general arts therapies research studies in client and /or therapist perception of treatment as well as intercultural case studies are available. The setting where the research took place was a UK mental health arts therapies department in adult psychiatry, treating adults, young people and the elderly. The fieldwork was in a young people's psychiatric unit emphasizing group treatment. A discussion of arts therapies group treatment aims to contextualise this in chapter 2.5.

The available literature draws on research from a wide variety of United States and European contexts. I therefore place the arts therapies in their UK context at the beginning of this chapter, so that a critical review of the literature can include a

consideration of its application to UK arts therapies practice. The second section discusses the psychotherapy research on therapist-client variables influencing outcome, particularly considering intercultural psychotherapy research. I considered whether to review the medical psychiatric literature on practice with different cultural groups, but found that most of the literature did not consider psychological therapy treatment. Where relevant I discuss this in the intercultural psychotherapy section.

The fieldwork of my research took place in the late 1990's. More up to date research is used to contextualise this within current practice.

## **2.1 Arts therapies in their cultural UK context : training and practice**

The first books considering the four arts therapies, as recognised separately in the UK, were published very recently (Jones 2005, Karkou and Sanderson 2006). Jones (2005) shows a pattern of development where a small group of interested and trained individuals gather together to develop definitions, identities and professional governance relating to their discipline and practice (Jones 2005). Originally arts therapies were developed by individual pioneers (Waller 1991, Jones 1996, Payne 1992, Priestley 1975, Nordoff and Robbins 1971). These individuals, in collaboration with others, developed practice, training and governance. Jones' emphasis on trained individuals is a more recent development. Individuals from one country train in another and return to their country of origin to establish the profession (Waller 1998, Dokter 1993).

The European Consortium for Arts therapies trainings (Ecarte website) has aimed to create a regional European arts therapies network. Its biannual conferences and publications provide an overview of different European practice and training (Kossolapow et al 2003). Waller (1998) already researched this area in relation to art therapy and critically reviewed both the UK (1991) and other European countries (1992, 1995), with a reference to the diversity within each country and its different socio-political and health service contexts. The Ecarte conference proceedings lack a coherent framework within which practice is compared (Kossolapow et al 2001, 2003, 2005 as well as earlier proceedings).

Waller (1998) follows a process model of professions (Bucher and Strauss 1961) and echoes Wertheim-Cahen's critique (1995) of the lack of structure and inconsistency demonstrated in the art therapy literature. Many studies indicate diversity without boundaries; chosen theoretical and political directions are seldom made explicit, although they may have great implications for the development of the profession. Karkou's (2006) research provides a UK overview from a systematic perspective, while Jones uses literature review and interviews to study commonalities and differences across arts therapies practice world wide.

Jones (2005) shows how different subgroups arrive at their own description and definition. Some identify themselves by their theoretical orientation, others by their practice context. Jones provides an overview of settings where arts therapists practice. He indicates that "the extent of practice can be limited by attitude, availability of therapists and systems of healthcare, alongside the economic and political situation"(Jones 2005: 19). Whilst arts therapists practise in similar settings, there can be a difference in emphasis in the modalities (Karkou 1999a).

Karkou's research involved 40% of arts therapists, registered in the UK through their professional associations. The sample comprised 51.6 % of art therapists , 21% music therapists, 19% dramatherapists and 7 % dance movement therapists. Of the respondents 48.5 % 's main working environment (many arts therapists work part time in a variety of settings) is the health service. 16.5 % work in education, 12.7 % in voluntary organisations, 12% in community settings, 7.6 % in private practice and 2.8% in other settings. Almost half of the sample work in the health service, while half of all arts therapists in the UK are art therapists.

Karkou (2006) shows how UK arts therapy definitions have changed over the years between 1989 and 2004. Waller also refers to this changing definition for art therapy in a European context (1998), as do Bruscia (1998) and Wigram et al (2002) on a worldwide basis for music therapy. The current UK definitions provided on the professional association websites are :

British Association of Art Therapists (BAAT website) “Art therapy is the use of art materials for self expression and reflection in the presence of a trained art therapist.....The art therapist is not primarily concerned with making an aesthetic or diagnostic assessment of the client’s image. The overall aim of the practitioners is to enable the client to affect change and growth on a personal level through the use of the art materials in a safe and facilitating environment”

British Association for Dramatherapists (BADth website) “Dramatherapy has as its main focus the intentional use of healing aspects of drama and theatre as the therapeutic process. It is a method of working and playing that uses action methods to facilitate creativity, imagination, learning, insight and growth”

The Association for Dance Movement therapy UK (ADMTUK website) “Dance movement therapy is 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”

British Society for Music Therapy (BSMT website) “ There are different approaches to music therapy.....Fundamental to all approaches, however, is the development of a relationship between the client and the therapist. Music-making forms the basis for communication in this relationship”

These changing definitions reflect an ongoing debate within the professions whether or not arts therapies are primarily forms of psychotherapy or artistic modalities (Karkou 2006). Jones (2005) identifies a second debate over whether the arts forms and processes should be divided into separate identities and services or one discipline which makes use of a variety of arts forms. Particularly intercultural combinations of arts forms and children’s expression which does not differentiate amongst forms, have been used to advocate this integration (to be discussed further in 2.3). Some authors and practitioners argue for an integrated approach (Petzold and Ilse 1990, Levine and Levine 1999). However, in the UK the choice has been made for separate modalities in their professionalisation process and practice.

Waller (1998) discusses the professional debate in art therapy where using the title 'art psychotherapist' was felt to devalue the art. She points out the roots of the 'art in education' movement in the UK and their contribution to the concept of what constitutes art. This debate is replicated for the other UK arts modalities (Karkou 2006). Jones discusses how the 'one or four disciplines' debate is influenced by issues related to the nature of the arts, cultural differences and the relationship between the arts and therapies in arts therapies (Jones 2005).

Karkou (2006) researched the conceptual frameworks that guide arts therapies practitioners in the UK. She did this through a first round of interviews with 'expert practitioners'. This was followed by a survey of registered arts therapists who tested the statements of the individual 'experts' as to their generalizability. She found that in order of influence humanistic, psychoanalytic / psychodynamic, developmental, artistic / creative and active / directive frameworks dominated. Second in importance, was an eclectic / integrative framework where practitioners drew on a variety of perspectives depending on the client or setting they were working in. She found that therapist background, age and training influenced the practitioners' conceptual preferences, as well as the setting and client group.

Practitioners working in mental health and hospital settings were most likely to use a psychoanalytic / psychodynamic framework. Issues for psychoanalytic / psychodynamic arts therapies practitioners were the existence of the unconscious as expressed through the arts processes or products. The link between the unconscious and conscious was encouraged through verbal communication. The therapy aimed to connect past and present through the transference in the therapeutic relationship (Karkou 2006). Artistic / creative approaches were often more a clinical methodology, used in conjunction with either humanistic or psychoanalytic / psychodynamic and / or developmental conceptual frameworks. The active / directive framework was more connected to learning theory and behavioral approaches. Behavioral approaches are more common in American than in British practice (Bunt 1994, Moreno et al 1990). A related area is the debate around the need for structure in arts therapies sessions, which does influence British practice (Oldfield 1995, Jones

1996, Priestley 1994). I will discuss this further in section 2.5 on arts therapies group treatment.

Inter arts modality comparisons (Karkou 2006) show that art therapists place a particular emphasis on psychoanalytic / psychodynamic theoretical underpinnings in comparison with music therapy and dramatherapy; dance movement therapists and dramatherapists value the humanistic framework more in comparison with music therapy, and dramatherapy emphasizes the humanistic orientation more than art therapy. Dramatherapy emphasizes artistic / creative practices more than the other arts therapies, especially than art therapy. The eclectic / integrative approach is relevant to all arts therapies, but not as important for music therapy.

Certain therapist variables influence the choice of conceptual framework (Karkou 2006). Therapists aged 41-50 are more in favour of psychoanalytic / psychodynamic frameworks than younger therapists. This may be a result of additional psychotherapy training and the fact that during the late 1980's and early 1990's there was a significant turn towards psychoanalysis to justify arts therapies practice (Waller 1991, Wood 1997). Younger arts therapists are more sceptical of distinct frameworks and favour a more eclectic / integrative framework within the postmodern context of diversity (Karkou 2006, Jones 2005). Specific arts therapies may also acknowledge other conceptual frameworks such as social constructionism in art therapy (Hogan 1997). Karkou does identify the latter for dance movement therapy (Best and Parker 2001).

The sample size of 39% respondents may be 'acceptable' (Karkou 2006), but the representation of the different arts therapies modalities was uneven. Karkou's research sample is proportionate across the arts therapies, but within each profession the proportion of respondents varies. Art therapy is described thus by approximately one seventh of its membership, music therapy and dance movement therapy by slightly more than a quarter of its members, and dramatherapy by more than a third. Given that the original 'expert practitioners' numbered only 12, I wonder whether the difference between respondents and non-respondents may be significant. Those practitioners who did not recognise themselves in the original statements might not

have responded. Karkou's original methodological framework is grounded theory, although she stresses multi-modality. However, she does not include a self reflective element in the research looking at the possible influence of her various identities as Greek migrant, educationalist and dance movement therapist.

Particularly when researching across the arts therapies the original affiliation of the researcher and practitioner needs to be incorporated (Beutler 1997). Especially those practitioners accredited via the 'grandparent' route (prior to the establishment of professional training programmes) have been shown to be strongly influenced by their original training, for example as artists or educationalists, in their preference for a creative / artistic or humanistic framework. Karkou states that further research is needed in order to identify the extent to which arts therapies training affects subsequent practice.

All arts therapies trainings are postgraduate. The first music therapy training started in 1968, art therapy trainings as an option in the art teacher's diploma in 1969, as a certificate in 1970, dramatherapy in 1977 (alongside the art therapy certificate training) and dance movement therapy in 1985. Over the years the level of training reached postgraduate level and from 2004 all training is at masters level. Currently 15 universities offer arts therapies training in the UK (Karkou 2006).

## **2.2 Intercultural psychotherapy research**

Where previously client variables were researched in isolation, the research field has developed to emphasize the interaction between client, therapist and treatment variables (Lambert 2004). Due to the evidence based practice debate (see chapter 3.2), psychotherapy research data shown by diagnosis has become increasingly prevalent (Roth and Fonagy 2005). This assumes that diagnosis transcends other client characteristics. Advocates of empirically supported therapies (EST) may consider their methods to be universally valid and suggest that research on these methods with white caucasian clients should simply be applied with ethnic minority groups (Hall 1997). There is no evidence however, that they are valid for ethnic minorities (Matt and Navarro 1997, Miranda 1996, Sue 1998, 1999). These studies

are mostly American, but also in the UK the critique is that many researchers fail to capture the diversity of their resident populations (Roth and Fonagy 2005: 29)

“Though they are increasingly attentive to this problem, and demographic characteristics are now regularly reported, the impact of ethnicity is rarely examined .....The implicit assumption is that what we know treatment effectiveness generalises across groups with widely varying cultural beliefs and treatment expectancies, a proposition that is largely untested.”

Many models of culturally sensitive therapies (CST) were developed in the US (e.g. Sue et al 1996, Ramirez 1999). In the UK intercultural therapy has been advocated (Kareem and Littlewood 1992). Research has shown that therapist adjustment to client variables is crucial to the outcome of the therapy. Client expectations affect therapeutic engagement and alliance, although not the overall treatment outcome (Joyce and Piper 1998). Research undertaken at the Nafsiyat intercultural therapy centre in the UK (Moorhouse et al 1989) showed that client choice was a deciding factor in engagement with therapy over client – therapist ethnic match.

Clients from black and ethnic minority groups (called BME communities in the UK context) experience higher levels of both physical and mental health problems (Nazroo 1997, Erens et al 2001, Bhugra et al 1999). However, they access health services to a lower degree. Social exclusion is one area outlined in the government’s mental health national service framework (Mental Health NSF 1999). Minority ethnic groups encounter barriers to access and are much less satisfied with services once contact is made (Littlewood and Lipsedge 1997, Callan and Littlewood 1998, Commander et al 1999). The reasons for the dissatisfaction are cultural stereotyping in assessment and recommendations for treatment. The latter includes higher levels of compulsory admission for certain ethnic groups (Sashidharan 1993, Bhui 2002). Clients from all minority ethnic groups are more likely than white majority people to be misunderstood and misdiagnosed; more likely to be prescribed drugs and ECT rather than psychological therapies (Wilson 1993).

In order to address the EST neglect of individual variables (Howard et al 1996, Seligmann 1995), researchers advocate client focussed psychotherapy research,

monitoring individual client treatment progress and using individual client feedback in a variety of areas (Lambert et al 2001). However, specific effects of client focussed psychotherapy research with ethnic minorities remains to be examined (Beutler 1997).

Pre-treatment client variables have a plausible impact on therapy, but as soon as therapy begins, client variables are in a dynamic and ever changing context of therapist variables. Therapist responsiveness to client variables will effect outcome (Stiles et al 1998). A recent meta analysis of psychotherapy research into client variables concludes that “client characteristics are central to the motivation for and the nature of participation in psychotherapy” (Clarkin and Levy 2004: 216). In efficacy research therapist factors are seen as an error that needs to be controlled. However, in research with depressed clients the reciprocal relationship of therapist and client qualities are shown to influence outcome (Beutler, Clarkin and Bongar 2000).

Beutler et al’s (2004) meta analysis of studies, excluding non-outcome and analogue studies, showed that the ethnic background of the therapist indicates unidentified moderators of treatment effect. The small size of the effect indicates a need to look at client and therapist cultural beliefs as a moderator of treatment effect, as well as therapist age. The analysis showed no effect of therapist experience. It is clear in the meta analysis that inferred therapist traits interact with various client attributes (Kaplan and Garfinkel 1999).

Findings suggest that less than 10% variation in outcome can be accounted for by the quality of the therapeutic relationship. The therapeutic alliance as a construct in research needs further development. The existing body of research shows that the quality of the therapeutic relationship during early sessions successfully predicts long term treatment benefit (Beutler et al 2004). Early establishment of a positive therapeutic alliance has been advocated as important to BME clients (Jenkyns 1997).

One difficulty in interethnic comparison is the heterogeneity within an ethnic group. When examining within-group heterogeneity important relationships are often found between various factors. These are: country of origin, immigration history, education

level, motivation for leaving country of origin, acculturation, ethnic identification, religion and the preferred language of communication. Difficulties arising from most research studies are generalisability and small sample size. The other difficulty with interethnic comparison is that the BME group is usually compared with majority white caucasians, assuming that they are a homogenous, highly acculturated group.

To address these difficulties the intercultural research focus is now on individual differences within a particular group, rather than comparison between groups. Socio-economic status pre and post migration, education level, type of living environment and English proficiency need to be monitored in interaction with the cultural variables (Zane et al 2004). Using direct outcome measures is problematic, as few measures have been examined for cultural bias. I will discuss in chapter 3 how I have taken the difficulties around intercultural psychotherapy research into account in the design of my study. Here, I emphasize bridging the need for evidence based practice with access to psychological therapies for BME clients. The following quote (Zane et al 2004: 794) illustrates my point:

“There is a growing appreciation for the need for effectiveness research to complement efficacy investigations. Effectiveness studies determine whether treatments have favourable and useful effects with clients who typically use mental health services in real life community settings and circumstances. A major interest in the study of effectiveness centers on how certain contextual and individual difference variables moderate the effects of treatment. Factors often considered sources of error in efficacy studies are allowed to vary.....to assess their impact.....socio cultural factors constitute a subset of these variables. “

The lack of empirical support for psychotherapy effectiveness and the ethical rationale concerning access to psychological therapies for BME clients suggest the need for conceptual models (Hall 2001). The manualised approach to therapy (EST) has been critiqued by intercultural psychotherapy researchers who argue that culturally sensitive therapy is a dynamic process (Ramirez 1999, Sue 1998). Several culturally sensitive (CST) theoretical models of psychotherapy have been developed for the US context. These incorporate the differing world views of multiple ethnic backgrounds (Sue 1998, Sue and Sue 1999) and racial identity development for African Americans (Carter 1995). The sociopolitical context, issues around

empowerment, indigenous problem solving and incorporation of network resources are proposed for American Indians (LaFromboise et al 1998). Asian conceptualisations of distress, value systems and shame are suggested as core components for Asian Americans (Zhang et al 1998). The family structure as the psychotherapeutic focus is proposed for Latino families (Szapocnik et al 1997). Across different ethnic groups interdependence, spirituality and discrimination are identified as distinguishing factors between majority and minority communities.

Hall (2001) identifies that most efficacy research has been conducted by clinical psychologists, while most research into culturally sensitive psychotherapy has been done by counselling psychologists. He also comments on the BME identity of the researchers as effecting the studies. Most EBP researchers are white, most CST researchers in the USA have been from ethnic minority backgrounds. There has been a debate whether non-minority researchers should conduct research for clients from minority backgrounds (Aitken and Burman 1999, LaFromboise and Jackson 1996). This may not just be an issue of territoriality and suspicion about researcher motivation, but a questioning of the non-minority researcher's ability to take in the relevant information (West and Talib 2002). Hall (2001) advocates research collaborations to bridge the divide.

Most research on therapist ethnicity addresses the effect of ethnicity on therapist attractiveness (Atkinson and Matsuhita 1991), or on clinical judgement (Lopez and Hernandez 1987, Malgady et al 1987, Pavkov et al 1989). The opinion dominates that ethnic sensitivity of the therapist (Leong 1996, Sue et al 1991, Sue and Sue 1999) enhances the efficacy of psychotherapy. This opinion has limited support from psychotherapy research (Beutler et al 2004). Among naturalistic studies of therapy outcomes, only the drop out rate appears to be consistently and negatively affected when therapist and client come from different backgrounds. Interpretation of data needs to take into account that minority clients do not seek out traditional mental health services. Conclusions based on historical reviews of the literature that concern the role of ethnic similarity may be dependent on the ethnic identity of the reviewer (Abromovitz and Murray 1983). The effects of this for researcher ethnic identity were mirrored in a recent paper (West and Talib 2002) with findings (in a heuristic

framework) that showed the need for the researcher to culturally contextualise themselves within the research.

Cultural attitudes are most strongly reflected in values, attitudes and beliefs with linked research into religious belief systems. While most psychotherapists would agree that psychotherapy is a value laden process, the nature of the values inherent in that process is not well understood. Worthington (1988) distinguished between those values of the therapist inherent to the therapy used (therapy values) and personal values (therapist values). However, in practice the two become intertwined. Bolter et al (1990) demonstrate confounding between personal and professional beliefs by finding that brief therapists have corresponding personal and professional values. Research indicates that psychotherapy values may differ substantially from those of the average (nb American) citizen. Therapists are more permissive of sexual expression (Khan and Cross 1983) and value autonomy, expression of feelings and personal growth more than their clients, while they devalue submission to authority and God (Bergin and Jensen 1989).

Many therapists are brought up in a religious tradition and believe that client problems often reflect religious conflicts or concepts, but few therapists believe that religious themes are within the province of psychotherapy work (Bergin and Jensen 1989, Shafranske and Malony 1990). A therapist-client match of religious beliefs was shown not to affect outcome as long as the therapist was able to provide religion-congruent interventions (Propst et al 1992). This may, however, reflect some common values that cut across religious affiliation (Worthington et al 1996, Jensen and Bergin 1988). Worthington et al (1996) found that the more fundamentalist the religious identification, the more this identification may interfere with the development of the therapeutic relationship. Outcome research on therapist religion remains 'embarrassingly sparse' (Worthington et al 1996: 477). The body of evidence is currently too limited to connect outcome with client or therapist religious orientation and match (Beutler et al 2004). However, there is a body of literature that may provide targets for new and more focussed research (Miller 1999, Richards and Bergin 2000 a and b, Schafranske 1996).

Three intercultural psychotherapy research studies, all American, are of potential relevance to arts therapies intercultural research. The first concerns a clinical assessment measure, namely the kinetic family drawing test (Wegman and Lusebrink 2000). Research that investigates the use of KFD with non- American children is rare. None of the authors describe their methods clearly, so they can not be duplicated and there is no clear definition of variables in the scoring system (Handler and Habenicht 2004). Wegman and Lusebrink set out clear criteria and scoring systems and compared Taiwanese, Swiss and American children's drawings and propose on the basis of those a revised scoring method and verified reliability. This style of assessment is rarely used among British or European arts therapists, but shows a potential adaptation of a standard measure to other ethnic groups. Within-group heterogeneity is not addressed though, so the usual critique on interethnic group comparison applies.

Two further studies look at culturally sensitive therapy for a particular client group. Onizo and Onizo (1989) conducted a randomised control trial (RCT). The aim was to determine whether visual art activities (use of photographs, mobiles, murals and drawings) would be helpful in moving children from self consciousness to self awareness. This was tested in the context of small group counselling sessions for 8-12 year old Hawaiian children. They conducted pre and post tests on self esteem. In their research they looked at both universal and culturally specific strategies employed in the process of expression. They concluded that counsellors need to be aware of the relevant metaphors and traditional healing processes of the client culture they work with. Some art therapists, US based, followed up this research, and I will discuss their work in the following section (Carr and Vandiver 2003, Rousseau et al 2003, Ivanova 2004).

Constantino et al (1986) investigated the use of *cuento* (story telling using traditional folk tales) therapy. The aim of the therapy was to transmit cultural values, to provide models for beliefs and behaviour and to illustrate appropriate relationships for American Puerto Rican children. They were 4 to 8 years old. The researchers compared the outcomes of a cuento therapy, an art / play therapy and a non-intervention group. Younger children showed significant improvement after 20

weeks of cuento therapy in the form of significantly reduced anxiety and increased comprehension. In comparison to the non-intervention group the art / playtherapy group reduced anxiety, but did not increase comprehension. Standard tests were used to measure anxiety and comprehension. Cuento therapy reduced anxiety and aggression (Constantino et al 1990). A later study compared the children with a control group and found reduction of anxiety and phobic symptoms and better school conduct for both children and adolescents (Constantino et al 1994). Zane et al (2004) comment that one additional outcome study, preferably not conducted by Constantino, would make cuento therapy evidence based therapy.

Much of the published literature on psychotherapy with ethnic minorities is conceptual without actual hypothesis testing (Hall 2001), with the exception of the above described cuento studies. I will now look at the available arts therapies literature in the field, which has a similar problem to the intercultural psychotherapy field; conceptual description without much hypothesis testing. I will provide an overview of arts therapies' research into client and therapist variables, where available, to contextualise the more case study based publications in the intercultural field.

### **2.3 Intercultural arts therapies' practice and research**

A critical appraisal of arts therapies research needs to acknowledge that the evidence based practice criteria of medicine's evidence hierarchies (Jones 1998, McLeod 2001) would exclude most of the available arts therapies research. Indeed, Roth and Fonagy (2005) do not include them, while Parry and Richardson (1996) only make a short reference to their existence. The intercultural research studies quoted in Zane et al (2004) are all classified as outcome research. Where there is no adequate body of evidence available for meta analysis, such as in the case of the effect of client-therapist religious belief, this is stated. Several arts therapists discuss evidence based practice related concerns for arts therapies research (Gilroy 1996, Jones 2005, Edwards 2002, Grainger 1999, Wigram et al 2002). Gilroy proposes an alternative for the evidence based practice (EBP) hierarchy of evidence. She suggests criteria for

inclusion. Studies need to be relevant, effectiveness oriented and methodologically rigorous. I have mostly included these studies, but where other studies contained relevant material, but were not directly effectiveness oriented or methodologically rigorous, I have incorporated them with that proviso. The issues around EBP will be further discussed in chapter 3.2.

Direct arts therapies research into culturally sensitive therapy for clients from different cultural background is in the area of child and adolescent treatment. Some of the studies concern individual, some group therapy. Most are in the overlap field of structured art therapy interventions and art education (Gilroy 2006). The only RCT available is the above described Onizo and Onizo study (1989). Follow up research was undertaken by Ivanova and Rousseau. Ivanova (2004) researched art therapy with orphans in Bulgaria, while Rousseau et al (2003) worked with migrant and refugee children in an educational setting using myths. They used observation and action research methods. Image making and story telling were shown to lead to improved self esteem, concentration, participation and behaviour. All studies included group treatment, and raised the need for structure and flexibility (Carr and Vandiver 2004). I will return to this in section 2.5 when discussing research and debates around arts therapies group treatment.

Various arts therapists have researched therapist perception of their practice and the inherent value systems embedded in that practice. Roger Grainger (1999) used qualitative investigation to study the values of dramatherapists. He applied Kelly's personal construct method to identify constructs related to spirituality. He randomly selected 11 UK based dramatherapists. He asked them to construct a repertory grid to establish the degree and significance of their ways of evaluating dramatherapy processes and techniques. He then analysed implicit religiousness criteria in the constructs. He concluded that the results show the significance of factors in dramatherapists' values which are normally associated with spiritual awareness and religious belief (Grainger 1995). It is difficult to know if and how these values affected practitioner practice as the research is not outcome oriented.

Aldridge (1996) drew on Kelly's construct theory to analyse music therapists' ways of construing their practice with children. The therapists created their own constructs, when asked to select clients with whom they were working and their associated personal meanings. Two therapists were asked to select three individual cases. Aldridge used the findings to identify issues for supervision; to enable the identification of different constructs between supervisor and supervisee, either as a basis for looking at transference, or as a base for looking at cultural differences in ways of construing. Clients were ranked as different-similar and near-far on two construct continuums. The different-similar was of the clients to each other, the near-far was between the client and therapist. Personal constructs were then charted along these two axes and evaluated with the therapists, using their own words. Aldridge advocates this 'construct method' as a form of qualitative self-inquiry, with a collaborative inquiry between researcher and practitioner.

These two studies, though valuable as a way of looking at therapist values and research methodology, do not provide data for client and therapist background variables. Neither Grainger nor Aldridge considers the effect of cultural variables on the values and meanings given by the therapists to their work with the clients. Aldridge does look at cultural perception of musical instruments, but an analysis of cultural background variables of client and therapist is absent.

Therapist characteristics, as considered useful by therapists in affecting outcome, were more directly researched by Valente and Fontana (1993). The researchers identified characteristics by interviewing 12 leading UK dramatherapists; a similar strategy and sample size used by Karkou across the arts therapies (2006) and Grainger in the construction of repertory grids (1995). From the 12 sets of data Valente and Fontana identified 354 categories of dramatherapy qualities and influences. These were categorized in a questionnaire and sent out to all UK registered dramatherapists through the professional association. Over 50 % responded, 84% of whom were registered dramatherapists, 14 % associates-mostly from differing professional backgrounds with an interest in dramatherapy. The study does not differentiate between the two categories in its findings. The respondents identified the most important role skills (listening, observing, supporting, identifying issues and staying

calm in crisis), desirable personal qualities (self-insight, motivation, empathy, sensitivity and spontaneity) and the most important theoretical influences (group dynamics, psychotherapy, theories of play and creativity, child development, client centred therapy and imagination).

The role and personal qualities identified in Valente and Fontana's research can be usefully compared with therapist characteristics associated with the development of a positive therapeutic alliance (Ackerman and Hilsenroth 2001, 2003). That research identified seven important therapist characteristics: empathy, warmth, understanding, perceived trustworthiness, experience, confidence and perceived investment in the treatment relationship. Casson's (2004) research involved client perceptions of useful therapist characteristics, which valued warmth, empathy and understanding, being respectful, dependable and trustworthy. Casson's research can also be used to compare the theoretical influences identified by Karkou (2006). He identified -in order of influence- humanistic, eclectic / integrative, artistic / creative and psychodynamic trends. In contrast to Valente's findings the developmental orientation was not significant, although Karkou's comment on a combination of approaches may suggest that the developmental aspect is integrated with the psychodynamic, or with an emphasis on creative artistic play.

Regarding therapist values, Gilroy (1995) looked at pivotal youth influences on 16 art therapy trainees that led to their choice of career, with an emphasis on their development as artists. She identified three types of origin of interest. The interest is seen to arise from the encouragement the artists receive, their talent and 'love affair with the world' and the individual's pathology. Value influences regarding the importance of art in early youth were present for all. Regarding therapy values, Gilroy (1995) studied the 'psychosocial' relationships of art therapy trainees in their training groups for two consecutive years, identifying their VCIA roles (members who are Influential, Active and who's Values are Congruent with the goals in the group). These are the roles identified as facilitating and experiencing therapeutic change, although it is interesting to note that the trainee's values affect their congruence with the group. Gilroy indicated that Liebermann's research (Liebermann et al 1973) showed that VCIA members self-perception changed during the group.

Changes identified by Gilroy (1995) were in the areas of increased group cohesion, spontaneity, openness and reduced fear. Public (perceptions from others) and private (self) perceptions differed, the latter usually perceiving greater changes than the former.

Correlating occupational motivation with changes in perception, art therapy students (in parallel with psychotherapy students) experienced significant losses in their childhood and adolescence, as well as emotional distress, unhappiness and severe physical illness as adults. Fifty percent used art as a means of self exploration and to escape from unhappy circumstances. How these early difficulties had been integrated and whether they affected their practice outcomes could be a useful area for further research, given psychotherapy outcome research indicating that therapists with better levels of adjustment have better outcomes (Roth and Fonagy 2005). Payne (1995) also ascertained, through interviews, the use of the training group for the personal development of dance movement therapy trainees. The impact of training on practice as suggested for further research by Karkou (2006) could build on some of these existing studies, but the lack of demographic detail limits their potential benefit for this study. The interesting aspect of these final two pieces of research is that client perceptions form the basis of the research and are based on group therapy. Generalisability to clinical contexts will require further research.

Demographic arts therapist variables have not been researched, but certain publications provide conceptual descriptions. Social constructionism influences Hogan (1997, 2003). She looks at gender as an aspect of client and therapist identity, connected to the effects of oppression in the areas of sexual orientation and race:

“The therapeutic relationship that is central to the treatment process has been identified as a critical variable in working with people of colour (Comas-Diaz 1994; Jenkins 1990) as well as with women generally.... This relationship is dependent on the awareness of the therapist’s knowledge and self awareness of ethnocultural and racial factors and how they affect therapist and client” (Hogan 2003: 189)

Hogan’s advocacy of the culturally sensitive approach is echoed in Campbell et al (1999), edited by five art therapists from different cultural backgrounds. They self identify as African-Caribbean, British, Irish and Jewish and stress the importance of

their respective cultural backgrounds on their UK practice. Barber and Campbell (1999) reflect, analogous to Gilroy's research, on their early formative experiences affecting their professional development as art therapists, including the effect of racism. They differentiate the racialised (linked to ethnicity and culture) and colourised identity (as black women sharing the experience of oppression and discrimination). Although drawing on some psychodynamic concepts, they identify narrative and co-construction approaches as useful to their practice as black art therapists (Anderson and Gulishian 1992). Lawrence identifies her spirituality as an important element in her professional and personal development and identity, connected to her Caribbean and African ancestry (1999). Schaverien studies client-therapist match around Jewish identity, drawing on a psychodynamic perspective of racism and the scapegoat transference (1999, 1996). Roy (1999) identifies the multiplicity of identities within a cultural group which affect expectations about therapy, drawing on Falicov's (1995) multi-dimensional framework for cross-cultural therapy from a systemic perspective.

Further discussion on the effects of racism is provided by Jones and Liebmann. Jones (1999) self identifies as white, working class and Anglo-Irish, but focuses in her description on black-white differences and racism, rather than on her own migrant and class identity. Liebmann (1999) does the same, but draws on her identity as a second generation Jewish migrant to identify with oppression. The volume also includes two chapters on art therapy training in the UK from a black perspective. Brooks (1999) critiques the cross-cultural perception of 'the other' as being different and training being geared towards a black client-white therapist dyad. Ward (1999) interviewed black and Asian art therapy trainees (sample size not given, nor structure of interviews clarified). Her chapter advocates developing 'cultural reflexivity' in training (Toledano 1996). She emphasises the need to adapt art therapy practice, potentially a move away from the more classical psychodynamic model to more arts oriented approaches (Huet 1997). Huet's practice area was psychiatric rehabilitation, so may additionally be applicable to the setting / treatment variable of my fieldwork.

Campbell et al's volume is placed in context by a slightly earlier American volume (Hiscox and Calisch 1998). Annoual (1998) reviews the available intercultural art

therapy literature and critiques it for not addressing racism directly, with some exceptions (Lewin 1990, Venture 1977). The literature raises the need to study ethno-cultural factors in therapy (Campanelli 1991) and the importance of the art making process in its socio-economic and cultural context (Ciornai 1983). The Campbell et al volume addresses UK racism and emphasizes 'black' and 'white' identity as an important distinction for self-identification.

Annoual (1997) uses 'blackness' as an identity construct to differentiate between subjective and objective identities. Issues of racism can be addressed in the therapy situation through 'blackness'. In the same volume Sidun and Ducheny (1998) address white racial identity and its impact on clinical work. The authors critique the unspoken aspects of being white in art therapy training. In 1995 91.5% of art therapy trainees in the US were white (Pearson 1995). They use white racial identity models for development (Helms 1992, 1995; Ponterotto 1988) to develop an experiential training model. This model aims to develop cultural self reflexivity in art therapy training. The rest of the volume discusses, in a similar manner to American intercultural psychotherapy research, adaptations of approaches to particular cultural backgrounds, i.e. an Afrocentric approach (Boston and Short 1998) and adaptations of practice for Native Americans (Ferrara 1998, Farris-Dufrene and Garrett 1998). The practice is sometimes different to UK practice in its emphasis on personality assessments (Ferrara 1998) or art tasks set to facilitate identity formation (Mauro 1998). The latter may occur in the UK depending on the group therapy orientation of the art therapist (see 2.5). The connections to training (Hiscox 1998) and supervision (Calisch 1998) raise similar issues to those in the Campbell volume. The chapter by Gilroy and Hanna (1998) highlights the tensions between psychodynamic and organic approaches in Australian psychiatry. The Australian socio-economic health climate of 'down sizing' is applicable to current UK psychiatry, with its emphasis on the National Institute of Clinical Excellence (NICE) guidelines and EBP.

So far, this review of intercultural arts therapy practice has focussed particularly on art therapy literature. Jones (2005) critiques the separation of the arts as being an inherent western dominated tradition, where the practice separation of the arts form have resulted in a separation of the arts therapies modalities (see 2.1). He warns that

“People whose culture of origin does not recognise this division may find the separation of the arts restrictive, alien and even racist in its assumption” (Jones 2005: 53).

Certain case studies emphasise the combination of arts approaches. Eldredge and Carrigan (1992) combine art and story telling. In the UK this practice tends to be separated between art and dramatherapy, although other art therapists have also drawn on story telling (Rousseau et al 2003). UK examples comprise Afro-Caribbean dramatherapy practice using dance, theatre and music (Braithwaite 1998) and integrative arts therapy practice with a Ghanaian client (James 1998). Both Braithwaite and James discuss their dramatherapy work in a context of post colonial oppression and racism. The issues of gender and the effect of first generation migrant isolation on mental health are addressed through South Asian dance, music and myths in dance movement therapy (Subramanyam 1998). Regretfully, neither of these therapists discusses the impact of their own identity on the therapeutic process.

In contrast, Mereni (1996, 1997) discusses and uses his sub Saharan African identity to look at the potential connection between traditional healing ceremonies in Africa and his UK training in music therapy. He looks at musical forms as well as concepts of healing and illness in a similar approach to Subramanyam. Mereni identifies two core concepts in Afro-centered music therapy: kinesis and catharsis. Mereni’s articles provide a conceptually driven, rather than a practice driven analysis. Some early intercultural music therapy practice papers are also from Africa (Benjamin 1983, Dervisch and Vervaeck 1986). They locate the music in African hospitals as part of a cultural context, which combines music with drama and dance. Music is used as a vehicle to reach those who are isolated and withdrawn and reintegrate them into social relationships. The Tunisian context (Dervisch and Vervaeck 1986) combines dance, painting, claywork, role play and singing to integrate personal experience and emotion in a social context of relationships. The rationale is that in Arab tradition the body is regarded as the meeting place between soma and psyche, locating psychiatric illness within social relationships. Culture is seen as a source of meaning through cognition and social relationships.

Ruud, a Scandinavian music therapist, also stipulates that music therapy needs to be studied as part of a socio-cultural and political community (Ruud 1998). Stige, a Norwegian music therapist, advocates culture-specific music therapy (Stige 2002). She refers to Brown (2001) for a Canadian context, Estrella (2001) for intercultural supervision and Forrest (2000/1) for an Australian context in recent discussions of multi-cultural music therapy. Stige (2002) advocates cultural reflexivity on music therapy as a culture to develop new ways of conceptualising about practice, as well as practice adapted to a variety of cultural backgrounds. Stige's ethnographically informed research uses three case research studies. The first two relate to group and individual therapy with learning disabled clients, the third concerns 'individual music psychotherapy' in a psychiatric clinic. The focus is on meaning making in a culture-centered perspective, using hyper-textuality as a conceptual framework, potentially interesting to compare with Grainger (1995)'s research into message and meta message in dramatherapy. Stige looks at client metaphors used to give meaning to the music therapy experience. The demographic background details of client and therapist are regrettably not part of the case study. I will refer back to this research when looking at methodology (chapter 3), rather than explore it in further detail here.

Casson (2004) incorporates client perceptions of what is helpful and hindering in individual and group dramatherapy and psychodrama in a psychiatric context. The sample of 15 clients was diagnosed as schizophrenic (14), psychotic (5), depressed (3) or personality disordered (2). Casson's humanistic / creative therapist perspective is critical of the 'medical model' diagnosis. He placed hearing voices, the focus of his research, in a cultural context of meaning. His researched practice is in the UK, comprises three groups of 20 weeks each. The groups were offered sequentially. One comprised men only, two were mixed gender. Of the 5 women and 10 men, 4 dropped out (1 woman and 3 men). The clients were 20 to 50 years old (15 in their 20's and 30's; 5 in their 40's and 50's). Their cultural / ethnic background was given as 1 African, 1 South East Asian, one half Jewish, one second generation from Ukrainian migrant parents and one half Spanish adopted at birth by British parents. Three of these clients were from refugee backgrounds.

The helping and hindering factors were obtained through client diaries and interviews. The interviews were conducted by research assistants pre, during and post the 2<sup>nd</sup> and 3<sup>rd</sup> group and through focus groups with the therapist during the 1<sup>st</sup> group. The helping factors were identified as: fun and play, laughter, empowerment, flexibility, freedom and showing rather than telling (especially for those clients who were less verbally articulate). In group therapy cohesion, positive attachment, catharsis, self esteem, interpersonal learning and instillation of hope were felt to be particularly helpful. Unhelpful factors were more difficult to ascertain. Out of 13 respondents, 6 could not mention any. The 7 respondents mentioned interpersonal difficulties within the group, a lack of consistent group attendance and a lack of support outside or beyond therapy as unhelpful. Casson did not provide full demographic cultural background details of either himself or the other 'white' identified clients in the group. Nor did he connect client perceptions with individual cultural background variables. The context of his approach and orientation within arts therapies group therapy is discussed in 2.5.

The culturally sensitive models of psychotherapy proposed in the American intercultural psychotherapy research literature are discussed in a variety of arts therapies practice based articles. These chapters and articles do not necessarily conceptualise, but identify intercultural issues for practice and potential conceptualisation in the following areas. The issue of empowerment (as identified by Casson's clients) is reflected interculturally as important by Ryde (2002), Bradt (1997) and Lewis (1997). Different client-therapist expectations concerning the non-directive role of the therapist were identified by Hanna (1990), an American dance movement therapist in Taiwan and Case (1990), a UK art therapist in Hong Kong. Waller (1993) also identified this different expectation of the therapist in a European context, influenced by religious value systems (1993). A psychodynamic theoretical orientation of the therapist may play a role here, although Casson's humanistic / creative orientation still resulted in client feedback that they needed him to be more "visible and audible" (Casson 2004: 220). It is important to note that acculturation stress is exacerbated if the client is expected to adapt to the therapist's value systems (Skaife 2000, Jones 2005).

The arts therapies' discomfort with medical model diagnosis (i.e. Karkou 2006, Jones 2005, and Casson 2004) needs to be considered interculturally. Labelling and types of treatment offered are influenced by ethnic, cultural and class factors. Offered treatment needs to incorporate the possibility of differing worldviews (Sue 1998). This awareness is shown in articles discussing acquiring bi-culturality for Ethiopian immigrants in Israel (Cohn 1997), Black Canadians (Braithwaite 1997) and a Japanese American (Linden 1997).

The issue of group interdependence as different from individual independence is identified in intercultural psychotherapy research (Sue 1998). This issue is raised by Orth (1992, 1998) a music therapist in the Netherlands working with Vietnamese refugees and in the aforementioned work of Case (1990, 1998). Boston and Short (1998) contrast an Afrocentric group orientation with a Eurocentric individualistic approach. In the East Asian context therapist valuing of openness (Gilroy 1995) may run counter to a client expectation of the need to preserve face and family honour (Case 1998, Orth and Verburcht 1998). The practice with refugee populations may need to take socio-political, as well as cultural considerations into account (Callaghan 1996, Dokter 2003, Lloyd and Kalmanowitz 2005).

Client-therapist ethnic match may be important for those less acculturated clients whose English proficiency is limited (Zane et al 2004). Arts therapies as a potential non-verbal medium in this context (Wong 1981, Wengrower 1992), has been critiqued (Waller 1993: 15):

“Images certainly provide another means to express ourselves, but without the dialogue which surrounds the making and reflection on them, there is a limit as to how much can be shared and their various levels explored “

Others stress the cultural specificity of the non-verbal form; in images (Moon 2000, Acton 2001), in embodiment (Dosamantes-Beaudry 1997) or the selection of music on the basis of religious meaning (Henderson 1991, Amir 1998). The latter connects to psychotherapy research on the therapist using congruent interventions (Propst et al 1992). When the client operates in a second language the power dynamic between

client and therapist needs to be considered again (Casson 2004, Jones 2005, Dokter 1998).

Almost all these case studies are written from the therapist's perspective. A limited amount of literature is available about the client experience of arts therapy. In addition to the already quoted Casson (2004) study there are some client narratives in the available literature (Warriner 1994), some co-written with their therapist (James 1998). The latter practice, though interesting, is likely to be heavily influenced by the therapist perspective or the effect of audience. The clients may articulate what they think the therapist wants to hear. This effect is also prevalent with other data collection methods, such as therapist facilitated focus groups (Casson 2004) or therapist generated client narratives of their therapy experience (Hibben 1999). Hibben's volume contains client and carer generated narratives of music therapy experiences too, but regrettably the cultural context of the experiences is not detailed. Most of the narratives document American practice, although occasional narratives from Europe (Italy, Great Britain and the Netherlands), Israel, Australia and Japan are included. A client-therapist match is assumed, but not stated or analysed within the case studies. Client perspectives on art therapy have been obtained through retrospective picture reviews (Schaverien 1992, 1995). I will return to this in chapter 3.

The above narratives on client and therapist variables influencing their perception of the effectiveness of the arts therapy are partly rooted in humanistic psychotherapy research into client – therapist congruence. In the final sections of this literature review I present research on client – therapist congruence and arts therapies group treatment in the context of arts therapies in UK psychiatry.

#### **2.4 Client-therapist congruence**

Most research into helping and hindering processes as perceived by clients and therapists can be found in humanistic / client centred psychotherapy research, as reflected in Casson's (2004) research. Congruence in client centred therapy is understood as authenticity (Lietaer 1992, 2001; Mearns and Dryden 1990),

immediacy (Turock 1980) and genuineness (Greenberg et al 1983). Congruence has also been appropriated by researchers studying concordance in client and counsellor attitudes, beliefs or reactions (Benbenishty and Shul 1987). Grafanaki and McLeod (2002) identify various client and therapist micro processes that contribute to the accomplishment or creation of moments of congruence and incongruence.

Toukmanian (1996) reviews different studies investigating the processes that mediate changes in client perception. The methods tend to be twofold. The first strategy is mainly quantitative. Although the client may be called upon to provide information about their experience of therapy, it is usually indirect. These studies rely mainly on the researcher's understanding of the nature of change in psychotherapy. Their weakness is the exclusion of the client as a valid source of information about the therapeutic process. The second strategy is qualitative, which tends to be concerned with the client experience per se. Psychotherapy, like any other strand of social interaction, is seen as a co-constructive process that can be studied only from the vantage point of the client's and therapist's experience. Consequently, all these studies elicit both therapist and client perceptions through a variety of research methods, such as post session questionnaires with evaluation rating scales and interviews (Lietaer 1992, Lietaer and Neirinck 1986 Angus and Rennie 1988, Angus 1986). The analysis tends to be a mixture of quantitative and qualitative.

All studies concern individual therapy and do not look at client - therapist individual cultural variables, but are more concerned with process factors in the therapy itself. An additional difficulty is identified by Grafanaki (1997, pp 30):

It seemed to us that one of the difficulties involved in studying congruence was that it represents a core value within humanistic therapy...it is taken for granted and not reflected upon in any way. This is surely because of the profound cultural importance within modern western societies of notions of 'sincerity' and 'genuineness'. If this is the case, then it would seem highly probable that people with different cultural backgrounds would have different experiences and preferences in relation to this process.

She suggests multiple case study designs with clients of different cultural backgrounds. I will return to this in my methodology discussion. Despite earlier

mentioning the importance of the two way relational interaction, she does not mention the possible effect of therapist cultural background.

## **2.5 Arts therapies group treatment in UK psychiatry**

This section reviews the different orientations within arts therapies group work as practised within UK psychiatry. Some of the main tension points and debates are highlighted to place the fieldwork practice in its national UK context.

UK arts therapists working in health comprise 48.7 % of music therapists, 58.7 % of art therapists, 29.4 % of dramatherapists and 27.5 % of dance movement therapists (Karkou 2006). The respondents in Karkou's study worked 59.9 % in mental health. As this covers all forms of emotional / behavioural difficulties some of these therapists may work in educational settings. A number of the arts therapists working in health treat clients with learning disabilities, those in general health, child or elderly psychiatry. The percentage of arts therapists in adult psychiatry will thus be smaller than indicated.

Historically the use of the arts in psychiatry has been an important route for arts therapies development (Jones 1996, 2005; Waller 1994, Stanton-Jones 1992, Wigram and de Backer 1999). Originally the arts might have been connected to occupational activities (Gilroy and Lee 1995), to diagnosis or recreation (Edwards 1989). The original work might have been group based in the form of studio work (Hill 1945, 1951) or might have consisted of "drama in conjunction with psychiatry and psychoanalysis in a group psychotherapy setting" (Solomon 1950: 247).

Jones stresses a shift towards more contemporary understandings of arts therapy during the 1980's and 1990's. Definitions increasingly stress (Jones 2005):

- the therapeutic use of art making in a professional relationship
- creating art and reflecting on the arts product and processes
- an explicit expectation of changes in the client's condition resulting from the intervention
- arts therapies as therapies in their own right.

Despite the long standing relationship between arts therapies and psychiatry, Jones, like Karkou (2006), identifies the tension between arts therapists, their clients and “medical model practice” (Jones 2005: 89). He also connects this to the tensions in the quest for EBP.

Jones identifies different orientations in arts therapy group treatment, from activity-orientation to a more counselling / psychotherapy orientation. He looks at music therapy (Dawes 1987), but a similar range is identified in art therapy by Skaife and Huet (1998), when they review the development of art therapy group practice in the UK. Waller (1993) discusses the evolution of an open studio model in art therapy within psychiatric hospitals, but also the development of group dynamic practice from the late 1960's. Liebman's book (1982) straddles between art therapy and more therapeutic art making groups, a form of practice reflected in the other arts therapies by creative drama in groupwork (Jennings 1986), creative movement in groups (Payne 1989), as well as Campbell's book on creative art in group work (1993). Recent publications show that this theme-centered, therapeutic arts practice continues across the arts therapies (Pavlicevic 2003, Meekums 2002).

The use of therapist initiated structures is an issue of contention for group analytic / group dynamic oriented arts therapists (McNeilly 1983, 1987, 2006; Davies and Greenland 2002, Holden 1990, Woodcock 1987). The issue is discussed in the context of the debate about directive versus non-directive approaches (Karkou 2006). The original art therapy group studio practice continues to be practised in the current psychiatric context (Case and Dalley 1992, Killick 1997, Saotome 1998), while several arts therapists combine a number of approaches, both directive and non-directive, and orientations in their practice (Skailles 1990, Strand 1990, Loth 2002). The models of practice may be timelimited groups with a closed membership, open groups (changing membership each session), slow open groups (ongoing with a set number of members, when someone leaves they are replaced by a new member).

Waller wrote the first book on art therapy group practice (1993), which drew strongly on existential roots. In the special issues of the journal *Group Analysis* that she guest

edited (Waller 1990) dramatherapy was absent. In her more recent publication, Karkou (2006) also does not discuss group therapy practice in dramatherapy. She does look at different orientations in group therapy in art, music and dance movement therapy. It may be that this is an area for conceptualisation in dramatherapy, as practice descriptions abound (Jennings 1987, 1992; Mitchell 1996, Donovan 1996 amongst others).

Skaife and Huet (1998) critique the 'purist' group analytic model of art therapy. They indicate it may require adaptation to the variety of settings and client groups art therapists work with. Adaptation may especially be needed for clients in states of higher dependency on authority figures than traditional group analytic clients. They raise three dilemmas in art therapy group work. The first is whether using the art effects the working through of group transference. They state that the use of the art in groups is the chief factor of empowerment. It creates a reduction in dependence, not appreciated on a cognitive level. Two case examples illustrate this in elderly and addiction contexts (Byers 1998, Springham 1998). However, both are written from the therapist's perspective. Given the emphasis on a lack of cognitive appreciation, the therapist perspective potentially excludes other perspectives. Skaife and Huet identify secondly: does the symbolic / metaphorical aspect of art take precedence over the working through of feelings in a visual / aesthetic medium? Does the verbal aspect threaten to predominate over art making? The understanding of the symbolic aspect of art is that all images are considered as indirect client communications about the relationships in the therapy session (Springham 1998). Art is seen as a sign in the context of semiotics (Karkou 2006). Schaverien (2000) discusses similar symbolic processes when discussing diagrammatic (type of icon) or embodied (symbol) images. The dilemmas are addressed through individual space for client art making, while the group dynamic therapeutic process is enabled through group art making. However, the authors (Skaife and Huet 1998: 14) state that

“with clients, who could make use of a verbal analytic therapy group, dilemmas arise between the use of verbal interaction as the therapeutic medium and art making”.

In relating the individual art making to group process they use McNeilly's concept of resonance (1990) to connect the individual (images) unconsciously to the 'group-as-a-whole' dynamic (Foulkes 1964).

Jones (2005) identifies similar dilemmas for group work in dance movement therapy (Stanton-Jones 1992, Steiner 1992). Dance movement therapy group work that is psychodynamically informed (Whitehouse 1979) influences group 'authentic movement'. This emphasizes unconscious movement, which is considered to convey underlying emotions (Levy 1988). Groupdynamically informed DMT (Sandel and Johnson 1983) is distinguished from the interactive Chacian approach (Schmais 1986, Karkou 2006) and from a movement based approach centered on movement analysis (North 1972, Higgins 1993).

Music therapy reflects the dilemma in a dialogue about the use of music in group analytic experiential music therapy training groups (Davies and Greenland 2002). Skaife and Huet (1998) discuss their experience in art therapy experiential training groups. They discuss the structuring of a session between talking and image making. This creates a tension between interactive verbal work and the making and considering of art work. Payne (1995) invited student perceptions of the uses of movement in their movement therapy training group, but looked more at the purpose of personal development components in the training of therapists.

Arts therapies research on group practice in a psychiatric context is varied. Kymiss et al (1996) provides an outcome study of the effect of group art therapy with inpatient adolescents. It studied 4 brief art therapy groups of 12 weeks with adolescents with a variety of psychiatric diagnoses (a parallel discussion group used as a control). The findings showed the greatest improvement in the art therapy group (although the difference was not statistically significant), and that the art work facilitated group cohesion.

Gilroy's (2006) overview of art therapy research with adult psychiatric populations is grouped under different diagnoses and covers both brief and longer term therapy, as well as work in different settings. Relevant to this study is the research into trauma,

eating disorders, addictions, severe and complex problems. Group treatment in addiction focussed primarily on brief time limited interventions (Springham 1998, 1999; Julliard 1995), as did the work with trauma (Waller 1992, Brooke 1995). Dance movement therapy research on group intervention with female sexual abuse survivors (Meekums 2000) included longer term work to develop a symbolic 'metaphoric' body through creative process oriented movement work. Art therapy group interventions for clients with eating disorders stressed the role of the art as mediator between client and therapist (Waller 1994, Luzzato 1994), the development of symbolic thought (Levens 1995) and structuring a long term group with clearly demarked time for talking and image making (Rust 1994). A 6 month dramatherapy group intervention echoed the art therapy findings of developing symbolic thought and working through the arts process rather than interpretation (Dokter 1996).

Art therapy research into severe and complex problems is mainly focussed on clients with psychotic disorders, often in the context of longer term group or individual work. The importance of the physical space and setting, as well as the therapeutic relationship (Greenwood and Layton 1987, Killick 1995, 1997) is stressed. The use of drama to give meaning to hallucinations (Casson 2003) or restructure cognitive processes (Grainger 1991, 1999), both in time limited groups, provided a more creative / action orientation to the group work research.

Dance movement therapy, dramatherapy and music therapy research has also focussed on the development of diagnostic tools (Higgins 1993, Dent-Brown 1999, Pavlicevic and Trevarthen 1989). Early music therapy research is available using questionnaire evaluation on a residential psychiatric ward (Bunt, Pike and Wren 1987). Music was used in the context of group psychotherapy to encourage the awakening of emotion and to help clients cope with unconscious intrapsychic conflicts (Gross and Schwartz 1982, Kaufmann 1983). It was also researched in treating schizophrenia (Pfeiffer et al 1987, Schmuttermayer 1983). Group music therapy was the treatment of choice in adolescent psychiatry (Behrends 1983, Friedman and Glickman 1986), especially in the area of drug abuse.

Odell-Miller (1999) analysed significant moments for individuals in group music therapy related to outcomes desired at referral. The group was psychodynamic, slow open ongoing and takes place at a psychiatric day centre. The clients were from mixed psychiatric diagnostic backgrounds and gender (aged 30 to 56 years old). The methodology invited regular evaluation through client perceptions elicited in the group. Their perceptions were used for the design of a research project looking at therapy outcomes. The study elicited both therapist and client perceptions, as well as using standardised tests (Odell-Miller et al 2001). I will return to this when looking at methodology in chapter 3.

## **2.6 Chapter findings and conclusions**

This chapter has identified the main debates / questions that influenced my research question and methodology. The findings are:

- UK Arts therapies' debates center round self definition as a form of psychotherapy or an artistic modality and the separation of the modalities. National registration is through the Health Professions Council as separate professions. Self definition affects therapist theoretical orientation; as do setting and previous training (Karkou 2006). Intercultural research and practice studies show some integration and adaptation of different modalities in practice.
- The latest review of intercultural psychotherapy research identifies the importance of the interaction between client, therapist and treatment variables affecting outcome (Zane et al 2004).
- In both the US and UK there is a debate around empirically supported therapies (EST) or culturally sensitive therapies (CST). Diagnosis as transcending individual difference variables, as assumed in EST, has been critiqued by CS therapists who advocate adaptation of therapeutic technique and identify the difficulty for BME clients of accessing psychological

therapies. They advocate the use of individual client feedback and monitoring of individual clients in research.

- The early establishment of a positive therapeutic alliance is especially important to black and minority ethnic clients (Jenkins 1997). One research difficulty is inter-group comparison with whites as an assumed homogenous group. Current research needs to focus more on within group comparison, with a major interest within the study of effectiveness centering on how contextual and individual client and therapist difference variables moderate the effects of treatment (Zane et al 2004).
- Arts therapies research has identified certain therapist values inherent in dramatherapy and music therapy practice (Grainger 1995, Aldridge 1998, Valente and Fontana 1993). Two additional pieces of research looked at trainees' changes of values through an experiential art therapy and dance movement therapy training groups (Gilroy 1995, Payne 2005). Generalisability of all arts therapies research to BME groups is difficult, because the necessary demographic details on client and therapist background are not systematically available.
- Arts therapies intercultural practice studies indicate a similar debate to that in psychotherapy around the need for culturally sensitive therapy (Hiscox and Calisch 1998) and the effects of racism in the therapeutic relationship (Campbell et al 1999), incorporating some effects of client and therapist ethnic / cultural background.
- A wider body of articles of varying validity and generalisability provides an insight into therapist-client conflicts in the areas of power and oppression in the therapeutic relationship, understandings of health and illness, individual or group orientation and the verbal / non-verbal cultural context of the arts form.
- Generalisability of US intercultural psychotherapy research is problematic, humanistic congruence research provides practice findings more akin to UK

arts therapies practice. Its methodology incorporates client and therapist perspectives and stresses the usefulness of multiple case study research.

- Arts therapies' psychiatric group treatment incorporates different models of practice (time limited closed groups, open groups, studio based groups, slow open groups) and theoretical orientations. Conceptual debates are directive vs. non-directive approaches, the dilemma between individual and group space and whether the symbolic / metaphorical process of arts making takes precedence over the working through of feelings verbally (Skaife and Huet 1998).
- The dilemmas identified are conceptually driven by the therapists. The client perspective and a look at the interaction of client, treatment and therapist variables affecting actual practice are needed. This is in parallel to the needs for research identified in intercultural psychotherapy (Zane et al 2004)

I discussed in chapter 1 how the intercultural psychotherapy research questions the direction of my research. The EST / CST debate was echoed in the UK practice setting, while congruence research raised some issues about methodology. I will elaborate on the formulation of the hypothesis and the methodology chosen in the next chapter.

## **Chapter 3 Research design**

### **3.0 Chapter overview**

This chapter outlines the journey of the search for a research perspective to the formulation of the research question and the choice of methodology to address that question. I will discuss how the setting and the pilot studies influenced the design.

The initial search for a research perspective included published work up to 1997. During the actual field work and analysis stages other studies were published which influenced the multi-modal approach to data gathering and analysis. The findings are contextualised in the up to date literature review.

### **3.1 The research question and its basic concepts**

I formulated the following hypothesis for the research:

“Intragroup cultural background differences of therapist and client will adversely affect client – therapist consonance in their perception of the efficacy of arts therapies’ group treatment”.

Intragroup differences are differences defined by the heterogeneity within a cultural group. Sue (et al 1991) stated that ethnicity involves shared social and cultural characteristics that have a bearing on psychological functioning. Ethnic groups are those who conceive of themselves as alike by virtue of common ancestry, real or fictitious, and who are so perceived by others (McGoldrick 1996). Culture is a system of social institutions, ideologies and values that characterise a particular social domain. Its traditions and beliefs are systematically transmitted to succeeding generations (Landau 1982). McGoldrick distinguished 8 within-group cultural heterogeneity factors. Cultural differences refer to variations in actual attitudes, values and perceptual constructs that result from different cultural experiences (Zane and Sue 1991).

As noted before, psychotherapy research identified differences in perception and meaning between therapist and client that affect congruence (Benbenishty and Schul 1986, Lietaer 1992, Toukmanian 1996), contributing interculturally to client

engagement or drop out (Sue, Zane and Young 1994). The establishment of an early positive therapeutic alliance was found to be crucial, particularly for black and minority clients (Jenkins 1997). My hypothesis aims to find out whether intragroup cultural differences may also contribute to value divergence between clients and therapists leading to perceptual differences of helping and hindering processes in arts therapies groups.

In art therapy the clients engage both with the therapist and with the artistic medium in a triangular relationship (Case 1990, Schaverien 1990, 1992; Wood 1990). This concept of a triangular relationship was further developed (Schaverien 2000) and also adopted by other arts therapists (Jones 2005, Karkou 2006). I used the concept of a triangular relationship as part of my study. To indicate this, I used the concept of consonance in the hypothesis. This term links the understanding of the arts to the more humanistic psychotherapy concept of congruence. It is defined as follows: consonance is an agreement in meaning, a musical concord. I want to look at the consonance between therapist and client about the meaning of the arts therapy group. What do they think is useful in the sessions, what is not? Does this relate to clients continuing or dropping out of therapy and if so how? Is dissonance affected by cultural identity, if so which variables play a role? Which treatment variables affect client-therapist dissonance in interaction with client and therapist variables?

### **3.2 The journey to a research perspective**

The fieldwork takes place in the arts therapies department of a large psychiatric hospital. It was originally established as a 'lunatic asylum', but has now become a mental health NHS Trust. The region it serves includes two cities and a large rural (non-urban) population, including small market towns and villages. The art, drama, music and dance movement therapists work in a joint department under the management of a music therapist, going out to various acute inpatient wards (adult and elderly), day patient settings (some rehabilitation), as well as providing outpatient work (individual and group). The department has studios for each of the modalities, but therapists also work on the wards and units themselves.

Hall (1992) emphasises that we all speak from a particular place, out of a particular history, experience and culture. The cut and mix approach of diaspora experience and identity needs to be looked at in a post-modern context of self and identity, both for the therapist and the client.

The literature search focussed my interest on the third research question Sue, Zane and Young (1994) formulated. Which client, therapist and situational variables are associated with positive treatment outcomes? The lack of intragroup comparison and the assumption of a white highly acculturated homogenous group are applicable to the region setting chosen for the research. I often encountered the response that inter-cultural practice is not relevant to this area as the clients and therapists are mainly white. This seems to be a mixture of the colour blind (Acton, 2001) and focussed multicultural (Bradt 1997) approach. A more active culture of racism may also be present in the National Health Service (NIMHE 2003). This echoed Pajaczkowska and Young's critique (1992) that the difference is located outside the self without an awareness of the effect of one's own identity.

Zane and Sue (1991) emphasize the need to distinguish between ethnic and cultural differences. Ethnic difference is the difference in group membership that implies differences in culture. The cultural differences refer to variations in attitudes, values and perceptual constructs that result from different cultural experiences. Ethnic differences are only indirect indexes of more important cultural differences, which tend to be more proximal to psychotherapy processes and outcome. Essentially the study of cultural influences is the study of individual difference variables that are associated with ethnic group experiences. McGoldrick et al (1996) identifies eight factors influencing ethnicity, which I use to analyse client and therapist cultural background for the purpose of my research. The variables identified are:

1. Migration history (first, second or third generation influences)
2. Language spoken in the home (first or second language)
3. Race and country of origin (experience of discrimination, nationality)
4. Family's place of residence (reinforcement of difference by surrounding community)

5. Emotional process re ethnic identification
6. Socio-economic status, educational achievement and upward mobility
7. Political and religious ties to the ethnic group
8. Life cycle

Similar variables have been identified in later research characteristic of within-group cultural heterogeneity (Zane et al 2004):

1. Country of origin
2. Immigration history (voluntary/involuntary)
3. Place of residence (urban / rural)
4. Education level (both in UK and country of origin)
5. Motivation for leaving country of origin
6. Acculturation level
7. Socio-economic level
8. English proficiency
9. Ethnic identification
10. Preferred language

In the context of the Trust department studied all therapists are white, and culturally heterogeneous. Most clients are from similar mixed white backgrounds.

Intercultural psychotherapy research showed that attrition was a direct identifiable outcome factor resulting from intergroup client-therapist cultural differences (Sue, Zane and Young 1994). The research also identified a need to look at interacting client, therapist and treatment variables in the context of within group heterogeneity. The evidence based practice initiative (Pringle 1996, Gilroy 1996) influenced my interest in outcome related research. The literature review showed the debates between empirically supported (evidence based) and culturally sensitive therapy researchers. The UK Department of Health introduced the Effectiveness Initiative in 1995. Its objective was “All health care staff to work together and in partnership with patients to increase the proportion of clinical services shown by evidence to be effective” (EBM 1995).

Evidence based practice (EBP) is characterised by a cycle of activities that seek to guarantee that all interventions are effective, based on rigorous research and to ensure that services are delivered in the most efficient and economic way (Gilroy 2006). Its paradigm is contested, because EBP has created a situation where the methodology of the randomised control trial (RCT) is privileged as evidence above all others. The NHS hierarchy of evidence (Mann 1996: 16) rates:

- A RCT's
- B Other robust or observational studies
- C More limited evidence, but the advice relies on expert opinion and has the endorsement of respected authorities

The Parry and Richardson (1996) review showed how EBP can be developed in the psychological therapies. Together with Roth et al (1996) they show how EBP research should be developed from clinical practice. Qualitative research is not included. This has been critiqued by arts therapists (Gilroy 1996, 2006; Jones 2005), but there is also an acknowledgement that

“art therapists have no choice but to engage with EBP, but...should do so in full awareness of the principles and policies that situate EBP in the UK public sector market place”(Gilroy 2006: 25).

Arts therapies do not yet have the critical mass of outcome research required by EBP and had this even less so at the start of my research journey. A review of arts therapies' research at that time showed the debate around efficacy and ways of researching this. Various authors (amongst others Gilroy and Lee 1995, Payne 1993, Wheeler 1995, Aldridge 1996, Smeysters 1997) wrote about research methodologies potentially useful to arts therapists. Most of this literature concerned qualitative research written with the aim of describing and analysing arts therapies processes. Some arts therapists, the majority music therapists, did quantitative research. They published the controlled trials and correlational studies recognized as experimental research in journals like *The Lancet* (Hoskyns 1982) and the *Journal of Rehabilitation* (Bolton and Adams, 1983). Other researchers (Meekums and Payne 1993, Aigen

1995) advocated new paradigm research, allowing for subjectivity, participatory and holistic knowing and knowledge in action (Reason 1988). Gilroy and Lee (1995) stressed the necessity for outcome studies if arts therapists were to demonstrate that their work is effective.

The new paradigm critique saw traditional experimental research as divorced from the subject and the real world of the clinical environment (Meekums and Payne 1993). Single case study research (Smeysters 1991, 1993, 1997; Aldridge 1993, 1996) was offered as a viable alternative closer to the clinical environment and existing practice. Some single case study researchers advocated the combination of quantitative and qualitative research methodologies to give wider evidence of effectiveness (Lewith and Aldridge 1993, Smeysters 1997, Langenberg and Frommer 1994). I kept in mind Grafanaki's (1997) recommendation of a multiple case design for intercultural congruence research (see 2.4).

My MSc social anthropology familiarised me with the main forms of ethnographic research methodology: participant observation, interviews with key informants and the study of artefacts. Applied ethnography with a combination of quantitative and qualitative analysis of data was my preferred choice of methodology to allow for the combined study of culture and efficacy. Miller and Crabtree (1992) presented a qualitative alternative approach that located clinical research in the nexus of applied anthropology and the practice of health care. They offered a view that made the practitioner and the patient co-participants in the reality of medical treatment. This model treated the medical and social body as a contested site for multiple narratives and advocated a multi-method approach.

As an alternative to ethnography I considered grounded theory. Both perspectives were used in symbolic interactionism by Goffman (1961, 1983, 1989). The advantage of grounded theory over ethnography was that it followed a systematic set of procedures for gathering and analysing data (Travers 2001, Strauss and Corbin 1998). It had also been used for theory building in music therapy research (Aigen 1995). Amir (1992, 1993) applied grounded theory to research client and therapist experiences of music therapy with the aim to describe and understand the experience

of music therapy- including the complexities of subjective relationships and multi-level intrapersonal relationships between clients, music and therapist (Amir 1996).

Art therapy studies into client experience through client interviews were also available (Dalley, Rifkind and Terry 1993; Lett 1993, Spaniol 1998). Grocke's work on client and therapist perspectives of pivotal moment in music therapy, phenomenological in orientation, was published in 1999. This connected with my literature review of congruence research, which studied both therapist and client perspectives on helping and hindering processes in therapy (Toukamanian 1996).

I wanted to problematise the arts therapies as a cultural concept, as some music therapists had done. Ruud (1998) worked in an interdisciplinary way with music education, therapy and anthropology. Based on research interviews and musical autobiographies he analysed the relationship between musical experiences and the formation of identity (Ruud 1997). Stige's ethnographically informed clinical research into music therapy meanings for clients and therapists followed an interpretive, rather than more descriptive, approach to theory building (Stige 1993, 1996). She used both qualitative research interviews with clients and participant observation as research methods (1998). Her clinical setting included adult mental health. Client perspectives in that setting were scarce at that time.

I considered the third ethnographic method of studying artifacts as a possibility. This would have been in line with art therapy methodology such as the retrospective picture review (Schaverien 1995). She drew on philosophical, phenomenological and case study perspectives. Quail and Peavey (1994) did the same, but used a phenomenological perspective. I decided against the study of artifacts for reasons discussed in 3.6.

Modern ethnography contains a strong focus on self criticism and reflexivity to counter criticism of past ethnocentric research (Hammersley and Atkinson 1995). The importance of this had been argued by qualitative arts therapies researchers. I chose the ethnographic research perspective and methodology, but combined this with the evaluation questionnaire and rating scales used in congruence research. This

would, together with attrition details, enable more of an outcome focus for the client and therapist generated meanings. Monitoring of individual client-therapist variables enabled a study of within-group heterogeneity in the majority white population. This was potentially useful for further intergroup research (Hiscox and Calisch 1998), as well as for the development of culturally sensitive arts therapies practice (Campbell et al 1999). To problematise arts therapies as a cultural concept might enable different meanings for therapists and clients to emerge. It would also allow me to study context (setting and treatment) variables in interaction with the individual difference variables (Sue, Zane and Young 1994, Zane et al 2004). Client perspectives on group treatment were even scarcer than those on individual treatment. As group treatment could potentially be preferable in an intercultural context (Callaghan 1996, Orth 1996), the choice was made for the study of group treatment.

### **3.3. The research setting, the pilots and the evolution of the multi-modal approach**

The arts therapies' department in which the research took place had existed in some form for 25 years. In the 1970's as part of the social psychiatry movement, an art therapy department had developed. In the early 1980's a music therapist joined as part of the occupational therapy department. Later that decade a dramatherapist did the same. The service expanded and after a few years all arts therapists came together in one department, under the management of an arts therapist. They survived in that format through various NHS reforms in the 1990's (Johnson et al 1995).

At the time of the fieldwork the arts therapies department consisted of three art therapists, four music therapists (two part time), one dramatherapist and two part time dance movement therapists. Elsewhere in other parts of the trust, funded and managed under different structures, other arts therapists worked. They did so either on a sessional basis, or under a different professional identity such as occupational therapy. The arts therapies department provided individual and group arts therapy to both adult and young people's psychiatry, as well as the elderly in acute, outpatient and rehabilitation settings.

Outcome research was taking place in the department using a mixture of qualitative and quantitative research methodologies. The national context was one of emphasizing evidence based practice. The arts therapists were attempting to respond to and influence the agenda. I was aware of a potential conflict in problematising the cultural concepts, but also felt the ethnographic perspective might allow for a combination of insider-emic and outsider-etic perspectives (Geertz 1993). The context of the setting was studied in three phases, including two pilot studies.

Pilot 1 videoed an open art therapy, dramatherapy and music therapy group session within the same week, followed by semi structured individual interviews with therapists and clients. I contextualised these therapists and clients by interviewing the other arts therapists in the trust and participated in their staff meetings as a participant observer. The arts therapies in the NHS Trust studied had developed in a particular institutional and cultural context. I described this in a socio–historical study, based on literature review and interviews with key informants (Dokter, 2001).

Pilot 2 incorporated participant observation, qualitative interviews and evaluation questionnaires in three slow open ongoing arts therapies groups (dance, drama and music) in a day-centre setting. The research methods were applied with therapists, co-workers and clients.

During the pilot phase I applied different ethnographic research methods to evaluate which ones would work best with the clients and therapists in the setting. At the same time as setting up the pilots, I was involved in an international arts therapies research collaboration exploring a variety of research methods to study arts therapies efficacy (Dokter et al 1999). The pilots became the tools for evolving the multi-modal approach to data gathering and analysis (Crabtree and Miller 1992).

**Pilot 1** was designed to evaluate the efficacy of videoing as a research method, as well as evaluating the role of researcher. Three arts therapies (music therapy, dramatherapy and art therapy) employing open groups, were videoed on an acute psychiatric ward in the same week. A total of 10 clients attended the groups. 5 were in the art therapy group, the same 5 with 2 additional clients in the music therapy

group. 4 of the art therapy and 6 of the music therapy clients also attended the dramatherapy group.

The clients comprised 8 women and 2 men. All therapists were women. I saw both clients and therapists post session for semi structured interviews about helpful and hindering processes in the groups, as well as questions concerning their ethnic identification. The therapists were involved in the editing of the videos for teaching purposes. The edited video material was shown to clients and therapists to elicit a discussion about helpful and hindering processes.

### Pilot 1 Findings

#### Therapist perception:

The three therapists identified as useful:

- mutual interaction between therapist and client
- that everything happening in the session was open to discussion and elaboration (no repressed taboos)
- clients surprising themselves
- non-judgemental understanding
- creative play

They identified as unhelpful:

- Therapist assuming the role of performer (all therapists interacted with clients through playing or image making)
- Attrition / absences ( although the groups were open, therapists tried to encourage all clients who were on the ward into attending)

#### Client perception

Clients identified as useful:

- Self expression
- ‘unfreezing’ of emotion
- being given support
- interacting with others
- being part of a group

Clients identified as unhelpful:

- Inability to express
- Feeling isolated

Clients did not see the different arts modalities as serving a different function. 75 % of clients attended all three groups.

#### Cultural back ground variables

I only asked for ethnic self-identification in this pilot. The therapists self-identified as English, third generation migrant Polish (British self-identification) and South African first generation migrant. All self-identified as white, as did the clients. All clients self-identified as British, with two second and third generation Irish migration history.

#### Evaluation of methodology and findings Pilot 1

Methodology:

- *Videoing*: Being present with a video camera made the researcher presence very intrusive. Although a useful tool which threw up a variety of interesting data, I chose not to continue with video analysis as a primary tool beyond the first pilot. I found, with Collier (1988) that the interaction of filming disturbed the natural flow of events in such a way that it altered the nature of the data collected. I found that in order to be able to ascertain both therapist and client perceptions I needed to be able to operate between the two groups

while monitoring my own process. Asking clients to discuss all videoed session material proved impractical within given ward and time constraints, but asking clients to only comment on therapist selected material meant that they did so within a framework set by the therapist.

- *The effect of audience* was reinforced by clients attending the same discussion group as the therapists, although the format of group discussion proved useful.
- *Client-therapist variables*: As a researcher it proved difficult to ask for ethnic and cultural background details from clients in acute states. Questions about cultural background needed to be asked over time within a context of growing trust around disclosure.
- *Treatment variables*: nurse acting as co-therapist in both the art therapy and music therapy groups

**Pilot 2** involved researcher participant observation in three slow-open arts therapies' groups (dance movement therapy, dramatherapy and music therapy) in a psychiatric rehabilitation setting for 6 months. Out of 120 clients attending the rehabilitation centre, 20 % attended the arts therapies groups and 20 % of those attended more than one arts therapies group (maximum of two groups). 20 % of clients attending were female, 2 therapists were female, one male, the 3 co-therapists were female. The research methods piloted were participant observation, evaluation questionnaires (in the last three months of the pilot), post session separate group discussions with clients and therapists (throughout the six months).

### Pilot 2 Findings

#### Therapist perception

Therapists saw as useful:

- Self expression
- Interaction with others
- Clients developing self motivation
- Everything open to discussion

As unhelpful:

- Non-attendance
- Interruptions

### Client perception

Clients saw as useful:

- Self expression
- Playing for others (performance)
- Being seen, witnessed by others

And as unhelpful:

- Absences
- Interruptions
- Too much talking, not enough playing

The 20 % of clients who attended two arts therapies groups did not see the different arts modalities as serving a different function.

Participant observer findings: gender differences between clients and therapists affected perception and interaction. The issue of religion and festivals influenced the choice of music in dance movement therapy. Potential class issues were identified concerning the choice of instruments in music therapy (clients wanting more instruments related to popular music forms i.e. mouth organ, squeeze box etc). Clients' self consciousness about others' perception of their skills were especially relevant for dramatherapy (clients performed a pantomime) and music therapy, where non attending clients would make their preference known by turning up the radio if the playing was not to their liking. I noted that the older clients tended to attend the arts therapies groups (those 40 and over), while the younger ones did not. They might

attend the music band organised by centre staff. I wondered whether cultural form might influence group attendance when clients opt in or out of an arts therapies group.

### Cultural background findings (interview data)

The therapists were white. One was first generation migrant Italian, one self-identified as British Buddhist, one as British third generation Italian. The clients also all identified as white, but attached only nationality (Greek Cypriot and Irish being the main differential factors from British). I found that the therapists differentiated more than the clients. This finding is echoed in analogue studies in intercultural psychotherapy. Trainees are more ethnically aware as well as often more acculturated (Zane et al 2004). This makes data from analogue studies difficult to generalise to clinical areas. This needed to be addressed in the methodology.

### Evaluation of methodology and findings Pilot 2

#### Methodology:

- *Participant observation* over a longer period of time proved a useful methodology. Jorgensen (1989) suggests that participant observation is a method of choice when it would be considered an intrusion to have a total stranger present to witness and record the situation of interest, when the situation of interest is obscured from the public and when the inhabitants appear to have significantly different views than do outsiders. In summary: participant observation is indicated as a research method when a research question requires an understanding of the processes, events, relationships and the context of a social situation. Yin (1994/2003)'s identification of the weaknesses of participant observation, namely that it is time consuming, and can be selective and biased depending on the researcher's reflexivity needs to be addressed through the triangulation with other data sources.
- *Post session focus groups, held separately with clients and therapists.* The group interaction nature of focus groups is considered advisable when the researcher is trying to understand differences in perspectives between people

or categories of people, particularly when issues of differential power are involved. One of the first things clients asked me was whether I was client or staff. The literature review had raised issues concerning differential power between client and therapist, while pilot 1 had indicated the need for separate focus groups for clients and therapists.

- *Rationale for continued use of focus groups.* Focus groups are considered useful when the purpose of the research is to uncover factors that influence opinions, behaviour or motivation (Krueger 1994). At the time, focus groups had not been used much in arts therapies research, although some researchers used collaborative research strategies (McClelland 1993). The critique of ethnographic methodology is that the researcher dominates the agenda (Krueger 1994) and that there is a need for participants' voices and feelings to be given more dominance (Fontana and Frey 1994). The focus group creates multiple lines of communication (Morgan 1988, Wilkinson 1998). More traditional research methods can alienate traditionally marginalised groups (Maynard and Purvis 1994, Wilkinson 1998). This needed to be taken into account interculturally, as well as in the context of clients with mental health problems. Because focus groups emphasize the collective, rather than the individual, they encourage members of the group to speak up (Denzin 1989, Frey and Fontana 1993). Focus groups use more familiar settings than other research techniques (Frey and Fontana 1993), thus diffusing the power of the researcher (Madriz 2000). I used the familiar settings of the post session therapist review meeting and the post session coffee and cigarette for the clients as focus group opportunities.
- *Individual evaluation questionnaires.* Gilroy's finding that public and private perception of group process may differ (1995) meant that it was important to obtain individual feedback / evaluation on sessions, as well as group focus data. Individual evaluation questionnaires were therefore piloted in the second half of pilot 2. They proved a good method to obtain immediate reflections for comparison between clients, therapists and co-therapists. The influence of the wider multi-disciplinary team could be monitored, as well as perceptual

changes over time. The design of the evaluation questionnaire was derived from congruence research (Lietaer 1992, Lietaer and Neirinck 1986, Angus 1986). These were analogue studies and I found that I had to simplify the design for the clients. This involved reducing the number of questions as well as the rating scale used. It made the tool accessible to those clients who had literacy and numeracy problems, as well as those who had problems concentrating and focussing (a sizable proportion given long term mental health problems often starting in adolescence).

The multi-modal design of participant observation, focus groups for therapists and clients and an individual session evaluation questionnaire had been piloted and found a suitable way of addressing the hypothesis in the context of the setting. The mainly ethnographic perspective of participant observation was triangulated through the less researcher focussed alternative data sources. The difficulty of obtaining equivalent details of ethnic and cultural background from clients and therapists was addressed through the creation of a semi-structured interview format incorporating the heterogeneity factors (McGoldrick 1996) into the models of health and illness questionnaire (Kleinman 1972, 1989). Kleinman's questionnaire ascertained both client and therapist perceptions of client problems and if / how they felt treatment was addressing this. Specific questions about arts therapies group treatment were added.

- *Treatment variables* observed in the pilot studies were twofold. Firstly arts therapists' co-working and secondly their integration in the work of the particular Trust unit where they practised. The research design needed to incorporate the context of the multidisciplinary team, and involve co-therapists in the data gathering.

### **3.4 The delineation of the 'case' and ultimate research design**

The pilots showed that a multi-modal group research design in a setting with a slow open treatment group and clients of a similar age was the best option. It offered the means of ascertaining changes in perception while treatment developed. Clients in a day patient setting were more able to provide feedback as they were not in an acute phase of their mental health problems. The young people's psychiatric service was therefore selected as the best setting for the final fieldwork. The young people's service provided outpatient and day-patient treatment. At the time of the fieldwork outpatients were seen individually, while day patients received group treatment. The day patient unit was run along therapeutic community lines for a client group of twelve young people, aged 18 to 25. Their average expected stay was two years.

Arts therapies group treatment needed to be studied as part of the multidisciplinary team (MDT) approach. Within the young people's unit the arts therapies groups were part of the group programme attended by all clients, thus reducing the MDT variable of differing treatments for individual clients. The co-worker in the arts therapies group was an identified unit worker. They could provide data for triangulation purposes, as well as providing the possibility of cross referencing understandings of health, illness and treatment from therapists, clients and setting. It was decided with the team that the researcher would join the group as a participant observer for one year. She would be there for three months prior to implementing questionnaires and three months post completion, to allow for slow accommodation of the group at entry and closure to the researcher. The evaluation questionnaire and semi-structured interview questions were discussed with staff and clients prior to the research period in consultation about what they felt was accessible.

The completing of the session questionnaires took place at the end of each session and the focus groups at the end of the day. The focus groups followed the institutional culture of formal staff reviews and informal client reviews. The interviews took place after three months of client engagement in therapy. This date was set with staff and clients as a significant time after the initial engagement process was completed. The advantage of this was that the initial acculturation into arts therapies could be monitored through the session evaluation questionnaires and focus groups, while the interviews were able to follow up more individual processes and perceptions. This

was also a way of cross referencing between clients who all entered their group therapy at different times.

The purpose of the research is to determine whether intragroup cultural background differences of therapist and client influence client-therapist consonance in their perception of the efficacy of arts therapies group treatment. The research aims to identify which client, therapist and treatment variables interact with within-group heterogeneity factors (Mc Goldrick 1996) to influence consonance and dissonance.

The pilot studies identified differences in therapist and client perceptions, which could influence the consonance between therapists and patients, possibly due to differences in their cultural background. In both the acute and rehabilitation contexts only the clients saw the process of the individual arts therapies modality as interchangeable although they differentiated the forms that process took. Therapists expressed difference of opinion on this point. The research will incorporate more than one arts therapies modality, so that this issue can be additionally monitored as part of the non-verbal expression and the relation to the artistic form. The multiple case design aims to generate hypotheses for further study, as well as providing guidelines for training and practice to develop therapist reflexivity and cultural competence.

Combining ethnography and outcome turned my study in the direction of a multiple case study. Yin (1994, 2003) defines a case study as an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident. The case study inquiry copes with a technically distinctive situation in which there will be many more variables of interest than data points. It relies on multiple sources of evidence, with data needing to converge in a triangulating fashion (Yin 1994, 2003).

Theory development is essential in case studies, whether the ensuing study's purpose is to test or develop a theory. This theory development distinguishes it from pure ethnography.

Yin (1994) advocates six methods of data collection. I will use for this research:

1. Archival and documentary material: the clients' medical files will be used to ascertain the client's diagnosis, treatment and cultural background details. These will be triangulated with interview data monitoring client and therapist understanding of health, illness and appropriate treatment
2. Participant observation of the researcher for a period of one and a half years in the arts therapies' groups in the day-patient unit. This allows for covering of events over time. It covers the context of the events and can provide insights into interpersonal behaviour and motives
3. Interviews. These will take place three months after the client has joined unit treatment. They will be of a semi-structured nature, using Kleinman's (1978) questionnaire to ascertain understandings of their health, illness and what they consider appropriate treatment.
4. Session evaluation questionnaires, implemented at the end of each arts therapies session. They are completed by clients, therapist and unit co-worker to allow for triangulation. The session evaluation questionnaires will be triangulated with focus groups to monitor for audience and the retrospective time nature reflection with interviews.
5. Health diaries (Murray 1985). To triangulate the weekly and three monthly time intervals of questionnaires and interviews. This will allow for monitoring of daily fluctuations and their influence on perception over a period of two weeks.

Yin's additional methods of direct observation and the use of physical artefacts were excluded. The former was not ethically acceptable to the unit and arts therapists. Within their psychodynamic orientation direct observation was felt to interfere with treatment in a way that participant observation did not. The differences in physical artefacts between the arts therapies modalities made cross modality explanation building difficult. The art therapy artefacts could have been incorporated, but the video nature of the performance arts modalities had been shown to provide difficulties in the pilot phase of the research.

The analysis is a combined quantitative / qualitative one, triangulating a variety of data sources and keeping in mind the possibility of statistical generalization and

analytic generalization. The statistical data is used to generate a description of the context and the sample, which is then further developed through analytic generalization (Yin 1994).

The analysis will start with an overview of client and staff attrition from the sample. Roth and Fonagy (2005) state that attrition is one of the factors affecting generalisability of psychotherapy research findings. Zane et al (2004) comment that intercultural psychotherapy research findings have been compromised by a lack of contextualisation in place and time of the sample. I will thus analyse the make up of the sample of therapists and clients and how that contextualised within the trust and local population in chapter 4. The heterogeneity factors (McGoldrick et al 1996) provide the guidelines for the analysis.

This is followed by an analysis of helping and hindering factors in arts therapies group sessions, as identified by therapists and clients in chapter 5. Chapter 6 identifies the client, therapist and treatment variables that affected the consonance. The multiple case study method in chapter 7 looks at the interaction of these variables.

Throughout the analysis I look at the effect of the researcher's identity and presence, while also considering potential methodological problems in the methods used for data gathering and analysis.

The concluding chapter of the thesis summarises the research findings, discussing the implications for theory, practice and research. The critique of the methods chosen provides a framework for the generalisability and validity of the findings.

## **Chapter 4 Analysis of sample and its context. Attrition as dissonance**

### **4.0 Chapter overview**

This chapter presents the sample in total on an ‘intention to treat’ basis (Roth and Fonagy 2005) and analyses retention and attrition, contextualised within research into psychotherapy attrition. Pseudonyms are used for client names.

In the light of Zane’s (2004) critique the second context section provides the ethnic / cultural context of the region, trust and arts therapies department at the time the fieldwork took place. The chapter then analyses the sample of clients and staff in this research, contextualised within the local and trust community, identifying relevant client, therapist and treatment variables in relation to attrition.

### **4.1 The context**

#### **4.1.1 Attrition and retention in psychotherapy**

Dissonance in treatment can be expressed in a variety of ways, the first is through attrition. There is some evidence to suggest that drop out reflects dissatisfaction with treatment. Weismann et al (1979) reported that 98% of clients drop out because of dissatisfaction with treatment. Later studies compared drop out rates related to drug or therapy treatment (Wexler and Cicchetti 1992, Casacalenda et al 2002).

Clients’ self reported improvement is positively associated with their number of therapy sessions (Lambert et al 2001). A Los Angeles county study (Sue et al 1991) found significant statistical group differences in drop out of treatment after one session between different BME groups. However, results of research to date do not show a consistent picture. Although some differences have emerged about the number of sessions attended by different ethnic groups, they have not been consistent (Zane et al 2004). The authors speculate that the differing results could reflect the

influence of specific and local factors, time period differences or individual acculturation differences.

There is no arts therapies research into attrition, but those available in the psychotherapy field show that attrition in psychotherapy is high. Among children, adolescents and adults who started treatment 40 to 60 % dropped out prematurely and against the advice of the clinician (Kazdin 1996, Wierzbicki and Pekarik 1993). Most studies suggested that age is not important in psychotherapy attrition and retention (Clarkin and Levy 2004). Lower household income and negative attitudes towards treatment were independently associated with attrition in panic disordered clients (Grilo et al 1998). This was also a co-variant in group treatment for depression in clients from Latino low income families, where the drop out rate was higher than in the NIMHE multi-site depression study (Elkin et al 1989). Clients with obsessive compulsive disorder showed high attrition if they had strongly incongruent treatment expectations (Hansen et al 1992). Clients with personality disorders were found to be at high risk of drop out, whether in inpatient (Chiesa et al 2000) or outpatient (Gunderson et al 1989, Shea et al 1990) settings. Younger clients with borderline personality disorder and high initial hostility were shown to be more likely to withdraw early from treatment. Those who showed higher levels of interpersonal relatedness, better psychological resources and lower levels of psychopathology were more likely to stay (Hilsenroth et al 1995)

Meta-analyses of child and adolescent psychotherapy found that treatment tended to be more effective with adolescents than children. Individual therapy was more effective than group therapy and psychotherapy was equally effective for externalizing and internalizing problems (Kazdin 2000). The latter finding contradicts some of the diagnostic variables identified in the studies above, as well as Baruch et al's findings (1998) which showed that those 12 to 18 year old adolescents who externalise problems were more likely to drop out. Roth and Fonagy (1996) found that more intensive treatment worked better for young people, especially those with depression. Eclectic group treatment for suicidal adolescents was shown to significantly reduce the risk of repeated self-harm (Wood et al 2001). Depressed adults' dissatisfaction with groups was associated with attrition (McDermut et al

2001). In the light of these other studies Kazdin's findings may need re-evaluation. Meta-analyses are based on only 10 to 20 % of the available literature (Kazdin 2004), although those studies are carefully selected for robust methodology. The age group within this study is in the adolescent / young adult range.

Early establishment of a therapeutic alliance and an egalitarian attitude of the therapist were shown to be important for the retention of BME clients in the literature review (Ross 1983, Sue and Zane 1987, Jenkins 1997). An interpersonal orientation by the therapist could help to establish that early alliance (Jenkins 1997, Gibbs 1985). The client's age, gender, education and ethnicity were variables to which the therapist needed to adjust (Clarkin and Levy 2004).

Another potentially relevant research study, though older, showed that the greatest likelihood of drop out occurred in the first 4 months of treatment for 20 to 30 year olds when they were engaged in a mixture of individual and group treatment (Powdermaker 1953). The young people's unit where the research took place was for clients aged 18 to 25, but in practice the range was 17 to 29. It was an intensive day treatment programme along therapeutic community lines, with an emphasis on group therapy treatment, accompanied by individual work. Clients' diagnoses were mixed. Much of the attrition research data available is US research. Roth and Fonagy (2004) indicate the importance of attrition as a factor in UK practice research too.

#### **4.1.2 The cultural make up of the region, the trust and the arts therapies department**

The time period when the fieldwork took place was 1998-1999. Figures related to ethnic monitoring were sketchy, pre Race Relations Amendment Act 2000 and the National Service Framework for mental health (1999) focusing on social exclusion. The mental health trust studied served a population of whom 96.5% self-identified as white. This was according to the 1991 regional census results (Humm 1996), which also asked people to classify themselves as black (1%), Indian (1%), Bangladeshi (1%), Chinese (1%), other Asian (1%) and other (3%). The more recent 2001 census provides a more detailed breakdown (Office for National Statistics 2005). The trust

covers two cities (city P and city C) and two rural regions (region H and region F). The young people's service and the arts therapies department only served city C and region F. Table 1 shows the demographic profile from the 2001 census. It can be seen that city P has a large Pakistani population absent from the other areas, where less substantial ethnic communities can be identified. When migrants become more upwardly mobile, they often move out of concentrated neighbourhoods, although more into the suburbs than the provinces (Adonis and Pollard 1997). In more rural areas this does not hold true. Families and individuals tend to be more isolated from each other. Professional migration patterns, of academics for example, conform to an individual rather than a collective migration pattern. Table 1 shows that City C, regions F and H follow the individual rather than the collective migration pattern, because they have no sizable communities gathering in a particular area. It also shows that the rural regions have smaller non-white populations than the urban cities and have smaller numbers of non-Christian religious affiliations. The percentage of people born outside the EU is highest in city C, but is also the represented in the rural regions.

*Table 1 Regional demographic profile*

	City P		Region H		City C		Region F	
	No.	%	No.	%	No.	%	No.	%
<b>Total population</b>	156060		156950		238966		156739	
<b>White</b>	140003	89.7	152487	97.1	223657	93.6	154020	98.3
<b>Pakistani</b>	6980	4.5						
<b>Indian</b>	2876	1.9	592	0.03	2620	1.1	197	0.1
<b>Chinese</b>					2325	1.0	297	0.2
<b>Other</b>					1486	0.6		
<b>Born outside EU</b>	10906	7	7356	4.7	206828.	8.65	5204	3.32
<b>Muslim</b>	8963	5.7	983	0.63	3262	1.37	379	0.24
<b>Hindu</b>	1383	0.9	294	0.19	1709	0.72	199	0.13
<b>Sikh</b>	833	0.5	185	0.11	205	0.01	179	0.11
<b>Buddhist</b>	254	0.2	266	0.17	1510	0.63	230	0.15
<b>Jewish</b>	147	0.1	205	0.13	1148	0.48	159	0.1
<b>Christian</b>	106621	68.3	116887	74.9	157645	65.97	119616	76.35

Table 1 indicates that the BME population in the trust cities is 10.3 % and 6.4%. The rural areas comprise 2.9% and 1.7%. Irish and any other white background categories are not included. In the area that the arts therapies department serves (city C and region F) there is no dominant non-white ethnic group, but the census indicates that people of Indian and Chinese origin make up the majority, with a sizable variety of other minority ethnic identities.. The sizable group which is born outside the year 2000 EU region includes asylum seekers and refugees, as well as communities of Eastern European origin (especially Polish). The white population also includes Portuguese and Irish backgrounds.

The trust population in 2001 is shown in Table 2. There are no consistent ethnic monitoring figures in 1999. This was the first report of statistics gathered in the trust on the basis of the Race Relations Amendment Act (2000).

*Table 2 Ethnic identification; young people and adult psychiatry*

<b>Ethnic Group</b>	<b>YP</b>	<b>%</b>	<b>Adult MH</b>	<b>%</b>
<b>A.o Asian background</b>			2	0.1%
<b>A.o. Black background</b>			1	0.0%
<b>A.o. ethnic group</b>	1	0.4%	35	0.9%
<b>A.o mixed background</b>	1	0.4%	2	0.1%
<b>A.o White background</b>			7	0.2%
<b>Bangladeshi</b>			4	0.1%
<b>Black African</b>	1	0.4%	7	0.2%
<b>Black Caribbean</b>			10	0.3%
<b>Black other</b>			3	0.1%
<b>Chinese</b>			4	0.1%
<b>Indian</b>	2	0.8%	14	0.4%
<b>Not given/stated</b>	37	14.7%	634	16.0%
<b>Pakistani</b>			2	0.1%
<b>White/White British/Irish</b>	144	57.4%	2494	63.1%
<b>White and Asian</b>			1	0.0%
<b>White and Black Caribbean</b>			1	0.0%
<b>Blank</b>	65	25.9%	733	18.5%
<b>Total</b>	251		3954	

a.o. = any other

The trust asks for a more specific identification than the census. The census ‘other’ category includes other Asian backgrounds, black and mixed backgrounds etc. Not

given / not stated and left blank comprise 40.6% in young people's psychiatry and 34.5 % in adult mental health. This is particularly due to the left blank category. It is not clear whether clients refuse to delineate their identity or are more uncertain about this aspect of their identity. It may also be the case that members of staff have not asked clients' self-identification. In comparison with the regional population, there is a lower percentage of Indian and Chinese clients in the trust, but a higher number of clients in the 'other' categories, especially black African and Caribbean backgrounds. The 'other' category includes a higher number of clients from white other, any other and mixed categories. Given the numbers of blank and not stated, it is not really possible to say what this indicates about BME access to services. The type of service accessed can vary. Black clients are often disproportionately represented in the acute inpatient and secure services (Fernando et al 1998). This might explain the lower percentage in the young people's service. It provides day and outpatient psychotherapeutic treatment only. Clients from different ethnic backgrounds are traditionally less likely to be referred for psychological therapies (Bhui 2002, NIMHE 2003).

Some minority backgrounds remain invisible in the trust monitoring systems. The trust does not monitor Irish background separately. This might be necessary, as Irish people show higher levels of mental illness than the general British population (DOH 2004) three generations post migration. The region has a sizable community of travelers. They are not separately monitored, although their mental health and treatment needs have also been identified as needing special adjustments for access. Although not a designated dispersal area, the proximity to ports and airports means that the region receives several asylum seekers. At the time of fieldwork these were particularly from ex-Yugoslavia. A city based report identified their need for and difficulty in accessing mental health services (CRSG 1997), as well as nationally (DOH 2004).

At the time of the research the trust did not apply ethnic monitoring to its staff, so the arts therapists and young people's unit staff cannot be placed in their context. Ethnic monitoring forms were completed at application, but no statistics were drawn up from these for staff accepted into employment. This was implemented post 2000,

but a report from this monitoring was still due in 2005. The concentration of minority ethnic nurses in psychiatry reflects the pattern of recruitment that prevailed during the 1950's. The acute shortage of nursing staff was felt most keenly in psychiatry and geriatrics (Adonis and Pollard 1997). It was into those two areas that most ethnic minority nurses were recruited. In a trust in the South West, a similar region to the catchment area of the Trust I studied, 6 % of the workforce in the ex-asylum hospital was from visible BME backgrounds. Littlewood and Lipsedge (1997) discussed a similar situation for psychiatric consultants.

It has also proved difficult to look at the trust arts therapists in the context of the arts therapists in the UK. All arts therapies professional associations and training institutions have implemented ethnic monitoring forms, but none have published data from these. The BAAT Race and Culture committee published a report of questionnaire results in 1991, but regrettably only 18% of the membership completed the questionnaire (BAAT 1991). Of the respondents 94% self-identified race as white, 5.6% as black / brown / other. Culturally 75% identified as British and 42% as other or mixed. The 'other' category included a variety of backgrounds. There were 2.3% Irish, 1.84% Welsh and 1.38% S.African. A smaller 0.92% Scottish, N.Irish, Polish, Jewish, European, S.European and French backgrounds. Australian, Romany, Italian, Asian, Buddhist, Icelandic, Chinese and Caucasian comprised 0.46% each. The mixed backgrounds comprised 0.46% each of British / Middle Eastern, Russian / Italian / American, Iranian / European, British / European / Irish, Irish / Greek, English / Chinese / West-Indian, Swiss / German, Scottish / Brazilian, British / European, British / Latin, Irish / Austrian, Irish / European and British / Australian.

Religion as a factor in ethnic / cultural identity was not monitored in the BAAT questionnaire. Since 2000 it has been recognised as part of the national census data. One of the arts therapists participating in the pilots stated her religion as a factor in her ethnic self-identification. Religious background data is available for trust clients in 2001, but not for members of staff. Table 3 shows adult and young people's religious affiliations in the trust. It duplicates the monitoring of ethnic and cultural backgrounds in that there are a large number of blanks. In total 'not-known' and 'left blank' accounts for 67.7 % of young people and 52.6% of the adults in the trust. The

higher percentage of Church of England and Roman Catholic in the adult population self-identification and higher percentage of no religion and agnostic in the young people may reflect increasing secularisation. The statistics of orthodox Christian clients amongst young people are potentially skewed by the small numbers involved. In comparison with the regional population, as presented in table 1, the trust population has a higher number of Muslims and fewer Hindus. The smaller percentage of Christian (in its ecumenical sense) clients in the trust (39%), in comparison to the region, may be explained by the large number of not known / left blank.

*Table 3 Young people and adult religious affiliations in the Trust*

<b>Religion</b>	<b>YPS</b>	<b>%</b>	<b>Adult MH</b>	<b>%</b>
<b>Agnostic</b>	2	0.8%	9	0.2%
<b>Atheist</b>			11	0.3%
<b>Baha'I</b>			1	0.0%
<b>Baptist</b>			16	0.4%
<b>Buddhist</b>			11	0.3%
<b>Christadelphian</b>			1	0.0%
<b>Christian</b>	3	1.2%	78	2.0%
<b>Church of England</b>	46	18.3%	1219	30.8%
<b>Church of Ireland</b>			1	0.0%
<b>Church of Scotland</b>			4	0.1%
<b>Congregationalist</b>			1	0.0%
<b>Greek Orthodox</b>	2	0.8%	5	0.1%
<b>Hindu</b>			4	0.1%
<b>Jehova's Witness</b>	1	0.4%	9	0.2%
<b>Jewish</b>	1	0.4%	6	0.2%
<b>Methodist</b>	1	0.4%	21	0.5%
<b>Mormon</b>			2	0.1%
<b>Muslim</b>	1	0.4%	17	0.4%
<b>Non-Conformist</b>			1	0.0%
<b>None</b>	16	6.4%	190	4.8%
<b>Not Known</b>	71	28.3%	1952	29.5%
<b>Other</b>	1	0.4%	7	0.2%
<b>Other Free Church</b>			10	0.3%
<b>Pentecostal</b>			1	0.0%
<b>Presbyterian</b>			2	0.1%
<b>Quaker</b>			1	0.0%
<b>Roman Catholic</b>	7	2.8%	239	6.0%
<b>Salvation Army</b>			1	0.0%
<b>Sikh</b>			3	0.1%
<b>Spiritualist</b>			1	0.0%
<b>Unitarian</b>			1	0.0%
<b>(blank)</b>	99	39.4%	915	23.1%
<b>Total</b>	251		3594	

## 4.2 The sample and attrition

I will compare the staff and client sample involved in the research and discuss if and how they differ from their context as discussed above.

### 4.2.1 Client attrition

Table 4 presents all clients in the study, their period of joining and leaving. I have indicated whether the clients left the unit in agreement with the staff. This meant they would have been prepared for discharge, or, if the staff did not agree, self discharged. The latter usually indicated a gradual dropout of sessions or sudden leaving. All clients were followed up by unit staff on an outpatient basis, or were admitted to one of the adult acute psychiatric wards. When clients moved to outpatient status they did not participate in the arts therapies, so finished participation in the research. When they were admitted to Accident and Emergency or acute adult wards, the young people continued their treatment in the unit. This is not indicated as discharge.

*Table 4 Clients' Attendance at the Young People's Unit. Dates of joining and leaving*

Client	Joining Date	Leaving Date	Rejoin	Leaving Date	Discharge
LIZ	1994	Jan 1999			Agreed
CATE	18/5/1998	28/4/1999			Self
AL	16/9/1998	10/5/1999			Agreed
TED	16/9/1998				Agreed
BELLE	30/9/1998				Agreed
JACK	21/10/1998	27/1/1999	5/5/1999		Self
LIA	13/1/1999	10/2/1999	24/5/1999	22/9/1999	Self
KATE	13/1/1999	31/7/1999			Agreed
HATTIE	27/1/1999	7/7/1999			Self
SAM	27/1/1999	17/3/1999			Self
SALLY	24/5/1999				Agreed
JAN	14/7/1999	Mid August 1999			Self
VAL	13/10/1999	17/12/1999			Self
MANDY	13/10/1999				Agreed
NATHAN	20/10/1999				Agreed
DICK	20/10/1999	17/12/1999			Self
PAT	8/12/1999				Agreed
LEN	8/12/1999				Agreed

The engagement of clients with the therapeutic community day programme can be seen in table 5. Those clients who engaged with the treatment were identified as those

who attended regularly for longer than four months (Powdermaker 1953). Of the clients involved in the study this concerned 12 out of 18 (66%). In the study one of these clients was coming towards the end of her treatment. Seven were there throughout the period of research and three were in the early stages of their treatment towards the end of the research. During the fieldwork period six clients dropped out of treatment (33%). The above table indicates that for some clients there were many absences. Attendance in the arts therapies groups will be discussed in 4.2.3. The young people's length of treatment was as follows:

*Table 5 Length of treatment*

<b>Client</b>	<b>Years</b>	<b>Months</b>	<b>Comment</b>
<b>LIZ</b>	5		
<b>CATE</b>		11	
<b>AL</b>		11	
<b>TED</b>	3		
<b>BELLE</b>	2	6	
<b>JACK</b>	1	6	LCE
<b>LIA</b>		6	LCE, MA
<b>KATE</b>		6	
<b>HATTIE</b>		5	MA
<b>SAM</b>		2	
<b>SALLY</b>	2	6	
<b>JAN</b>		1	
<b>VAL</b>		3	MA
<b>MANDY</b>	2		
<b>NATHAN</b>	2	6	
<b>DICK</b>		2	MA
<b>PAT</b>	1	6	
<b>LEN</b>	2		

LCE= Longest Continuous Episode

MA=Many Absences

In comparison with the attrition rates in psychotherapy which showed 40 % and above in the research, the drop out rate for this particular unit is a more favourable 33.3. % .

#### **4.2.2 Staff attrition / turnover**

During the initial three months of participant observation, prior to implementing questionnaires and focus groups, several changes took place to the staffing and

programme. The music therapist took on other part-time employment, reduced her hours and changed from facilitating a day patient group to only seeing individual outpatients. Secondly there was a budget cut in the arts therapies department, so that one post became redundant. Simultaneously a therapist post became available in the young people's unit, because a dramatherapist on the unit staff left. When the dramatherapist was appointed as a member of the unit staff, the decision was made that a dance movement therapist from the arts therapies department would provide additional input.

The unit created a new group programme timetable. Instead of having different arts therapies groups dotted throughout the weekly group programme, the art therapist and dance movement therapist would each facilitate a group on the same day. This specific arts therapies day would be the day in the week that I would attend for my research. The arts therapists and unit co-workers completed evaluation questionnaires and took part in interviews. As the rest of the MDT took place in the session reviews, they were also interviewed. The variable of staff turnover was incorporated as an interacting variable potentially affecting dissonance.

High turnover of staff within the NHS is often cited as one of the difficulties consequent to health service reforms, management re-structuring and low morale amongst the workforce (Johnson 1995). The evidence of this small sample indicates a rapid turnover, which can be one of the contributing factors to a difficult establishing of the therapeutic alliance. In the last five years out of 14 arts therapists, 8 remained the same, but 3 went from full time to part time employment. This development enabled the employment of two new music therapists and two dance movement therapists. Half the dramatherapy post, lost in the zero budgeting restructuring, was replaced. In the young people's service weekly art therapy, music therapy and dramatherapy groups were provided by three arts therapists employed full time by the arts therapies department. Over the years this provision changed to one full time art therapist and one part time dance movement therapist employed in the arts therapies department. Traditionally, an arts therapist had also been employed by the young people's unit as one of their unit therapy staff. This member of staff took over the provision of the third arts therapies' group.

Over the last five years the turnover of staff at the therapeutic community part of the young people's service had been in a one and a half to two year cycle. A core team of 4 therapists worked in the therapeutic community under the consultant. One of the core team was the charge nurse. He remained constant, as did the consultant over the last five years. The other 3 therapists changed. From 1996 to 1998 there were 3 full time permanent therapists. In 1998 they changed to one locum therapy post, which became permanent after three months. This therapist went on long term sick leave after six months. She was replaced by a locum worker (who co-worked the art therapy group) for one year. The other therapist was the dramatherapist who co-worked both groups on the arts therapies day of the treatment programme. When he resigned a locum replaced him for six months. This pattern of locum posts, occasionally becoming permanent, continued after I finished my fieldwork.

The level of staff attrition occurring in the first three months of participant observation meant that staff turnover as an interacting variable on client-therapist dissonance was included in the study.

#### **4.2.3 Attendance**

Table 5 showed that several clients had many absences. It became therefore important to study all research participants' attendance in the arts therapies groups as a potential reflection of engagement with therapy, even if they did not drop out.

In table 6 the attendance is monitored from May 1998 to December 1999, including the six months participant observation prior to introducing the questionnaires and interviews. There is a difference between the weeks in the group and the number of sessions attended. This indicates the frequency of breaks. They are due to the treatment group going on a residential away from the unit, or a break in the unit based therapy programme. Staff holidays led to a change in programme during the August and December months, necessitating breaks in the therapy programme. Staff training days also created breaks.

Table 6 Arts therapies session attendance

	Dance Movement			Art			
Client	Weeks in Group	Sessions Attended	% Attendance	Weeks in Group	Sessions Attended	% Attendance	Male / Female
LIZ	14+2	10/13	77	14+2	11/13	85	F
CATE	32	11/21	52	32	11/21	52	F
AL	34	18/23	78	34	16/23	70	M
TED	67	35/41	85	67	33/41	80	M
BELLE	65	20/39	51	65	23/39	59	F
JACK	14+34	19/26	73	14+34	17/26	65	M
LIA	4+25	1/16	6	4+25	4/15	27	F
KATE	27	14/19	74	27	13/18	72	F
HATTIE	23	9/16	56	23	8/15	53	F
SAM	7	5/6	83	7	4/6	67	M
SALLY	34	18/19	95	34	19	100	F
JAN	3	2/3	67	1	1	100	F
VAL	10	1/6	17	10	1/7	14	F
MANDY	10	6/8	100	10	7/7	100	F
NATHAN	10	4/6	67	10	5/7	71	M
DICK	10	3/6	50	10	2/7	29	M
PAT	3	1/1	100	3	1/3	33	M
LEN	3	1/1	100	3	3/3	100	M
ATH				67	35/41	85	F
DMTH	67	40	98				F
CO-TH 1	34	15	65	34	16/23	70	M
CO-TH 2				62	30/35	86	M
CO-TH 3	17	8	73				F
Researcher	67	41	100	67	41/41	100	F

The table shows that there were differences in attendance between the art therapy and dance movement therapy group. The average client attendance was 68.6% in the dance movement therapy group and 61.5% in the art therapy group. The therapists had a 98% (DMT) and 85% (AT) attendance. The co-workers in the dance movement therapy group 65% and 73%, in the art therapy group 70% and 86%. Co-workers facilitated the art therapy group in the therapists' absence, continuing to use art as a medium. Although the dance movement therapy group continued, the group changed to a more activity based group, not using dance movement as a medium. The attendance of the dance movement therapist was higher than that of the art therapist, but the attendance of the co-therapist lower in the DMT group. The art therapy group was part of the young people's unit for considerably more years than the dance movement therapy group, which only started in May 1998. This could mean that the

co-workers had become more familiar with the medium, but both unit co-workers CO-TH 2 and CO-TH 3 only joined the groups in respectively October 1998 and August 1999.

Therapist experience can be a factor influencing attrition, the art therapist, nurse co-therapist (Co-th 3) and dramatherapist co-worker (Co-th 1) practised for 10 years. The dance movement therapist and nurse co-therapist (Co-th 2) in the art therapy group were relatively new to the profession and the unit. The association between lower attrition and greater experience is reasonably consistent in the research literature and is especially evident in the more psychodynamic therapies (Krauskopf et al 1981, Crits-Christoph et al 1991). A meta-analysis suggests that while there is no difference in attrition within university counselling centres, there may be in different mental health settings (Stein and Lambert 1995). Therapist experience may thus be a factor to be considered when studying attrition.

Some clients attended the art therapy group more than the dance movement therapy group. All of these clients were female. The clients who attended the dance movement therapy group 3% more than the art therapy group were male. This indicates a potential effect of gender on the engagement with the medium, so gender will be one of the interacting variables included when looking at dissonance in chapter 6.

The clients, who attended the unit consistently for longer than eight months, attended the arts therapies groups 71.6%. The drop outs had an average attendance rate of 47.6%. Although this may be an expected pattern, there were individual variations that bucked this trend. Of the consistent attendees Cate and Belle had attendance rates of 52% and 55% respectively. Some of their absences were due to admissions after an overdose. The other consistent attendees had attendance rates of 70% and above. The exception to an average 50% attendance rate of the dropouts was Sam (75%). He was the only client who responded to follow up in the research. His story is included in the case studies in chapter 7.

### 4.3 Analysis of the sample

This section looks at the within-group heterogeneity variables identified in 3.1. It also analyses the diagnostic, age, gender and class variables indicated in 4.1 as potentially interacting factors affecting clients' attrition and retention.

#### 4.3.1 Ethnic and Cultural background variables

##### 4.3.1.1 Self-identification

Table 7 presents client and staff ethnic and cultural self-identification. Those clients who agreed to be interviewed (10 out of 17) were additionally asked how their ethnic/cultural background was perceived by others. This was based on the definition of ethnicity given in chapter 1 of this thesis. .

*Table 7 Client Ethnic and cultural self-identification*

<b>Client</b>	<b>Ethnicity</b>	<b>Cult Bg</b>
<b>LIZ</b>	English	British
<b>CATE</b>	English	English
<b>AL</b>		
<b>TED</b>	English	English
<b>BELLE</b>	English	English
<b>JACK</b>		
<b>LIA</b>		
<b>KATE</b>	Irish/British	Irish/British
<b>HATTIE</b>		
<b>SAM</b>	Indo/Brazilian	English/Brazilian
<b>SALLY</b>	White English	White English
<b>JAN</b>		
<b>VAL</b>		
<b>MANDY</b>	British	English Islam
<b>NATHAN</b>	White British	Jewish
<b>DICK</b>		
<b>PAT</b>	White British	English
<b>LEN</b>	White English	English

Only two of the clients felt they were perceived differently by others. One self-identified as Indo-Brazilian, but was perceived by others as 'Paki'. The second self-identified as Irish-British, but was perceived by others as white British. One member

of the unit staff, not a co-therapist, reflected that he would be identified by others in the UK as Indian, but perceived in India as anglicised.

Ethnically 4 out of 18 clients' self-identification was not known. 5 identified as English (1 white English), 4 British (3 white British), one UK, one Irish-British and one Indo-Brasilian. Two clients self-identified ethnically as white. This meant that, of 18 clients, 6 (33%) self-identified skin colour and 12 (66%) nationality under ethnicity. The distinction between cultural background and ethnicity was only made by those clients who were interviewed. For those whose self-identification depended on medical records this was not possible. Of 12 people interviewed, 3 (25 %) distinguished culture from ethnicity. 2 did this in terms of religion (Jewish, Islam) and 4 (33 %) distinguished nationality. This meant 50 % of the clients distinguished ethnicity from culture, supporting Sue et al (1991)'s assertion that both need to be monitored (chapter 2).

Of 17 staff, 16 identified as white. Some distinguished N.European (1), European (1), N.W.European (1) and British (3). 8 identified as British, 2 as English and 1 as mixed Indian/UK. 4 did not distinguish ethnicity from culture, but 13 did, more than 75 %. They distinguished in the areas of nationality (Norwegian, Scottish, Italian and Indian), region (W.European, Yorkshire, London, S.England), class (middle and working) and religion (Jewish).

The unit staff was mainly white, with the consultant as the only person self-identifying as mixed Indian / UK. The other unit staff identified as British, white British or English, 2 specified class as a cultural variable.

The 3 young people's unit arts therapists self-identified ethnically as white. The other 11 arts therapists in the Trust also did so. In addition to the 'white' category they added European (1), English (1) and British (7). Under cultural background, 1 of the unit arts therapists identified as Jewish / Norwegian, 1 as British colonial, 1 Italian, 1 Western European, 1 middle class and 1 Yorkshire.

#### **4.3.1.2 Migration history**

Migration history can impact over at least three generations on ethnic / cultural identity and mental health (Bhui 2002, DOH 2003). I asked all participants' family history of migration over three generations.

##### **First generation**

All clients whose details were known, were British born (14 out of 18). The staff were not all born in Britain, 4 out of 17 were not. They were born in India, Norway, Hong Kong, Italy and Wales. This meant that 25% of staff were first generation migrants.

##### **Second generation**

In the sample of 14 clients, 3 had one parent born outside the UK (Ireland, Israel and Brazil). One client's parent was born in the UK, but grew up in the US. 1 client and 1 member of staff were unable to say, as they were adopted and did not know their birth parents. In the staff team, 3 first generation migrants came from parents and grandparents rooted in their birth country (S.India, Italy and Norway). 2 more therapists identified one parent as Scottish. In the second generation 5 staff and 4 clients knew migration experience.

##### **Third generation**

In the third generation 1 additional client identified Irish grandparents and 4 members of staff identified mixed (grand) parentage (Scottish/Irish, Gaelic/Italian, Scottish and Welsh).

Over 3 generations the migration experience can be summarised as follows. The client sample did not include first generation migrants, but counted 4 second generation and 1 third generation migrants. This is in total 35 % of clients. The staff included 4 first generation, 1 second generation and 4 third generation migrants. This totalled 55%.

Additional migration experience in the form of temporary living abroad was experienced by one client, who lived in the US for several years in childhood, and another client whose mother grew up in the US. Of the staff 4 more members of staff had lived in different countries from the UK (US, United Arab Emirates, Netherlands, France, Germany). Two of the first generation migrants had lived in other countries besides the UK (Switzerland, Israel and Ireland). There were no refugee backgrounds amongst staff or clients. Involuntary migration is known to contribute to the heterogeneity in ethnic and cultural self-identification (Zane et al 2004).

#### **4.3.1.3 Influence of the surrounding community**

Reinforcement of the surrounding community can strengthen ethnic and cultural identity (Zane et al 2004). Urban conurbations are more likely to have communities that are of similar backgrounds living together (Adonis and Pollard 1997). Community groups funded by the C. City Council Arab, Bangladeshi, Bosnian, Caribbean, Vietnamese, Chinese, Polish, Indian and Pakistani (Humm 1996). The Irish and Jewish community groups were invisible in the region's census results. 50% of clients had moved frequently during their childhood, of those 40 % lived in the city and 10 % in a village or small town in the rural region. Of the other 50 % who had only moved rarely, 45% lived in the city and 5% rural. 20 % of the frequent movers had lived in urban, rural and small town communities. Those clients, who identified as ethnically or culturally different, had not lived surrounded by communities similar to their difference. Staff said the same, although the first generation migrants had contacts with people from the same language, religion, culture and nationality across a wider region.

#### **4.3.1.4 English second language / English language proficiency**

One client and one arts therapist knew English as a second language. Both were bilingual in their first and second languages. The therapist had a distinct accent in speaking English, but the client did not. All clients and staff said English was the main language of communication, both inside and outside the home.

#### **4.3.1.5 Religious affiliation**

In the 2000 census religion was monitored as a part of cultural identity (ONS 2005). Cultural / religious differentiation can indicate a maintaining of cultural identity beyond migration (McGoldrick et al 1996). The religious backgrounds of parents can indicate a maintaining of (grand) parental cultural identification; the religious background of the children can indicate a further passing on of that identification or a break with it.

Table 8 presents the religious affiliation of clients and staff, both for themselves and for their parents.

The table shows that fifty percent of clients self-identified as not religious, fifty percent as religious. One client (Liz) identified herself as adhering to the same religious tradition as her (adoptive) parents. One client (Mandy) adhered to the same religion as her mother (who was separated from her father). She and her mother were newly converted by a family member to Islam. One client (Kate) self-identified as Christian, thus unifying her parents' religious backgrounds of Church of England and Roman Catholicism. Two clients felt they were reared in a particular religious tradition. One was christened in Church of England (Sally), although she did not identify either of her parents as having a religious tradition. The second (Belle) identified herself as having been reared a Roman Catholic, from a Methodist father and Roman Catholic mother. Both these clients identified themselves at the time as not religious. Two clients had experienced contact with the Spiritualist church. One had attended healing ceremonies, the other through her mother's occupation as a spiritualist preacher. The Jewish identification of Nathan is in the cultural, rather than the religious sphere. The 2 white British clients, who came from mixed ethnic/cultural backgrounds had not adhered to their religious backgrounds. The 2 clients who identified their mixed backgrounds remained faithful. The maintaining of religion as part of ethnic /cultural identity is reinforced by this finding. The client, whose family were recently converted, perceived this as separating them from the surrounding community.

Table 8 Religious affiliation: self and parents

Client	Declared Affiliation? Self	Declared Affiliation? Parents	Tradition – Self	Tradition – Parents
<b>LIZ</b>	Yes	Yes	RC	RC
<b>CATE</b>	Yes	No	no particular tradition	F none, M many including Spiritualists
<b>AL</b>	No	No		
<b>TED</b>	No	No		
<b>BELLE</b>	No	Yes	none, raised RC	M RC / F Methodist
<b>JACK</b>	No	No	None	n/k
<b>LIA</b>	Yes	No	C of E, attends spiritualist healing	n/k
<b>KATE</b>	Yes	Yes	Christian	M C of E, F RC
<b>HATTIE</b>	Yes	No	none/C of E	n/k
<b>SAM</b>	Yes	Yes	Catholicism	M RC
<b>SALLY</b>	No	No	christened C of E, non practising	
<b>JAN</b>	No	No		
<b>VAL</b>	No	No		
<b>MANDY</b>	Yes	No	Islam	M Islam
<b>NATHAN</b>	No	No	.	M Jewish
<b>DICK</b>	No	No	n.k	n.k
<b>PAT</b>	No	No	none.	C of E
<b>LEN</b>	No	Yes	None	None

### Codes used

RC - Roman Catholic, C of E - Church of England, M - Mother, F - Father, n/k - not known

The religious affiliations of the staff differed from those of the clients. For staff, 7 identified as not religious (approx 40%), 10 as adhering to a religion (60%). Five out of 17 staff continued the same religion as their parents, 6 a different one. One member of staff still felt a strong cultural link to the religious background of his parents. Of the 7 staff identified as not religious, two self-identified as lapsed.

Table 9 Staff religious affiliation; self and parents

Staff	Declared Affiliation? Self	Declared Affiliation? Parents	Tradition – Self	Tradition – Parents
ATH	Yes	Yes	Jewish	Norwegian Lutheran
DMTH	Yes	Yes	CofE	CofE
Arts th	No	Yes		M CofE
Arts th	Yes	Yes	CofE	MCofE, F none
Arts th	No	Yes	None	(Adoptive) Methodist
Arts th	Yes	No	Christian	None
Arts th	Yes	Yes	Buddhism	M vaguely Christian
Arts th	No	Yes	None	Quaker
Arts th	Yes	Yes	Christian	Buddhism
Arts th	Yes	Yes	RC	RC
Arts th	Yes	Yes	CofE	CofE
Co-Th1	Yes	Yes	RC (lapsed)	RC
Co-TH2	Yes	Yes	Christadelphians	Christadelphian
Co-Th3	No	Yes	None	CofE
Unit staff	No	No	None	'not really'
Unit staff	No	Yes	confirmed CofE, not practising	CofE
Unit staff	No	Yes	strong cultural influence	Hindu

### Codes used

RC - Roman Catholic, C of E - Church of England, M - Mother,

F - Father, n/k - not known

The range of religious backgrounds for clients included Christian, Islam and spiritualist orientations, for staff Christian and Buddhist orientations. The range of client and staff Christian backgrounds included Methodist, Church of England and Roman Catholic; for staff, Quaker and Christadelphian backgrounds were added. A higher percentage of staff professed to a religion than clients, and a higher percentage maintained the parental religious tradition (4 out of 14). Age may have played a role in an increasingly secularised society. 3 out of 18 clients continued in the same religious tradition as their parents, a smaller percentage than that of the staff.

### 4.3.2 Diagnoses

The psychiatric diagnoses of the clients varied between depression, including bi-polar affective disorder (Liz, Ted, Belle, Jack, Nathan and Pat), obsessive-compulsive disorder (Kate, Sam), personality disorder, including borderline personality disorder

(Cate, Jack, Lia, Sally), adjustment disorder (Liz, Sam, Sally), chronic anxiety and/or panic attacks (Ted, Lia, Sam, Mandy). Addiction problems included eating disorders (Belle, Jack, Lia, Hattie, Mandy, Nathan), while many of the clients showed other self-harming symptoms like cutting and overdosing. Co-morbidity has been shown to be an issue influencing attrition and retention in psychotherapy outcome research (Roth and Fonagy 2005). In common with other psychodynamic therapies in the NHS, the young people’s psychiatric service added their own psychodynamic diagnosis indicating the aetiology of the clients’ problems. These were in the areas of parental separation and / or death, separation difficulties and past histories of sexual / physical / emotional abuse. I will monitor which ways of understanding the different therapists used. The clients adhered to either psychiatric or psychodynamic understanding of the cause of their problems, but sometimes added their own models of understanding. These will be discussed in the case studies.

*Table 10 Client diagnoses and treatment history.*

<b>Client</b>	<b>Diagnosis</b>	<b>Other Stressors</b>	<b>Treatment History</b>
<b>Liz</b>	BPD,S,D	SA,A	AAP(in)
<b>Cate</b>	BPD,S,AD	PS, BS,SA	AAP(in),DT,CAP(out),C,FT,P
<b>Al</b>	D,,PD	BS,SP	AAP(outand in),CBT,DT
<b>Ted</b>	D,AP		DT
<b>Belle</b>	D,S,ED	SA,PEA,F	CAP(in),AAP(in),DT
<b>Jack</b>	PD,AD,DD,S	BS,PS,F	AAP(in),DT,CAP(out),P
<b>Lia</b>	BPD,S,AD,DD	BS, YC(2)	CAP(in),AAP(in),DT,FT
<b>Kate</b>	OCD,S,D	PS,	DT
<b>Hattie</b>	BPD,AD,S,D	SA, YC	CAP(out),DT,AAP(in)
<b>Sam</b>	AP,BPAD	BS,FE	DT,AAP(outand in)
<b>Sally</b>	BPD,S,AD		CAP(inand out),DT
<b>Jan</b>	BPD,S,ED,D	PS	CAP(in),DT,AAP(in),C
<b>Mandy</b>	AP,ED	PS,BS,SP	DT,C
<b>Nathan</b>	BPAD	PS	DT,P,AAP(out)
<b>Pat</b>	D,ED,OCD	PD,BS	CAP(out),AAP(out),DT
<b>Len</b>	AP	PS	DT,C

The analysis of the diagnoses shows that 45% (8 out of 18) clients had a diagnosis of personality disorder, of which 6 were borderline. The 5 cases of adjustment disorder also fell in these diagnostic categories, a high 45 %. 50% of clients also suffered depression and 50% self-harmed. The co-morbidity with addiction was 45 %, 8 out of 18 abused alcohol, drugs or food. The smaller diagnostic groups were obsessive

compulsive disorder 11% (2 out of 18), bipolar affective disorder 11% (2 out of 18) and 2 diagnoses were not available in the medical file. In chapter 6.4 I will look at the relation between certain diagnoses and attrition in this sample as in the literature PD, OCD and BPAD are all associated with higher drop out rates.

Two clients were known to have mild learning difficulties (Liz and Jack). The main identified stressors in clients' lives were parental separation and death (8 out of 18), bullying at school (7 out of 18) and sexual abuse (4 out of 18). Smaller numbers of clients had experienced stress through adoption and fostering (3 out of 18), being a single parent to young children (2 out of 18), somatic problems (2 out of 18) and family employment problems (2 out of 18). In chapters 6.4 and 7 I will look at whether these stressors influenced attrition or dissonance.

Table 11 provides an overview of the particular clients concerned:

*Table 11 Diagnostic clusters*

<b>Diagnosis</b>	<b>Clients</b>
Addiction problems (inc. eating disorders)	Belle, Jack, Lia, Hattie, Mandy, Nathan, Jan
Depression (inc. bipolar affective disorder)	Liz, Ted, Belle, Jack, Nathan, Pat, Jan
Chronic anxiety and/or panic attacks	Ted, Lia, Sam, Mandy, Len
Personality disorder (inc. borderline p.d.)	Cate, Jack, Lia, Sally, Jan
Adjustment disorder	Liz, Sam, Sally
Obsessive-compulsive disorder	Kate, Sam

Co-morbidity was present for 60 % of clients (10 out of 18), single diagnosis for 40 % of clients (8 out of 18). The psychodynamic stressors indicated co-morbidity of somatic problems for Al and Mandy.

Many clients received previous treatment before coming to the young people's psychiatric service. Previous treatment indicates repeated episodes, chronicity and severity of problems (Roth and Fonagy 2004), another factor influencing engagement with therapy. Previous treatment might involve treatment from the child and adolescent psychiatric service (Liz, Cate, Belle, Sally, Pat) or previous admissions in the acute adult psychiatric service (Liz, Cate, Belle, Jack, Lia, Hattie, Nathan). For Liz, Cate and Belle these continued during treatment at the young people's service.

Admissions were usually due to self-harm incidents. Several clients had no previous admissions. These were Al, Ted, Kate, Sam. Sam continued treatment in the adult acute psychiatric service after he left the young people's service. Al, Ted and Kate did not continue to need services post discharge. This might have been due to completed treatment in the young people's service and / or problems of lesser severity. All clients had received previous drug treatment and continued this during their treatment in the young people's psychiatric service. The aims of the treatment included the reduction of drug treatment when and where possible.

*Table12 Previous psychiatric history clusters*

<b>Previous Psychiatric Treatment</b>	<b>Clients</b>
No previous admissions	Al, Ted, Kate, Sam, Len, Mandy
Treatment from child/adolescent services	Liz, Cate, Belle, Sally, Pat, Jan
Admissions to adult acute services	Liz, Cate, Belle, Jack, Lia, Hattie, Nathan, Jan
Ongoing admissions to adult acute services	Liz, Cate, Belle

33.3 %, 6 out of 18 clients, had no previous treatment, except drug treatment. 66.6 %, 12 out of 18, received previous treatment indicating severity and chronicity of problems. Severity and co-morbidity need to be looked at as interacting factors when studying attrition and dissonance.

*Table13 Psychodynamic stressor clusters*

<b>Psychodynamic stressors</b>	<b>Clients</b>
Bullying at school	Cate, Al, Jack, Lia, Sam, Mandy, Pat
Adoption/fostering	Liz, Jack, Belle
Abuse (physical/emotional/sexual)	Liz, Cate, Belle, Hattie
Parental separation/death	Cate, Jack, Kate, Jan, Mandy, Nathan, Len

Psychodynamic stressors that may affect socio-economic circumstances are family employment problems and single parenthood. This affected Sam, Lia and Hattie and needs to be considered when looking at NS-SEC and attrition in 6.2.

### 4.3.3 Socio-economic variations

Lower socio-economic class can interact with ethnicity / culture and diagnosis to affect attrition (Elkin et al 1989). Socio-economic and educational achievements can influence the within-group heterogeneity of a cultural group and interact with the influence of the surrounding community. Table 14 presents the clients' socio-economic class.

*Table 14 Client NS-SEC*

<b>Client</b>	<b>Present (self)</b>	<b>NSEC</b>	<b>Past (self)</b>	<b>Father</b>	<b>Mother</b>	<b>Head of Household</b>
<b>Liz</b>	Unemployed	6(P6)	Nanny	Post office job	Home help / Teacher	Father
<b>CATE</b>	Unemployed/SB	8(P1/2)		Accountant	Preacher	Lives independently
<b>AL</b>	IT company (admin)	6 (P2)	Pub, bar work.	Accountant	Housewife	Lives independently
<b>TED</b>	Unemployed	6 (P6)	Mechanic	Electrician	Housewife	Partner (hairdresser)
<b>BELLE</b>	Unemployed/SB	8 (P7)	Waitress	Factory Worker	Receptionist	Lives independently
<b>JACK</b>	Unemployed/SB	8 (P5)		Engineer	Shop worker	Mother
<b>LIA</b>	Unemployed	8 (P2)		Biochemist	Nurse	Lives independently
<b>KATE</b>	Student	8(P2/4)		Graphic Designer	Teacher	F/M alternate
<b>HATTIE</b>	Unemployed/SB	8(Pn/k)		n/k	n/k	Lives independently
<b>SAM</b>	Student	8(P4)		Business Language school	Business Language school	Father
<b>SALLY</b>	SB	8(P5)	Secretary School	Policeman	Disabled (ex-nurse)	Father
<b>JAN</b>	Student	n/k		n/k	n/k	Father/independent
<b>VAL</b>	No data	n/k				
<b>MANDY</b>	Unemployed	8(P8)		Unemployed	Unemployed	Brother (window cleaner)
<b>NATHAN</b>	Student	8(P2/3)		Scientist	Artist	Mother
<b>DICK</b>	No data	n/k				
<b>PAT</b>	SB	8(P5)		(step) Fireman	Hairdresser	Stepmother
<b>LEN</b>	Unemployed	8(P8)		Unemployed	Unemployed	Father

Abbreviations: SB = Sickness Benefit, n/k=Not Known,

From 2001 the national statistics socio-economic classification (NS-SEC) was used for all official statistics and surveys as a good predictor of health and education

outcomes (NS-SEC 2000). I derived class by the simplified method, which looks at the SOC (Standard Occupational Classification) 2000 unit group. Students and the unemployed are 'not classified'. The NS-SEC treats those currently not in paid employment by allocating them via their last main paid job (NS-SEC 2000). All clients, while in the unit, fell into this category, so I classified them according to their parents' household. In cases of parental separation the head of household rule applies. When going by parental occupation of the 14 clients for whom data were available 6 clients (33%) were in analytic class 2 and 3. These are the two classes therapists tend to be assigned to. The other clients were assigned to class 4 (1), 5 (3), 6 (2) and 8 (2). So, 8 clients were below the class of the therapists and 6 equal or above. If I went by the analytic class assigned to long term unemployed or non-employed all clients were in analytic class 8.

*Table 15 Staff NS-SEC*

<b>Occupation</b>	<b>NS-SEC Self</b>	<b>Partner</b>	<b>Father's Occupation</b>
AT	2	Scientist	Preacher
DMT	2 or 3	Self employed builder	Aviation underwriter
Arts therapist	2 or 3	Single	Wing commander (RAF)
Arts therapist	2 or 3	GP	Archaeologist
Arts therapist	2 or 3	Single	Professor of medicine
Arts therapist	2 or 3	Single	Prison governor
Arts therapist	2 or 3	Shop worker	Army officer
Arts therapist	2 or 3	Single	n/k
Arts therapist	2 or 3	Psychotherapist	Policeman
Arts therapist	2 or 3	Psychotherapist	Businessman
Arts therapist	2 or 3	Teacher	Wages clerk
CO-TH1 Arts therapist	2 or 3	Nurse	Postman
CO-TH2Nurse therapist	3	Housewife	Drycleaner
CO-TH3Nurse therapist	3	Single	Policeman
Nurse therapist	3	Single	n/k
Nurse therapist	3	Single	Teacher
Consultant	1 or 2	Single	Journalist

Admin = administration, RAF=Royal Air Force

All staff gave their father as head of household, so only this is indicated. The two members of staff who did not know their father gave mother's occupation as housewife and mother. When comparing parental and own analytic class for the arts

therapists and nurse therapists it is noticeable that many of the arts therapists fell in a lower analytic class than their parents. This was the case for 8 out of 11 arts therapists. For the nurse therapists the situation was reversed, 4 out of 6 were in a higher analytic class than their parents.

The level of educational achievement differed between therapists and clients. Although the age of the clients might mitigate their circumstances, at the time 35 % had not completed their statutory education. Their mental health difficulties started in early adolescence and bullying at school had affected their education. Two clients' educational achievements were not known, but 8 completed their statutory education and three were enrolled in higher education. Of the staff 15 out of 17 had higher education degrees, and two professional further training as nurses (one had not completed his statutory education either).

Downward mobility was shared by both clients and arts therapists. Family employment problems affected three clients, while single parenthood affected two more clients. There were socio-economic status differences between some clients and therapists, so this variable will be monitored as a potential influence on attrition and dissonance in chapters 6.2 and 7.

#### **4.3.4 Age and gender**

Attrition research could not conclusively indicate that this factor might influence engagement. Client age varied between 16 and 29 at the end of the fieldwork period, as shown in table 15. Younger clients with borderline personality disorders and high initial hostility have higher attrition rates (Hilsenroth et al 1995), which may apply to Sally and potentially Cate.

The sample included 10 female clients and 8 male clients. The arts therapists at the time of the research were two men (one also a unit staff arts therapist) and 10 women. The unit staff sample included a male arts therapist, two male nurse therapists, a female nurse therapist (an additional female replacing the arts therapist later in the year) and a male consultant.

Both arts therapists in the study were female. In art therapy the co-therapy relationship between art therapist and unit staff remained male – female. In dance movement therapy the co-therapy relationship was at first male – female, and then became all female. Research into psychotherapy attrition has not been able to identify gender as a deciding factor. However, given the differential gender attendance in AT and DMT, this variable will be considered in the case studies in chapter 7

*Table 16 Client age (December 1999) and gender*

<b>Client</b>	<b>Age</b>	<b>Gender</b>
<b>Liz</b>	29	F
<b>Cate</b>	19	F
<b>Al</b>	22	M
<b>Ted</b>	25	M
<b>Belle</b>	19	F
<b>Jack</b>	23	M
<b>Lia</b>	23	F
<b>Kate</b>	18	F
<b>Hattie</b>	27	F
<b>Sam</b>	21	M
<b>Sally</b>	17	F
<b>Jan</b>	26	F
<b>Val</b>	n/k	F
<b>Mandy</b>	19	F
<b>Nathan</b>	24	M
<b>Dick</b>	n/k	M
<b>Pat</b>	16	M
<b>Len</b>	21	M

#### **4.4 Researcher identity**

As stated, research showed that the orientation and identity of the researcher (Beutler 1997, Luborsky 1999, West and Talib 2002) can affect the research outcomes. Researcher identity and process will be part of the reflective component of this research. My professional identity was identified in chapter 1.1.

My ethnic/cultural self-identification is white Dutch, religious orientation Christian (parents Dutch Calvinist). First language Dutch, second language English (main

language spoken in the home is English). I am a first generation migrant, in a mixed partnership with an English partner. At the time I lived rurally, but had moved many times between rural and urban environments. There was no surrounding Dutch community, but I was in touch with others via a wider regional network. NS-SEC self and partner was 2 to 3, my gender is female.

I mentioned in chapter 1.1 that in my personal and professional journey towards this research I developed an interest in majority group heterogeneity. Factors influencing heterogeneity that I had become aware of were: language, nationality, gender, power, class and cultural form in the arts modality. Training after dramatherapy in group analytic psychotherapy made the psychodynamic orientation of the unit and arts therapies department a familiar framework within the psychiatric context. I had worked as a dramatherapist within the trust studied, but in a specialist unit separate from the department and the young people' service. If that had not been the case, establishing a separate identity and position as participant observer might have been very difficult with both the staff and client population.

My first generation migrant identity placed me in the 25% of staff who were first generation migrants and one of the regional 'white others', who followed a mainly individual pattern of migration. My English second language first migrant identity was similar to that of the art therapist, while my professional identity was closer to the dance movement therapist. My religious orientation placed me in the regional majority, linking me with the 7 out of 17 staff who professed to a Christian identity and 4 out of 18 clients.

My socio-economic status in relation to that of my background was similar to the unit staff in upward mobility, while most of the arts therapists were of a lower socio-economic status than their parents.

If and how my identity, professional and personal, impacted on the research is part of the next analysis chapters.

#### **4.5 Methodological difficulties in studying the sample**

During the fieldwork and analysis stages of the research I became aware of various methodological difficulties. These were the time interval between fieldwork and the contextualizing of the sample, incomplete ethnic monitoring, NS-SEC classifications for mental health clients and high levels of attrition.

Prior to the Race Relations Amendment Act (2000) and the National Service Framework for mental health (NSF 1999) ethnic monitoring was shown to be sparse and sporadic. The trust data in clients' medical records during the fieldwork was based on the 1991 census identity criteria, which did not allow for within group heterogeneity and mixed identity. Prior to the NSF, which set targets for trusts to monitor access for excluded groups, ethnic monitoring of clients was not systematically performed. Sometimes staff would complete forms on behalf of clients (most of this was done at admission when clients tended to be in a distressed state), or left them incomplete. As was seen in the data, there is still a sizable percentage of not known / blank returns. However, since 2000 the categories allow for greater diversity, staff have been trained in the performance of ethnic monitoring and the legal framework has provided the motivation for a better documentation system.

The implication of this for my research was that for those clients who I was not able to interview, or who did not respond to my follow up after drop out, I had to rely on scarce documentation in medical records. Additionally, the regional and trust contextualization figures were not from the same time period, but two years later. There was no indication that in those two years significant population changes took place, but I have included data from local voluntary organizations that were available for the two years before the fieldwork (Humm 1996). Given the different criteria used it was difficult to be precise about exact population changes.

The lack of available trust data for staff monitoring meant that I was not able to contextualise the unit and arts therapies staff data with that of the trust population. Instead, I used the data from another trust in a similar regional area a few years prior to the fieldwork. The lack of arts therapies professional association data meant that I

was not able to contextualise the arts therapists' identity within the national professional context.

NS-SEC analytic categories proved difficult to use with young people and those in the mental health system. Connections with parental NS-SEC were used to overcome this.

The differential systems of diagnosis in the psychiatric and psychotherapeutic contexts, the presence of co-morbidity for 60 % of the clients and the variation in severity as indicated by previous treatment received, shows the relativity of outcome research based purely on diagnosis. Diagnosis appears to be subject to as much variability as ethnicity and culture. It needs to be studied as an interacting factor taking that heterogeneity into account. Psychotherapy research confirms this finding (Roth and Fonagy 2005), although there is as yet scant evidence that this finding is effecting the evidence based practice debate (Gilroy 2006) and NHS evidence hierarchies (Mann 1996).

High attrition rates can affect the validity of psychotherapy outcome research. I did find that of the 6 clients who dropped out before 4 months, I was only able to follow up 1. This limited the amount of data available for drop outs. I relied on interview data for the database details of ethnic/cultural and socio-economic identity, as well as client perception of diagnosis. Clients who dropped out were sent the semi structured questionnaire offering an interview or SAE for return. Only one out of the 6 drop outs agreed to this. His data will be used as an individual case study, but its generalisability is likely to be narrow given the lack of contextualization with the other clients who dropped out. Future research needs to incorporate a different methodology to enable systematic monitoring of the reasons for client drop out.

The high attrition rates from the group also meant I had to extend my fieldwork period in the light of the change over of staff and clients from one to one and a half years. The differing stages of treatment of clients in the group and the changing group composition needed to be monitored as another potentially influencing factor on dissonance.

## 4.6 Chapter findings and conclusions

- Attrition. Research indicates that 40 to 60 % of clients drop out of psychotherapy treatment in the early stages (Lambert 2004). There are no specific arts therapies figures. The sample shows 33.3 % attrition within the first four months, while 66.6 % of clients remain in therapy. The data shows a different average attendance of arts therapies for those clients who drop out (47.6%) and those who remain in therapy (71.6%), while they are attending the unit. Client attendance has been shown to be an indicator of attrition.
- The data shows a different attendance in the dance movement therapy (68.6%) and art therapy group (61.5%), with a higher attendance of male clients in DMT and of female clients in AT. Gender is thus one interacting client and therapist variable to be studied.
- Staff turnover has been identified as an interacting treatment variable to be studied.
- Consistent ethnic monitoring has changed since the introduction of the new census categories and legislation, but professional associations and trusts still either monitor inconsistently or do not publicise their findings, making systematic research of the effect of demographic variables problematic.
- Diagnostic heterogeneity within mental health makes psychiatric diagnosis as a determining variable problematic within this sample.
- The sample in its context. There are differences in cultural diversity between the urban and countryside population; there are 2 % of sample clients from visible minorities in a trust and locality context of 2.4% and 2.1% (0.3% in the rural community). The therapists are all white. One member of staff and one client in the sample are from visible minorities (classification used by National Office for Statistics). Rural communities (clustered in villages and small towns) have a much smaller percentage of 0.3% visible minorities. The sample

shows a higher percentage of first generation migrants amongst the staff: 25% in comparison with the 8.65% in the city and 3.32% in the rural region. When two further generations are incorporated staff migration history amounts to 55%, while clients total 35%. The census and trust figures only reflect this if it is part of ethnic self-identification.

- Religion as a cultural diversifier is present. The religious orientation of staff is similar to that of the city (65 % and 60%), but lower than the rural population (75%). The clients in the sample have higher rates of no religious affiliation (50%) than the staff, local and adult trust populations.
- Staff members have higher migration history rates than clients and then the local population. This may be generalisable to other NHS trust staff, but lack of systematic monitoring and high non-completion rates make comparison difficult.
- Both staff and clients are downwardly mobile (NS-SEC) in relation to their parents. For the clients this is due to a combination of their age and mental health difficulties, for the arts therapists their choice of career is potentially due to other factors than those of socio-economic class (Gilroy 1995, Grainger 1995).

Treatment variables potentially affecting dissonance identified were: stage of treatment, group composition, staff turnover and absence. The presence of the researcher is one of the aspects of group composition. This will be monitored in the analysis of the data in the next chapters.

## **Chapter 5 Helpful and hindering aspects of art therapy and dance movement therapy groups**

### **5.0. Chapter overview**

The previous chapter analysed the sample. This chapter studies client and therapist perception of the therapy groups. Chapter 2.4 showed how humanistic congruence research studied client and therapist definition of helpful and hindering aspects of (individual) therapy (Lietaer 1992). This chapter does so for arts therapies' groups.

This analysis will be presented in three steps; firstly the qualitative analysis of the data from the session evaluation questionnaires. Through clustering, themes are identified concerning consonance and dissonance between clients and therapists in the group context. The qualitative comments and ratings from the questionnaires are triangulated with the focus group data to ascertain the importance / 'weighting' given to various themes by the clients and therapists.

Researcher consonance and dissonance is contextualised within the client and therapist data and methodological difficulties are analysed, before summarising the chapter findings.

### **5.1 Art therapy and dance movement therapy themes identified by clients, therapists and co-therapists**

Clustering is a tactic that can be applied at many levels to qualitative data. It may be at the level of events or acts, of individual actors, of processes, of settings/locales, of sites or cases as wholes. In all instances, we are trying to understand a phenomenon better by grouping and then conceptualizing objects that have similar patterns or characteristics. (Miles and Heberman 1994: 249)

Clustering is the process of inductively forming categories and the iterative sorting of things – events, actors, processes, settings, sites- into those categories. I will use this clustering method as a first step of identifying dissonance and consonance themes.

The data analysis of the session evaluation questionnaires were completed by the researcher and a research assistant. Independent of each other they identified the themes by scanning through the client comments in the questionnaires, looking for overarching themes (clusters). These were then correlated and formulated in the following coding system. The coding system used is that A or D at the beginning denotes Art Therapy or Dance Movement Therapy. The themes are numbered 1 to 20, the + or – indicates whether they are useful (+) or unhelpful (-) themes. An extra D before the + or – indicates that this is a dissonant theme between clients and therapists. The co-therapists' data are used to triangulate those of the therapists and clients.

### **5.1.1 Art therapy consonance**

Both clients and therapist identified as useful:

- A1+ The session being relaxing; people being able to do their own thing, people focusing on their own private space and everyone being allowed to be.
- A2+ The art work being central, expressive and 'for real'
- A3+ Contact between people in the group
- A4+ Enough time to paint and / or talk
- A5+ Strong issues being allowed to surface

Triangulated with the co-therapist the following themes were identified

- Chance to express feelings on paper (theme A2+)
- Having enough time, the time being well used (theme A4+)
- The atmosphere in the session being relaxed (theme A1+)
- Being able to focus(theme A1+)
- Interaction between group members (theme A3+)
- Time to think / reflect (theme A4+)
- Painting/art work (theme A2+)
- Space for individual work (theme A1+)

Not triangulated by the co-therapist was theme A5+. Not mentioned by the therapist was the time to think/reflect (mentioned by both clients and co-therapist, incorporated in theme A8-)

Both clients and therapist identified as unhelpful:

A6- Absences

A7- Lack of group connection: i.e. people not sharing their work, no sense of trying together, distance between people

A8- Time being experienced as problematic: session not long enough, balance between talking and drawing (either too much of one or too much of the other)

A9- Lack of focus: too much 'larking about'

Triangulated with the co-therapist the following themes were identified:

- Absences (theme A6-)
- People not sharing their work (theme A7-)
- Time not being used fully (theme A8-)
- Joking about as a defence (theme A9-)

### **5.1.2 Art therapy dissonance**

The differences between clients and therapist in what was identified as useful provided the following themes:

A10D+ Art as distraction. The therapist does not mention this, but the theme comes up for clients in two ways. Firstly the clients identify art as a distraction as helpful "because it takes my mind off my nerves", "doing a picture which does not mean anything as it helps me forget what I am feeling". Secondly the group interaction allows for distraction "being able to prat around", "talk while I am drawing "and "continuous japes and jollities"

A11D+ Boundary issues. The therapist regularly mentions the importance of a respect for boundaries, the clients do not mention this.

Triangulated with the co-therapist:

-co-therapist triangulates with the clients in stressing the importance of humour (theme A10D+)

-co-therapist triangulates with the therapist in stressing containment and focus – working in silence while painting, then talking (theme A11D+)

There were also differences between clients and therapist as to what they perceived as unhelpful:

Clients identified:

A12D- Feeling obliged to draw something meaningful

A13D- Interpretation; analyzing things which meant nothing

A14D- ‘Blame game’: strong dislike expressed of self, fellow clients and/or staff

Therapist identified:

A15D- Boundary issues: timing, absences, therapist personal material intruding on the session, lack of focus left unaddressed

A16D- Co-therapy issues: co-therapist absences in particular

A17D- Level / depth of the therapeutic work; strong undercurrents of feeling left unaddressed in the group.

Triangulated with the co-therapists:

- Co-therapist triangulates at times with clients in the ‘blame game’: one client experienced as disruptive or dominant/isolating himself to the detriment of the group. In the absence of therapist, the co-therapist comments “when the cat is away the mice will play “(lack of focus in the group) theme A14D-
- Co-therapist triangulates with the therapist on boundary issues of timing and absences, joking about as a defence (theme A15D-)
- Co-therapist picks up on issue of clients not sharing their work as unhelpful (A15D-, A17D-)

### 5.1.3 Dance movement therapy consonance

The therapist and clients both identified as useful:

D1+ Connecting with other people in the group; interacting

D2+ Space to talk

D3+ Expressing feelings (either through talking or movement)

D4+ Clients being able to initiate

D5+ Having fun, the session being enjoyable, being able to play i.e. 'not having to act my age' (clients)

D6+ Use of certain structures, such as props i.e. kicking balls to let out frustration (client), kicking the balls against the wall highlighted feelings (therapist) and relaxation; 'learning how to do it', 'relaxed some pressure' (clients)

D7+ Moving ;'to get rid of stress' 'to express our feelings'(clients), 'to express non-verbally what can't –yet- be put into words', to get in touch and explore feelings'(therapist)

More ambivalence between clients and therapists existed about the usefulness of being able to sit out and watch. Some clients stated they found it useful, but then also stressed the benefit of finding a way to join in as 'I would have got more out of it if I had joined in'. The therapist stressed the importance of tolerance and gentleness with members who sit out and were asked to join in. Both clients and therapist also stressed the usefulness of everyone working together, all joining in.

The co-therapists triangulated on the themes of:

- Clients being able to initiate (theme D4+)
- Having fun (theme D5+)
- Use of certain structures (theme D6+)
- Interaction and connection (theme D1+)
- Space to talk (theme D2+), they stress the importance of honest reflection and evaluation, therapist and clients emphasize expression more

The co-therapists were more ambivalent about the usefulness of movement and expression of feeling. One said that it was useful to express feelings through movement 'even though metaphorical'. Both tended to stress the usefulness of certain structures rather than the movement as such. This seems to mirror a theme that only the co-therapists mentioned; the importance of boundaries and containment.

In the art therapy group the art therapist was dissonant in mentioning boundaries. I wonder whether this may be a reflection of the nature of the co-working relationship with different therapists fulfilling different functions. On the other hand the co-therapist commented on an intervention by the dance movement therapist, which she herself did not mention / rate.

Co-therapist and clients related fun, humour and laughter. The therapist instead mentioned the ability to play. This may be an indication of a difference in terminology or meaning.

Clients and therapist agreed on unhelpfulness in the following themes:

D8- Lack of structure: 'No direction' (client), lack of structure at the beginning (therapist)

D9- Use of particular structures (safety issues): guided imagery ("imagining a field as it brought back bad memories"- client), balls "being out of control, hurting people"(clients and therapist),"warm-up increased self consciousness" (therapist), "walking around with my eyes shut", " being followed made me paranoid"(clients)

D10- Lack of connection between movement and talking: "my talking was quickly over washed by superficial music and movement", "all the talk at the beginning was boring"(clients), "not being able to come up with a way of facilitating movement", " not finding a way of continuing issues raised, not following through"(therapist)

D11- Absences, clients and staff being away, leaving the session.

D12- Clients not joining in (clients), not engaging (therapist)

D13- 'Blame game'; self, other clients or staff being found unhelpful: "AI being a misery guts", " I am unhelpable and a miserable cow", "the dance movement therapist and co-therapist 1 being patronizing wankers"

D14- Feelings not being expressed: " Difficult feelings blocked"(client),..." not being able to explore how he really felt the session –something else going on for him"(therapist)

D15- Physical space being too small e.g. to contain the kicking of the balls

Triangulated with the co-therapists:

- Absences (theme D11-)
- Smacking the big ball being overpowering (theme D9-)
- Blaming one member trying to sabotage the group, not joining in (theme D13)
- Clients not joining in (theme D12-)

The co-therapists were quite sparing in their use of the possibility for 'unhelpfulness' comments. One issue they raised, which the therapist but not the clients alluded to, is the 'intrusion' of issues in the wider unit (timetables, staff changes etc). Co-therapist 3 was particularly preoccupied with that: 6 out of 7 comments about what was unhelpful in the session related to issues outside the session intruding. Co-therapist 1, the other DMT co-therapist, found clients unhelpful 7 times out of 8. This mainly related to clients leaving, being absent, or not joining in.

#### **5.1.4 Dance movement therapy dissonance**

Clients identified as useful:

D16D+ Being able to sleep in the session

D17D+ Being able to sit out and watch (includes one client once stating she did not want to be invited in "as it would make me feel even more self conscious")

The therapist did not mention these themes, although they may relate to D12- (clients not joining in) experienced by both clients and therapists as unhelpful. It might have

been experienced as useful by an individual at a given time, but unhelpful by the other group members. The comment “People sulking because they wouldn’t join in” seems to indicate that possibility.

The therapist stressed the usefulness of:

D18D+ Thinking about physical pain as a way of thinking symbolically about emotional pain

D19D+ Smaller group enabling clients to express their needs and feel less anxious about taking part (the clients tend to always comment on people being absent as unhelpful. One client also said that he always thought a bigger group would make it easier, but when it happened, it wasn’t)

D20D+ Being able to be open about difficulties of confronting issues related to body image

The clients never mentioned the first (D18D+) or the third issue (D20D+) as a theme. This may be related to the fact that this is concept particular to the vocabulary of the therapist, based around the theoretical concepts of the efficacy of symbolism (see chapter 2.5). On the other hand it might be a difference in perception about the aims of dance movement therapy. The co-therapist stressed the importance of boundaries, while the therapist was more ambivalent. This may depend on the nature of the particular boundary; both therapist and clients commented on the usefulness of going outside into a different environment for one session (the co-therapists were absent).

Clients mentioned as unhelpful:

D21D- “Not being told it was all right to go to the loo” (therapist stresses self directedness)

D22D- “Being tired out by the session”, “ Group being too long”

There was a dissonance in the ratings between therapist and clients: where the clients would say and rate that a session was ‘absolutely shit’ (and rate it 0 or 1), the therapist conscientiously listed both positive and negative aspects of a session.

Therapist mentioned as unhelpful:

D23D- “Not being able to verbalise / articulate the meaning of a movement, i.e. ‘kicking’. Clients sometimes mention that talking about things is important, but also stress the relief of pressure through the movement.

D24D- Not being able to say goodbye (not articulated by the clients)

The co-therapist triangulated with the clients, in stating that “one client not joining in puts pressure on the others to perform” and in another session “the person who did not join in caused embarrassment to the other group members”. Not directly triangulated with the therapist, but sharing the same theme pre-occupation were a couple of comments about absent members and leavings

## **5.2 The group process: triangulation focus groups and questionnaires**

Having identified client and therapist themes, it was important to ascertain how much each theme affected the session for clients and therapists. The weighting of a theme may be reflected in the grading of the session or in the frequency with which a theme is used. If clients or therapists have a consistency in grading related to particular themes, the grades alone may be useful in a quantitative analysis of dissonance between therapists and clients. Certain themes may only be relevant to certain clients, or may only occasionally be relevant in a client’s perception of treatment. The frequency with which certain themes are used indicates their relevance either for the group as a whole or for certain individuals (triangulation focus group and individual questionnaires).

In Chapter 3 I outlined the rationale for using focus groups as part of the methodology. The focus groups took place each week at the end of the sessions, the staff and client groups met separately from each other. The questions asked were similar to those in the questionnaires (used as a semi structured questionnaire template) and recorded verbatim in a palm top computer. They were then analysed as

to the occurrence of the themes (clusters) and studied for differences and similarities with the questionnaires. The number of focus group participants varied between two and six participants in both the staff and client focus groups. Both groups were able to request the researcher to withdraw when they wished. The clients used this option, the staff did not.

### **5.2.1 Art therapy triangulation**

Table 39 presents the frequency of the AT themes identified in 5.1 in both questionnaires and focus group. You will see the mean grade the clients attached to these themes. In the tables below, if 2 comments were recorded from the same form, this is only counted once. The rating used with the themes is indicated in brackets behind the client, FG indicates the number of the focus group in which the theme was mentioned. The number of clients is linked to the number of clients using that theme.

The first question asked from this data was whether certain grades matched certain themes. It is clear in the table that the same client may attribute different grades to the same theme and that different clients attribute different grades. The mean grade is thus used as an indicator of overall group attribution of a particular theme to the usefulness and unhelpfulness of a session.

Table 17 AT Themes and grades\*; client questionnaires and focus groups

Theme	Clients/Grades	Mean Grade	Frequency	No. of Clients
A1+	MANDY (2), LIZ (5), LIZ (5)	2.67	3 FG6	2
A2+	NATHAN (2), HATTIE (3), CATE (4), BELLE (4), JACK (4), JACK (4), SAM (4), LIZ (5), LIZ (5), TED (5), SALLY (5), SALLY (5)	4.52	21 FG5	9
A3+	SAM (2), MANDY (2), LEN (2), BELLE (3), SAM (3), SALLY (3), KATE (4), TED (5)	3	8 FG4	8
A4+			0	-
A5+	JAN (3), KATE (4), MANDY (5), MANDY (5)	4.25	4 FG3	3
A6-	TED (5), KATE * (4), TED * (5), TED * (5)	4.75	4 FG5	2
A7-	SALLY (1), SAM (3), SAM (3)	2.33	3 FG6	2
A8-	TED (2), TED (3), LEN (3)	2.67	3 FG2	2
A9-	MANDY (2)	2	1 FG1	1
A10D+	LEN (2), BELLE (3), SALLY (3), JAN (3), LEN (3), LEN (3), BELLE (4), KATE (4), LIZ (5), BELLE (5), BELLE (5), BELLE (5), KATE (2)	3.62	13 FG2	7
A11D+			0	-
A12D-	SAM (2), SALLY (3), SALLY (3), MANDY (2)	2.5	4 FG3	3
A13D-	CATE (2), KATE (3)	2.5	2 FG5	2
A14D-	BELLE (1), BELLE (1), BELLE (1), SALLY (1), SALLY (1), SALLY (1), BELLE (4)	1.43	7 FG8	2
A15D- A16D- A17D-	Not used by clients		FG1	

\* Theme descriptors on pages 98-100

Looking at mean grades for the clients using the themes it becomes clear that the art work being central, expressive, ‘for real’ (A2+) and strong issues being allowed to surface (A5+) contributed to the usefulness of a session graded as 4 and above. Absences (A6-) did not affect the clients’ grading. A lack of group connection (A7-), a lack of focus (A9-), feeling obliged to draw something meaningful (A12D-) and too much interpretation (A13D-) contributed to a session being experienced as unhelpful, all graded as 2.5 and below . The strongest unhelpful factor was that of the theme identified by the researcher and research assistant as the ‘blame game’ (A14D-), when clients blamed each other, themselves or the therapists as unhelpful. This factor

contributes to the lowest grade of 1.43, indicating that this theme contributes most to the unhelpfulness of a session.

The varying grades within each theme indicate that each theme alone is unlikely to be associated with the overall usefulness and unhelpfulness of a session. Also, some themes are used much more frequently than others, potentially skewing the results in a small sample. It is therefore important to look at the highest frequency of themes in addition to the grading.

The second question asked from the data was whether the frequency with which themes emerged matched the grading. This might indicate the importance of certain themes in contributing to the overall usefulness or unhelpfulness of sessions. In the questionnaires the most used themes were the art work being central, expressive, 'for real' (A2+; 21 times) and art as distraction (A10D+; 13 times). In the focus groups the frequencies were wider spread, an additional 'useful' theme identified was the session being relaxing (A1+). More 'unhelpful' themes emerged in the focus groups: absences (A6-), interpretation, analyzing things which mean nothing (A13D-) and the 'blame game' (A14D-) came up at frequencies of 5 to 8. The focus group reinforces the questionnaire data about the usefulness of art being central, expressive, real (A2+), and the importance of art as distraction (A10D+).

Looking at the differences between the focus groups and the questionnaires shows that the greatest variety of clients mentioned art as distraction (A10D+), group contact (A3+) and the art being central, real and expressive (A2+) in their questionnaires. Independently of each other they identified these areas as useful. However, in the focus groups the importance of a session being relaxing (A1+) was added, although the questionnaires indicate this may be a theme that is relevant to a few individual clients in particular. Themes identified in the focus groups as contributing to the unhelpfulness of a session were a lack of group connection (A7-), too much interpretation (A13D-), the 'blame game' (A14D-) and absences (A6-). The questionnaire data indicate that these 'unhelpful' themes are of relevance to particular individual clients, rather than across the group as a whole. This will be elaborated on in chapter 7.

When comparing AT client themes with therapist themes to identify dissonance through frequency and grading, table 18 needs to be compared with table 17.

The same questions need to be addressed as for the clients. Firstly, which themes match which grades for the art therapist? The mean grades for the therapist varied between 2.5 and 3.5. Individual session grades varied between 2 and 4. Themes that for the therapist contributed to the usefulness of a session, associated with the highest grade of 4, were contact between people in the group (A3+), enough time to paint, talk (A4+) and strong issues being allowed to surface (A5+).

Therapist themes that contributed to the overall unhelpfulness of a session were graded 2 for individual sessions: absences (A6-) and boundary issues (A15D-). The therapist used varying grades for particular themes. The mean grading showed though, that a session was experienced as useful when strong issues were allowed to surface (A5+), there was contact between people in the group (A3+) and the art was central, expressive and real (A2+). The session was experienced as unhelpful if there were absences (A6-), boundary issues (A15D-) and strong issues were left unaddressed in the group (A17D-). The most frequently used themes by the art therapist were A2+ (art being central, expressive and real), A6- (absences) and A15D- (boundary issues). The additional higher graded themes were used much less frequently than A2+ (art being central, expressive and real). When the therapist questionnaire frequency is triangulated with the focus group data the most frequently mentioned themes (10 times) were A6- (absences), A15D- (boundary issues) and A17D- (strong undercurrents of feeling left unaddressed in the group). A14D- ('blame game'), not mentioned by the therapists in the questionnaires, was raised 3 times in the focus group.

Table 18 AT Themes\* and grades; Staff questionnaires and focus groups

Theme	Staff/Grades	Mean Grade	Frequency
<b>A1+</b>	CO-TH 2 (3), CO-TH 2 (4), CO-TH 2 (1.5), CO-TH 2 (3.5) ATH (3.5), ATH (2.5), ATH (2.5),ATH (3)	3 3	4 4
<b>A2+</b>	CO-TH 1 (4), CO-TH 1 (4), CO-TH 1 (4), CO-TH 2 (2.5), CO-TH 2 (3.5), CO-TH 2 (3), CO-TH 2 (4), CO-TH 2 (4), CO-TH 2 (4), CO-TH 2 (3.5), CO-TH 2 (2.5) ATH (2.5),ATH (3), ATH (3), ATH (3), ATH (3), ATH (2), ATH (2), ATH (3), ATH (3), ATH (3), ATH (3),	3.54  3.17	11 FG5  11
<b>A3+</b>	CO-TH 2 (2), CO-TH 2 (4.5), CO-TH 2 (4.5), CO-TH 2 (2.5) ATH (3), ATH (4), ATH (4) ATH (3)	3.375 3.33	4 FG4 4
<b>A4+</b>	CO-TH 1 (3),CO-TH 2 (4), CO-TH 2 (2.5), CO-TH 2 (3.5) , CO-TH 2 (2.5), CO-TH 2 (3) ATH (2.5), ATH (4), ATH (no grade), ATH (2.5), ATH (4)	3  3.25	6  5
<b>A5+</b>	ATH (3), ATH (4), ATH (no grade)	3.5	3
<b>A6-</b>	CO-TH 2 (2), CO-TH 2 (2), CO-TH 2 (2.5), CO-TH 2 (2.5), CO-TH 2 (2) , CO-TH 2 (3) , CO-TH 2 (3.5) ATH (3), ATH (3), ATH (3),ATH (3) ], ATH (3), ATH (no grade), ATH (2), ATH (2.5), ATH (3), ATH (3)	2.6  2.8	7 FG 10  10
<b>A7-</b>	CO-TH 1 (3), CO-TH 1 (3), CO-TH 1 (3),CO-TH 2 (2), CO-TH 2 (4), CO-TH 2 (2.5), CO-TH 2 (1.5) ATH (2.5), ATH (2.5)	2.7  2.5	7 FG4  2
<b>A9-</b>	ATH (3), ATH (3)	3	2 FG1
<b>A10D+</b>	No staff comments		
<b>A11D+</b>	ATH (2.5), ATH (3)	2.75	2 FG1
<b>A12D-</b>	No staff comments		
<b>A13D-</b>	No staff comments		
<b>A14D-</b>	ATH (3)	3	1 FG6
<b>A15D-</b>	CO-TH 2 (2.5), CO-TH 2 (2) , CO-TH 2 (3) ATH (2), ATH (3), ATH (3.5)], ATH (3), ATH (3), ATH (no grade), ATH (2), ATH (2) [, ATH (2.5), ATH (3), ATH (3) , ATH (3 ) ATH (4)	2.5 2.91	3 FG10 13
<b>A16D-</b>	ATH (2.5), ATH (3), ATH (4) , ATH (3) [also A17D-]	3.1	4
<b>A17D-</b>	CO-TH 1 (4), CO-TH 1 (3), CO-TH 2 (4.5), CO-TH 2 (2), CO-TH 2 (2) , CO-TH 2 (2.5), CO-TH 2 (2.5) ATH (3) ], ATH (2.5), ATH (2.5), ATH (2.5), ATH (3), ATH (no grade], ATH (3) , ATH (3)	3.25  2.83	7 FG10  8

\* Theme descriptors on pages 98-100

Triangulating the grades and frequencies of the therapist and the co-therapist the therapist graded contact between people in the group (A3+) highest while the co-therapists graded the art being central, expressive and ‘for real’ (A2+) highest. The

therapist grade indicates as most unhelpful a lack of connection (A7-) the co-therapists boundary issues (A15D-). For individual sessions the theme associated with the highest grade for the co-therapists is group connection (A3+), the lowest with a lack of connection (A7-), and the fact that the session is relaxing (A1+) does not make any difference in its grading to its experienced unhelpfulness.

The co-therapists identified most frequently the art being central, expressive and real (A2+), group contact (A3+), enough time to paint and talk (A4+) as useful. A lack of group connection (A7-) was mentioned as unhelpful at a frequency of 5 and above.

The differences between the art therapist and co-therapist may indicate a difference in meaning and emphasis in the way the group is perceived. Unit dynamics may play a role and will need to be considered under treatment variables in chapter 6. It is not possible to 'verify' the art therapist's grading with that of the co-therapists as individually the mean grades are skewed by the frequency with which themes are used, and the variations in grading within a particular theme.

Comparing client and therapist themes and their importance for the overall usefulness and unhelpfulness of session the following picture emerges. The way the themes affect the overall grading is different for clients and therapists. Themes contributing to high grades for the overall session for clients are that the art is central, expressive, real (A2+) and that strong issues are allowed to surface (A5+). Absences (A6-) do not affect the high grading (higher than 4). For the therapist the highest grades are also associated with the art being central, expressive, real (A2+) and that strong issues are allowed to surface (A5+). In addition, group contact (A3+) and enough time to paint and talk (A4+) contribute to a session's usefulness. Sessions where absences occurred were rated lower by the therapist, although absences had no noticeable effect on the client's grading of a session.

There is agreement between most of the clients and therapist on the importance of the art being central, real and expressive (A2+) for the usefulness of a session. The greatest numbers of clients mentioned this theme independently of each other in the questionnaires. It was also most frequently mentioned in the focus groups and had the highest mean client grade attached. For the therapist the art being central was also

most often mentioned, but not accompanied by the highest mean grade. The highest mean therapist grade related to strong issues being allowed to surface (A5+). However, that mean was based on a small number of grades and the theme was not frequently mentioned in the staff focus group. Other themes associated with higher grading and mentioned by a variety of clients were the usefulness of contact between people in the group (A3+) and being able to use the art as distraction (A10D+). The art therapist did mention contact between people in the group (A4+) and enough time to paint and talk (A5+) as useful, but never mentioned art as a distraction as useful. Therapist themes (questionnaire and focus groups), mentioned absences and strong feelings being left unaddressed when the clients mentioned this theme.

The themes associated with sessions being unhelpful were the ‘blame game’ (A14D-) for the clients and absences (A6-) and boundary issues (A15D-) for the therapist. Although a lack of group connection (A7-) carried the lowest mean grade, this was based on only a few graded sessions and the theme was not mentioned often in the staff focus group. For the clients it was difficult to identify themes contributing to the unhelpfulness of a session due to the fact that most themes were only mentioned by a few clients. This skews the grading and themes will need to be looked at on a more individual basis. Absences (A6-) and feeling obliged to draw something meaningful (A12D-) were mentioned by slightly more individuals slightly more frequently than the other themes.

Summarising the questionnaire and focus group data AT consonant and dissonant themes are shown in table 19, consonant themes are C and dissonant themes D. Certain themes were of particular relevance to individual clients. These are A6- (absences) for Ted, A1+ (session being relaxing) for Liz, A5+(strong issues allowed to surface) and a lack of focus (A9-) for Mandy, A7- (lack of group connection) for Sam and A12D- (feeling obliged to draw something meaningful) for Sally.

Table 19 AT client- therapist consonance and dissonance

<b>Useful C</b>	<b>Unhelpful C</b>
A2 + (art central)	A6 - (absences)
A3 + (contact between people)	
<b>Useful D</b>	<b>Unhelpful D</b>
A4+ (enough time to paint and talk) – Ath	A12D – (feeling obliged to draw something meaningful)-clients
A5 + (strong issues allowed to surface) – Ath	A14D - (blame game)-clients
A10D - (art as distraction ) - clients	A15D - (boundary issues)-Ath
	A17D-(feelings left unaddressed)-Ath

I will compare these dissonance patterns with those in dance movement therapy before considering the variables affecting them in the following chapter.

### 5.2.2 Dance Movement therapy triangulation

Table 20 presents the frequency of the DMT themes identified in 5.1 in both questionnaires and focus group. The table presents the numerical grade the clients attached to these themes. In the tables below, if 2 comments were recorded from the same form, these were only counted once. The rating grade used with the themes mentioned is indicated in brackets behind the client, FG indicates the number of the focus group in which the theme was mentioned and the number of clients is linked to the number of clients using that theme. Analysing whether certain grades match certain themes, the picture is similar to that in art therapy. The table shows that the same client may attribute different grades to the same theme. Different clients attributed different grades to the same themes. The mean grade is used as an indicator of overall group attribution of a particular theme to the usefulness and unhelpfulness of a session.

Table 20 DMT Themes \* and grades; client questionnaires and focus groups

Theme	Clients/Grades	Average Grade	Frequency	No. of Clients
<b>D1+</b>	SAM (2), SAM (2), BELLE(3), DICK (3), TED (4), BELLE (4), TED (5), TED (5), BELLE (5), SALLY (5), SAM (2)	3.64	11 FG3	5
<b>D2+</b>	AL (4), KATE (5), HATTIE (1) , AL (4)	3.5	4	3
<b>D3+</b>	NATHAN (2), KATE (3), SAM (3), NATHAN (4), TED (5), TED (5), TED (5)	3.86	7 FG2	4
<b>D4+</b>			0 FG2	0
<b>D5+</b>	PAT (2), KATE (3), KATE (4), KATE (4), SALLY (4), LIZ (5), TED (5), KATE (5), SAM(2)	3.78	9 FG3	6
<b>D6+</b>	SALLY (2), CATE (3), BELLE (3), KATE (3), CATE (4), BELLE (4), KATE (4), KATE (4), HATTIE (4), HATTIE (4), SALLY (4), JAN (4), TED (5)	3.69	13 FG3	8
<b>D7+</b>	LIZ (3), LIZ (3), CATE (3), JACK (4), JACK (4)	3.4	5 FG3	3
<b>D8-</b>	JACK (4), JAN (1), TED (4), JAN (4)	3.25	4 FG3	3
<b>D9-</b>	SALLY (1), LIZ (3), BELLE (3), BELLE (4), KATE (4), HATTIE (4), TED (5), KATE (2), PAT (2)	3.11	9 FG4	7
<b>D10-</b>	SAM (3)	3	1 FG3	1
<b>D11-</b>	BELLE (4), TED (5), TED (5), BELLE (5), SALLY (5), KATE (4), KATE (4)	4.57	7 FG5	4
<b>D12-</b>	CATE (3), KATE (3), SAM (3), BELLE (5), MANDY (3), TED (5), TED (5), TED (5)	4	8 FG7	6
<b>D13-</b>	TED (1), TED (1), BELLE (1), BELLE (1), BELLE (1), KATE (0), BELLE (2), SAM (2), SALLY (2), TED (3), KATE (3), CATE (4)	1.75	12 FG8	6
<b>D14-</b>	NATHAN (2), NATHAN (4)	3	2 FG1	1
<b>D15-</b>	TED (5)	5	1	1
<b>D16D+</b>	BELLE (4)	4	1 FG3	1
<b>D17D+</b>	LIZ (3)	3	1	1
<b>D18D+</b> <b>D19D+</b> <b>D20D+</b>	staff comments only			
<b>D21D-</b>	visitor (no grade given)		1	
<b>D22D-</b>	LIZ(3),PAT(2),SAM(2), TED(1)(3)(4)	2.5	6	
<b>D23D-</b> <b>D24DF-</b>	Staff comments only			

\* Theme descriptors on pages 101– 105

In DMT only two themes contributed to a session being considered useful on a mean grade of 4 and above. The interesting thing is that the themes identified with these grades contributed to the unhelpfulness of sessions, namely absences (D11-) and clients not engaging/joining in (D12-). The physical space being too small (D15-) and being allowed to sleep (D16D+) had a high usefulness grade for the session associated with it. Both were used only once by one individual client. Their pattern needs to be considered in an individual case study. Clients not joining in and absences may interact with other themes to influence the overall usefulness of a session. In AT the absence theme also did not influence the grading. In chapter 6 I will consider this as one of the variables. In DMT, compared with AT, there is a greater convergence of grades in the middle range of 2.5 – 4. The ‘useful’ themes cluster in grading between 3.4 and 3.86 (compared to AT 2.67 to 4.52). The themes of group connection and interaction, having space to talk, expressing feelings through talking or movement and moving to express/ relax all contributed relatively equally to the usefulness of a session according to the grading. It is thus more difficult to use the grading alone as an indicator of which themes contribute more or less to the usefulness of a session. The number of people using the theme and the frequency with which they did so, may be a better indicator of the relative importance of certain themes.

Of themes associated with the unhelpfulness of a session, the ‘blame game’ (D13-) resulted in the lowest grade (graded 1.75). This was the same in AT, where it was also associated with the lowest mean grade. The blame was equally often apportioned to self, therapists or other clients. The other theme associated with an unhelpful DMT session graded 2.5 was that of a session being too long, too tiring (D22D-).

As in AT, some themes were used much more frequently than others, potentially skewing the results. It remains therefore important to look at the highest frequency of themes in addition to the grading. The second question is whether the frequency with which themes emerge, matches the grading. If they do, it may indicate the importance of certain themes’ contribution to the overall usefulness or unhelpfulness of sessions.

In DMT the most frequently mentioned questionnaire themes associated with the usefulness of a session were group connection, interaction (D1+), expressing feelings (D3+) and that a session was enjoyable and fun (D5+). Sometimes the use of certain structures (D6+) contributed to this. On the other hand, those structures could also contribute to the unhelpfulness of a session (D9-). The type of structures clients found useful were the use of props, kicking a ball to activate expression of feelings and relaxation. Unhelpful structures were those that raised safety issues or increased self consciousness, such as guided imagery and being followed.

Like in AT, when comparing the data from the questionnaires with the focus groups, the latter tended to focus more on aspects the clients had experienced as unhelpful. In addition to the use of certain structures these were absences (D11-), clients not joining in / engaging (D12-) and the 'blame game' (D13-). The 'blame game' is the lowest graded and most frequently mentioned in the questionnaires and focus groups. Like absences, it will be considered as one of the variables studied in more depth in chapter 6. The session being too long and too tiring was less frequently mentioned in the focus groups.

In order to compare DMT client themes with therapist themes to identify dissonance through grading and frequency, table 20 needs to be compared with table 21. The same questions need to be addressed. Firstly which grades match which themes for the dance movement therapist. The mean grade for the DMT varied between 2.5 and 4. The lowest individual grade was given to themes that contributed to a useful session, namely having space to talk (D2+) and clients being able to initiate (D4+). These were exceptions, linked to other themes, as the more usual grade given to sessions which featured this theme was 4. Other themes were consistently graded 3 and 4 by the therapist. The only theme graded more variable and with greater frequency was the theme of feelings not being expressed (D14-). Depending on what else happens within the session, this theme seems to interact with others in deciding the overall unhelpfulness of a session for the therapist.

Given the varying grades attributed to a theme, frequency needs to be looked at in the use of a particular theme. The themes most frequently used by the dance movement

therapist, as contributing to the usefulness of a session, were group connection, interaction (D1+) and using certain structures (D6+). Those most frequently seen to contribute to the unhelpfulness of a session were absences (D11-) and feelings not being expressed (D14-).

*Table 21 DMT Themes\* and grades; Staff questionnaires and focus groups*

<b>Theme</b>	<b>Staff/Grades</b>	<b>Average Grade</b>	<b>Frequency</b>
<b>D1+</b>	CO-TH 1(4)(3), CO-TH 3(4)(5)(4) DMTH(3)(4)(4)(4)(4)(4)(4)	3.9 3.9	5 FG 2 8
<b>D2+</b>	CO-TH 1(4),CO-TH 3(4)(5) DMTH(4)(4)(2)(4)	4.25 3.5	3 FG1 4
<b>D3+</b>	CO-TH 1(4), CO-TH 3(3) DMTH(3.5)(4)(3)	3.5 3.5	2 FG 3 3
<b>D4+</b>	CO-TH 1(4) DMTH(4)(4)(2)	4 3.3	1 3
<b>D5+</b>	CO-TH 1(4) DMTH((3.5)(4)(4)(4)(4)	4 3.9	1 FG1 5
<b>D6+</b>	CO-TH 1(4)(3)(4), CO-TH 3(4)(3)(4) DMTH(3.5)(3.5)(4)(3)(4)(4)(3)(3)(4)	3.7 3.5	3 FG3 9
<b>D7+</b>	CO-TH 1(3) DMTH(3)(3)(4)(4)(3)	3 3.4	1 FG3 5
<b>D8-</b>	DMTH(3)	3	1 FG1
<b>D9-</b>	CO-TH 1(3) DMTH(4)(3)	3 3.5	1 FG4 2
<b>D10-</b>	DMTH(4)(4)(3.5)(4)	3.9	4 FG3
<b>D11-</b>	CO-TH 1(4)(4)(4)(4)(4), CO-TH 3(3)(3) DMTH(3.5)(3.5)(4)(3)(4)(4)(2.5)(4)(4)(3)(4)(4)	3.3 3.7	7 FG10 12
<b>D12-</b>	CO-TH 1(4)(4)(3) DMTH(3)(3)(4)	3.7 3.3	3 FG10 3
<b>D13-</b>	CO-TH 1(3)(3) DMTH(3)(3)	3 3	2 FG8 2
<b>D14-</b>	CO-TH 1(3) DMTH(2)(4)(2.5)(2)(3)(4)(3)	3 2.9	1 FG5 7
<b>D15-</b>	DMTH(4)	4	1
<b>D16D+</b>			
<b>D17D+</b>			FG1
<b>D18D+</b>	DMTH(2)(4)	3	2
<b>D19D+</b>	DMTH(4)	4	1
<b>D20D+</b>	DMTH(4)	4	1
<b>D21D-</b>	CO-TH 3(4)(3)(3)(5)(4)(4) DMTH(2)	3.8 2	6 1
<b>D22D-</b>	DMTH(3)	3	1
<b>D23D-</b>	DMTH(4)	4	1
<b>D24D-</b>	DMTH(2.5)	2.5	1

\* Theme descriptors on p 101-105

Triangulating the grades and frequency of the therapist and co-therapists the highest mean grade of the therapist was 3.9. This grade was associated with group connection, interaction (D1+), but not affected by a lack of connection between movement and talking (D10-). The highest grading of the co-therapists was 4.25, associated with space to talk (D2+). The lowest grades were 2 for the therapist (connected to lack of self directedness in clients D21D-) and 3 for the co-therapists (associated with feelings not being expressed D14-, the 'blame game' D13-, the use of particular structures D9- and moving to express feelings D7+).

The co-therapists mentioned most often group connection and interaction (D1+) as useful and absences (D11-) as unhelpful. These were the same as the DMT, but she added the use of certain structures (D6+) as useful and feelings not being expressed (D14-) as unhelpful. The staff focus group triangulation shows that D11- (absences), D12- (clients not joining in) and D13- ('blame game') were most frequently discussed.

The frequency with which themes are mentioned does not indicate significant differences between the dance movement therapist and the co-therapists. The grading does indicate some differences in that the emphasis for the therapist seems to be more on the usefulness of moving to connect and express feelings, that of the co-therapists on the talking to connect and express. This could lead to possible dissonance and will be discussed in terms of unit and group dynamics in chapter 6.

Comparing client and therapist themes and their importance for the overall usefulness of sessions, the following picture emerges. Using grading, being tired out / a session being too long (D22D-) and the 'blame game' (D13-) caused the clients to find a DMT session unhelpful (graded lower than 3). The therapist identified unexpressed feelings, clients not initiating / being self directed ( D21D-) and not saying goodbye (D24D-) as unhelpful. For the clients absences and people not joining in raised ambiguity; sessions were graded high, but the comments indicated unhelpful rather than useful aspects of the session. For the therapist the highest grades were given for themes that also indicated ambiguity / ambivalence; good movement but a lack of connection between moving and talking (D10-). The way the themes affect the

overall grading shows that for clients the 'blame game' resulted in a session graded most unhelpful. The therapist graded a session low when she experienced the clients' lacking self directedness and when feelings remained unexpressed.

In frequently mentioned themes, clients and therapist agreed that group connection (D1+) and the use of certain structures (D6+) contributed most to the usefulness of a session, while absences contributed to its unhelpfulness. Clients mentioned the effect of people not joining in more (the therapist discussed this with her colleagues in the staff focus group, but only rarely in her questionnaires). The same applies to the 'blame game' theme and may occasionally not be unconnected. I will look at this in chapter 6.

The clients and dance movement therapist agreed that connecting and interacting in the group and the use of certain structures contributed most to the usefulness of a group. For the clients having fun came next in importance, a theme echoed by the therapist with an emphasis on the importance of play. They agreed that space to talk was useful. Clients and therapists diverged when the therapist valued clients' self directedness as a useful contribution, while the clients emphasized expressing feelings through talking or movement or moving to get rid of stress. Clients and therapists diverged further in their identification of those themes that contributed to the unhelpfulness of a session. They agreed on the effect of absences. The clients stressed the use of particular structures and the effect of clients not joining in as unhelpful. The therapist referred to these themes very infrequently. The therapist's most frequent 'unhelpful' theme, excepting absences, was that feelings were not expressed or were blocked, a theme only used by one other client. Although other clients said that expressing feelings was helpful, the therapist felt that group dynamics were not explored or verbalised.

Summarising questionnaire and focus group data DMT consonant and dissonant themes are shown in table 22, consonant themes are C and dissonant themes D.

Individual themes were D16D + (sleeping) for Mandy, D15-(space too small) for Ted, D17D+ (being able to sit out and watch) for Liz, D10-(a lack of connection between

movement and talking) for Sam and D14- (feelings blocked/ not expressed) for Nathan.

*Table 22 DMT client- therapist consonance and dissonance*

<b>Useful C</b>	<b>Unhelpful C</b>
D1+(group contact)	D11- (absences)
D6+(use of certain structures)	
D5+(having fun/play)	

<i>Useful D</i>	<i>Unhelpful D</i>
<i>D4+ ( client self directedness) - DMT</i>	<i>D9- (use of particular structures)- clients</i>
	<i>D12- (people not joining in) –clients</i>
	<i>D13- (blame game)- clients</i>
	<i>D14 - (unexpressed feelings)- DMT</i>
	<i>D22D – (being too tired / session too long)- clients</i>

### **5.3 Researcher dissonance**

When I compared my own grades and comments with those of clients and therapists, it became apparent that my grades were placed between those of the therapists and clients. The role of participant observer was usually described by the clients as “she is in between”, when a new client asked what my role was. Staff members would try to use me as a therapist, for example asking me to facilitate a group in the absence of one of the therapists. I always refused, as it would mean I would lose my ‘in between’ position as a researcher. Being present in both focus groups on the arts therapies group treatment day meant that I would have to restrain myself not to comment on clients’ or therapists’ reflections in the other focus group.

Once I was aware of a potential ethical problem. Only one client was present in the focus group. She discussed her difficulties with one of the staff members and her potential to harm herself. Fortunately this had been noticed by the staff group, so that they addressed it with the client. It made me realise the need to cancel a focus group if only one client or staff member was present.

I was asked to withdraw from the client focus groups in 4 out of 31 sessions, once I had to leave due to personal reasons. This meant an absence of 5 client focus groups and 1 staff focus group, out of a total of 31 focus groups. On one of the occasions that the clients asked me to withdraw from their focus group, there were also no client questionnaires completed. I was aware that some clients never completed questionnaires, because 2 out of 18 clients refused actively to take part in the research. Others opted out by absenting themselves (see chapter 4). At least one client took a questionnaire to complete, but mostly returned it blank in the envelope. Clients often refused to complete questionnaires or have a focus group after 'difficult' sessions. The dissonance between therapist and clients could be seen to be acted out through absence and non-completion. The peer dissonance for clients and the therapist – co-therapist dissonance for staff indicated in 5.2, also reinforced the sense that an additional qualitative source of data needed to be analysed to give meaning to these phenomena. Researcher's participant observation notes could be brought into triangulation with the focus groups and questionnaires in the form of a chronology to study group and unit dynamics. This alternative form of analysis will be discussed in chapter 6.

I completed questionnaires at the end of the session, the same as therapists, co-therapists and clients. My mean grading for both the DMT and AT group was virtually identical, respectively 3.25 and 3.28. The grading in DMT varied between 1 and 5 though, while in AT my range was limited between 2 and 4. In one group I thus reflected the client pattern in using the full range, in the other the therapist pattern of using a limited range.

The art therapist's mean grade of 2.96 was lower than the researcher's 3.25, the clients' 3.35 and the co-therapists' 3.1 and 3.37. The most frequently used themes by the researcher were A2+ (the art being central, expressive and 'for real'), A6-

(absences) and A7- (lack of group connection). The range of grades was used throughout all comments. Only absences (A6-) resulted for the researcher in a lower grading of the usefulness of the session. Highest consistent grading was connected with a session being relaxing (A1+) and with strong issues being allowed to surface (A5+). In comparison with the themes identified by the therapist and clients (table 43) I mentioned contact between people as important, but not as frequently as the clients and the therapist did. My being in a position at one remove from either side might provide an explanation for this. I echoed the therapist in finding it important that strong issues were allowed to surface. I did not echo the clients 'blame game', the need to use art as a distraction, nor the therapist's emphasis on boundary issues.

The dance movement therapist's mean grade of 3.53 was, in contrast to AT, higher than the researcher's 3.25 and the clients' 2.87. The co-therapists' mean grades were even higher than the therapist's, namely 3.7 and 4. Once again my grading was placed between that of the clients and the therapist. The most frequently used themes by the researcher were the use of certain structures to enable expression of feeling (D6+), moving to express and relax (D7+) and having space to talk (D2+) as useful. Absences (D11-) and not being able to express feelings (D14-) were experienced as unhelpful. My highest grade was associated with moving to express and relax (D7+) and the lowest with clients not joining in (D12-). The range of grades was used throughout all comments. Low grades were associated with a lot of distraction and disengagement. High grades occurred when everyone in the group was engaged both in the arts form and in honest reflection and discussion.

Comparing my themes with those of the dance movement therapist and the clients I shared their emphasis that absences were unhelpful and that the use of certain structures to express feelings was useful (therapist and clients). I echoed the clients' experience that it was unhelpful if clients did not join in and the therapist's experience that blocked feelings were unhelpful. I did not mention the therapist's emphasis on client's self directedness, nor did I join in the clients' 'blame game'.

As a researcher my emphasis in both arts modalities is on the use of the art form as a means of expression, with absences as a continuous unhelpful theme. Feelings being

blocked as unhelpful in DMT may be the counterpart of the importance of strong issues being allowed to surface in AT. The experience of a lack of group connection in AT may parallel the experienced unhelpfulness of people not joining in in DMT. There is more variety in the grading of the clients and therapists in the two modalities than in mine. The themes I identify as useful and unhelpful in AT and DMT have connections across the two arts modalities. For clients and therapists connection between people as useful and absences as unhelpful, also cross the modalities.

For the researcher the connection with the therapists seems to be in the area of emphasizing the usefulness of strong issues being allowed to surface and that feelings are not blocked. For the clients and therapists there are particular differences: self directedness and the effect of using certain structures in DMT, boundary issues, using art as a distraction and the feeling obliged to draw something meaningful in AT. As a researcher I picked up on the clients' ambivalence about clients sitting out. If they did not join in, it could be experienced as breaking the group connection. It could also increase the self consciousness of those who felt watched while moving.

#### **5.4 Methodological reflections**

In chapter 3 I discussed how the evidence based practice debate influenced my choice of research question and methodology for both data gathering and analysis. I discussed the combination of quantitative and qualitative measures to help support the 'evidence' base expected in an NHS setting. The 'gold standard' of a randomised control trial did not lend itself to my question regarding the effect of cultural background on the therapist – client perceptions of arts therapies treatment. However, incorporating a quantitative aspect to my research was likely to make it more acceptable as evidence in the current evidence based practice culture of the NHS.

This chapter has shown that the combination of quantitative and qualitative measures raises certain methodological difficulties. For the quantitative side these relate to sample size. A characteristic difficulty of psychodynamic psychotherapy (Roth and Fonagy 2005) and arts therapies research (Odell-Miller et al 2001) relates to sample size. It can make statistical inference problematic, but small-scale work can provide

ground for challenging accepted wisdom and being able to prompt larger scale research (Goss and Rowland 2000).

Two factors potentially skewed the statistics of my analysis. The first concerned the extreme ratings of individuals. Certain individuals can have a disproportionate effect on the mean, because they are there for the duration of the research (rather than a small part of it, see chapter 4). They complete more questionnaires than others. The completion rates of questionnaires is presented in table 23.

When you compare the non-completion with the attendance rates in table 6 on page 76, it becomes clear that some clients completed only very few questionnaires overall. Non-completion for some clients was an alternative to saying they did not want to complete the questionnaire (they hand in an empty questionnaire). Other clients use it as an option if they were not able to reflect or did not wish to articulate what was happening for them.

*Table 23 Completion rates of questionnaires*

<b>Client</b>	<b>DMT</b>	<b>AT</b>
<b>LIZ</b>	25%	20%
<b>CATE</b>	25 %	71.43%
<b>AL</b>	81.8%	100%
<b>TED</b>	17.24%	25.9%
<b>BELLE</b>	5.88%	23.53%
<b>JACK</b>	87.5%	78.57%
<b>LIA</b>	66.67%	75%
<b>KATE</b>	7.14%	42.86%
<b>HATTIE</b>	50 %	75%
<b>SAM</b>	0 %	25 %
<b>SALLY</b>	44.44%	57.89%
<b>JAN</b>	0%	0%
<b>VAL</b>	100%	100%
<b>MANDY</b>	50 %	28.57%
<b>NATHAN</b>	40%	66.67%
<b>DICK</b>	0%	50%
<b>PAT</b>	0%	0%
<b>LEN</b>	0%	0%

The focus groups were a useful alternative to ascertain how clients found sessions. It was thus possible to give some qualitative meaning to what quantitatively disappeared. However, when the researcher was asked not to come into the client focus groups no such data was available. Alternative data collection methods needed to be used to study possible explanations, such as group dynamics. The quantitative analysis indicated therapist – co-therapist dissonance and peer dissonance for clients in addition to therapist – client dissonance. This also indicated the need to look at group and unit dynamics as treatment variables. The importance of absences as a qualitative theme and the importance of the ‘blame game’ for clients in their overall lowest grading, provided additional quantitative indicators for studying group dynamics as an alternative explanation for dissonance.

When I analysed the number of clients using particular themes, it showed that certain of these were of cross group relevance, others of more relevance to individuals. The data can thus be looked at as part of a whole group process, but also in the form of individual case studies. Qualitative data can flesh out potentially misleading figures, but the latter can also become valid as potential parameters for qualitative data. This can be crucial when the quantity of the multi-modal qualitative data threatens to overwhelm the researcher. The different data collection methods of questionnaires and focus groups proved very useful to enable the analysis of individual and group differences.

The design of the evaluation scale added to some of the quantitative difficulties. The rating scale and questionnaire were designed in collaboration with the clients. Given their acute states of distress the scale and questions had to be simple and quick to complete. They found a 10 point scale, as indicated in the literature review (Lietaer 1992), but applied with trainee counsellors rather than clients, too complex. They suggested adaptation to a five point rating scale. The fact that therapists in practice only used the variation between 2 and 4 and the clients graded the full range of 1 to 5 meant that no valid statistical analysis of dissonance could be made on the basis of quantitative analysis alone. A scale of 1-10 probably should have been maintained to allow for a greater measure of variation, although the small sample size would

continue to make valid statistical analysis alone problematic, given the factors discussed above.

The researcher's reflective process in 5.3 showed both consonance and dissonance with therapists and clients. The 'in between' position of the participant observer needs to be taken into account, when the participant observation notes are used for the creation of a group chronology. The chronology enables the study of group and unit dynamics.

## **5.5 Chapter findings and conclusions.**

- Combining quantitative and qualitative analysis of the questionnaire and focus group data certain themes can be identified on which therapists and clients are consonant and dissonant as contributing to the overall usefulness and unhelpfulness of a session.
- Consonant themes identifiable for art therapy and dance movement therapy are as follows:  
DMT. Group contact, having fun / playing and the use of certain structures are useful. Absences are unhelpful.  
AT. Art being central, expressive and 'for real', as well as contact between people are useful. Absences are unhelpful.
- Dissonant themes identifiable for art therapy and dance movement therapy areas follows:  
DMT. Clients not joining in the movement as a useful choice or an attack on the group and whether the use of humour is the same as play and the symbolic nature of the movement.  
AT. Art as distraction of genuine therapeutic value (clients) or as defensive (therapists). The role of humour here can be useful or unhelpful as a lack of focus. Across AT and DMT relevant themes are: the symbolism in the art or movement, the use of interpretation and an emphasis on boundaries and containment.

- Certain themes are more relevant for individuals, others are of cross group relevance.
- The blame game is particularly associated with dissonance.
- Peer dissonance and therapist – co-therapist dissonance point to the potential effect of group and unit dynamics as a treatment variable affecting client-therapist dissonance. The effect of absences point further to this impact.
- Researcher reflection indicates that the ‘in between’ position of the participant observer can lead to blind spots. When these are incorporated, the participant observation notes can be included in the analysis to enable the creation of a group chronology. This could be a method to study the effect of group and unit dynamics as treatment variables over time.
- Additional expression of dissonance may be through refusal to complete questionnaires or participate in focus groups. This will need to be incorporated in the chronology.

Previous chapters have identified diagnosis as a client variable and stage of treatment as a treatment variable (chapter 4). The following chapter will look at all previously identified client, therapist and treatment variables that may affect dissonance independently of each other, before considering their interaction in the case studies in chapter 7.

## **Chapter 6 Variables affecting client – therapist dissonance**

### **6.0 Chapter overview**

This chapter looks at client, therapist and treatment variables affecting dissonance. Previous chapters showed how dissonance could be expressed in a variety of ways. Firstly through drop out and non attendance. Chapter 4 identified those clients for whom this was the case. Secondly dissonance could be expressed in a difference of perception of sessions as useful or unhelpful. Chapter 5 indicated this form of dissonance through a difference in grading between client and therapist, or through the themes influencing a session being experienced as useful or unhelpful. It also showed that non-completion of questionnaires or non-participation in focus groups could indicate dissonance, especially if previous and further sessions did not elicit such a reaction.

This chapter looks at those clients who were dissonant from the therapist and isolates the different variables that led to this dissonance. These variables were identified through the data collection and analysis described in the previous chapters. Differences in cultural background variables are one set of client and therapist variables. The literature review in chapter 2 also indicated class, gender and age. Chapter 4 indicated differences in attendance connected to stage of treatment, diagnosis and previous treatment history; these will be additional client and treatment variables considered. Group dynamics (including absences and unit dynamics) were identified in chapter 5 as additional treatment variables.

The reflective process of the researcher in chapter 5.3 indicated differences in dissonance patterns from the clients and therapist, as well as commonalities. The effect of the presence of the researcher will be discussed. This is followed by the study of methodological problems in the analysis of independent variables separate from alternative explanations.

Chapter 7 will look at the interaction of the variables in the form of individual client case studies.

## **6.1 Cultural background differences as variables affecting dissonance**

Chapter 4 distinguished three categories of clients: those who engaged with treatment over time, those who engaged ambivalently (many absences, not due to hospital admissions) and those who dropped out of treatment after a few months. Having ascertained their socio-cultural background variables, it is now possible to see whether there are differences between the three groups of clients as well as studying those clients who are dissonant in their grading or choice of themes.

Chapter 5.2 indicated client - therapist dissonance in the grading. Dick, Kate, Lia, Jack, Ted and Liz were dissonant in AT. Cate, Al, Belle, Hattie, Sam and Jan were dissonant in DMT. I looked at the clients who dropped out or ambivalently engaged with many absences, and those who engaged with the treatment (see chapter 4.2.1 tables 4 and 5). 50% of dissonantly graded clients dropped out / ambivalently engaged and 50 % continued in treatment. On the basis of grading only, no difference could be determined between those who engaged and those clients who did not. It is thus important to look at the qualitative data. Chapter 5.2 showed that certain dissonant themes were particularly identified with individual clients.

In AT Ted struggled when he felt the timing was problematic (A8-). When he used this theme he often felt a session was too long or too static (too much sitting down and talking). A lack of group connection (A7-) was experienced by Sam as problematic, exemplified in people not sharing their work or if there was no sense of people trying together. Mandy was affected by a lack of focus (A9-) particularly if other people were noisy and distracting. Belle and Sally were most inclined to use the 'blame game' in their questionnaires. However, when the 'blame game' was mentioned in the focus group by others, they would also use the theme. As such it was not solely identified with Belle and Sally. Of these clients Sam was the only client who dropped out, the others continued in treatment.

Group dissonant themes in AT were art as distraction (A10D+), used regularly by Len and Belle, while Sally, Jan, Liz used it once and Kate twice. It was also a regularly used group theme in the focus group. Feeling obliged to draw something meaningful

(A12D-), another dissonant theme, was used by Sam, Sally and Mandy with some back up from other group members in the focus group. Group themes were mainly identified by engaged members, with the exception of Jan.

In DMT Belle appreciated being able to sleep (D16D+), while Liz was happy to be able to sit out and watch (D17D+). Sam was dissonant when he felt there was a lack of connection between moving and talking (D10-) and Nathan when he felt difficult feelings were blocked (D14-). Only Liz's theme was never mentioned or echoed in the focus group, it was potentially peer dissonant as others would express disquiet at being watched and people not joining in. Sam was the client who dropped out, the others continued with treatment.

Group dissonant themes in DMT concerned the use of particular structures (D9-), mentioned at similar frequency in questionnaires by Sally, Liz, Belle, Kate, Hattie, Ted and Pat. People not joining in (D12-) and the 'blame game' (D13-) were used by the same people, although the 'blame game' was used more frequently by Belle and Ted. Mandy expressed a dislike of people not joining in. She frequently sat out and watched, but wondered whether she would have got more out of the session if she had. She did not blame others as the cause for her not joining in though, while Ted and Mandy did. It raises the issue of the 'blame game' as projection of unwanted feelings onto others. Kate, Cate and Sally used all group dissonant themes in both questionnaires and focus groups. The session being too long and too tiring was used most frequently by Ted (he does mention the same in AT), while Liz, Pat and Sam all mention it once. This theme is never echoed in the focus group. Sam and Hattie dropped out. The others continued with treatment, but expressed dissonance while in treatment.

Looking at dissonant clients and seeing whether there are variations in cultural background between clients and therapist, the following picture emerges.

## Ethnic and cultural self-identification

Table 24 Attrition and ethnic / cultural self-identification

Client	Engaged	Ambivalently Engaged	Drop Outs
LIZ	En-Brit		
CATE	En-En		
AL	N/k		
PF4			
BELLE	En-En		
JACK		UK-UK*	
LIA		White-White UK*	
KATE	Irish/Brit-Irish/Brit		
HATTIE		White-White UK*	
SAM			Ind/Bras-en/Bras
SALLY	White En-White En		
JAN			n/k
VAL			n/k
MANDY	Brit-En Islam		
NATHAN	White Brit-Jewish*		
DICK			n/k
PAT	White Brit-White Brit*		
LEN	White Brit-En		

Abbreviations: En - English, Brit - British, UK - United Kingdom, Ind - Indian,

Bras – Brazilian, n/k – Not Known

There is no identifiable difference in migration history between those clients who engaged and dropped out, with one exception. The one client who identified as a visible minority, without some identification of ‘English / UK / British’, dropped out. The way he felt perceived by others also marked him as different (he said others identified him as “Paki”, indicating an experience of racism). Mixed client differences referred to Irish and Jewish heritage, combined with a British / English self-identification.

The art therapist self identified as Northern European white, Norwegian / Jewish in her ethnic and cultural identity; the dance movement therapist as Caucasian white, British and Western European.

The variation in ethnic and cultural self-identification between client and therapist, and potentially the identification by others, needs to be considered in the individual case studies as an interacting variable influencing client-therapist dissonance.

### **Migration history**

The migration history is presented in Table 25

*Table 25 Attrition and Migration history*

<b>Client</b>	<b>Engaged</b>	<b>Ambivalently Engaged</b>	<b>Drop Outs</b>
<b>LIZ</b>	Adopted-n/k		
<b>CATE</b>	UK (3 <sup>rd</sup> Gen. n/k)		
<b>AL</b>	n/k		
<b>PF4</b>	UK		
<b>BELLE</b>	2 <sup>nd</sup> Gen (Irish)		
<b>JACK</b>		3 <sup>rd</sup> Gen (Irish)	
<b>LIA</b>		UK	
<b>KATE</b>	3 <sup>rd</sup> Gen (Irish), 1 P grew up in the USA		
<b>HATTIE</b>		n/k	
<b>SAM</b>			2 <sup>nd</sup> Gen (1 P 2 <sup>nd</sup> Gen, 1 P 1 <sup>st</sup> Gen)
<b>SALLY</b>	UK		
<b>JAN</b>			n/k
<b>VAL</b>			n/k
<b>MANDY</b>	UK, 1 P and GP n/k (fostering)		
<b>NATHAN</b>	2 <sup>nd</sup> Gen (Israel)		
<b>DICK</b>			n/k
<b>PAT</b>	n/k		
<b>LEN</b>	UK		

Abbreviations: n/k - not known, UK - United Kingdom, Gen – Generation,

P - Parent, GP - Grandparent

There is no identifiable difference in migration history between those clients who engaged and those who dropped out. Migration was known by five clients, 3 in the engaged, one each in the ambivalently engaged and drop out clients. The art therapist was a first generation migrant, the dance movement therapist and her family had no migration history in the previous two generations. Given the differential attendance in AT and DMT and the different migration history of the two therapists this factor

will need to be included as an interacting variable potentially affecting client – therapist dissonance.

## **Language**

Only one client spoke a different language, Portuguese, besides English at home. All clients spoke English as a first language. The art therapist used English as a second language; the languages spoken at home were Norwegian and English. The dance movement therapist spoke English as a first language.

The level of fluency in English as a second language (identified in the literature review as potentially influencing attrition / engagement with therapy) is not an identifiable influencing factor in this sample. However, given the difference in English as a first or second language between therapists and clients this factor will be considered in the individual case studies.

## **Place of residence**

All clients living rurally or in a small town engaged. However, they are in the dissonant sample, both in grading and themes. Dissonance experienced in treatment may thus be a factor. Of the 4 city dwellers one engaged, two ambivalently and one dropped out. Given the difference in make up of the rural and urban communities studied (see chapter 4) the influence of the surrounding community may need to be considered in terms of reinforcing a different or similar identity. In the city and region the trust serves there are no collective migrant communities, the pattern is one of individual migration (Adonis and Pollard 1997). However, the urban context is more diverse and Sam, a city dweller, had experienced racism. The therapists are city dwellers, who each moved frequently throughout their lives.

The influence of the surrounding community varies for individuals. The experience of diversity and / or racism may influence client – therapist dissonance, so this factor needs to be considered in the individual case studies.

## Religion

Table 26 Attrition and Client Religion

Client	Engaged	Ambivalently Engaged	Drop Outs
LIZ	RC (P-RC)		
CATE		none (M-Spiritualist/F none)	
AL	n/k		
PF4	None (P-none)		
BELLE	None, raised RC (M-RC/F Methodist)		
JACK	n/k		
LIA	C of E*		
KATE	Christian (M C of E/F RC)		
HATTIE		n/k	
SAM			RC (M RC)
SALLY	None, christened C of E (P-none)		
JAN			n/k
VAL			n/k
MANDY	Islam (P-none)		
NATHAN	n/k		
DICK	n/k		
PAT	n/k		
LEN	None		

The art therapist's religious orientation was Jewish, that of her parents Christian Lutheran. The dance movement therapist identified herself as non-religious and her parents as Church of England.

Given that there were 4 clients who self-defined as having a religious orientation, as well as the art therapist, while the dance movement therapist and the other clients self-identified as non-religious, the factor of religion will be considered as an interacting variable.

### 6.2 Class, gender and age ( including therapist age and experience) as an explanation for dissonance

As discussed in chapter 2, demographic therapist and client traits were historically much researched. Presently there is more study of complex variables of which demographics are a part. Clarkin and Levy (2004) state from meta analytic reviews of the literature that clients' class, age, gender, education and ethnicity are factors to which the therapist must learn to adjust, so these factors are considered as potential variables affecting dissonance for this sample.

## Age

*Table 27 Attrition and Client age*

Client	Engaged	Ambivalently Engaged	Drop Outs
<b>LIZ</b>	29		
<b>CATE</b>		19	
<b>AL</b>	22		
<b>TED</b>	25		
<b>BELLE</b>	19		
<b>JACK</b>	23		
<b>LIA</b>	23		
<b>KATE</b>	18		
<b>HATTIE</b>		27	
<b>SAM</b>			21
<b>SALLY</b>	17		
<b>JAN</b>			26
<b>VAL</b>			n.k
<b>MANDY</b>	19		
<b>NATHAN</b>	24		
<b>DICK</b>	n/k		
<b>PAT</b>	16		
<b>LEN</b>	21		

The clients were between 16 and 29 years of age. Although the unit catered for 18 to 25 year olds, some clients were able to access it earlier or longer for clinical reasons. Dembo et al (1983) showed that clients aged 18 to 30 with a therapist in the same age range showed less distress and isolation post treatment than those with therapists who were more than 10 years older. Cate was a client who dropped out, while Sally engaged, even though both showed the interacting diagnostic factors of personality disorder and high initial hostility. There is no clear indication from this sample that age may be an influencing factor per se. The effect of client age can interact with therapist skill and other client variables (Atkinson et al 1986).

The dance movement therapist was within 10 years of some of the (older) clients; she was in her early thirties, the art therapist was more than 10 years older in her fifties. Age may have interacted with therapist skill. The dance movement therapist was recently qualified and started practice in the young people's unit three months before the research started. The art therapist had more than 10 years experience and

facilitated an art therapy group in the unit for 5 years. Both therapists trained in their arts form and as an arts therapist in the UK.

Given that there is a differential attendance in AT and DMT the possibility of therapist age and skill interacting with other variables to influence dissonance needs to be considered in the individual case studies.

### **Socio-economic class**

To determine this for the clients alone is problematic, as discussed in chapter 4. I have therefore also indicated parental socio-economic class. The spread of analytic classes over the three groups of clients was:

*Table 28 Attrition and NS- SEC*

<b>Client</b>	<b>Engaged</b>	<b>Ambivalently Engaged</b>	<b>Drop Outs</b>
<b>LIZ</b>	6(P6)		
<b>CATE</b>	8(P1/2)		
<b>AL</b>	6 (P2)		
<b>TED</b>	6 (P6)		
<b>BELLE</b>	8 (P7)		
<b>JACK</b>		8 (P5)	
<b>LIA</b>		8 (P2)	
<b>KATE</b>	8 (P 2/4)		
<b>HATTIE</b>		8 (p n/k)	
<b>SAM</b>			8 (P4)
<b>SALLY</b>	8 (P5)		
<b>JAN</b>			n/k
<b>VAL</b>			n/k
<b>MANDY</b>	8 (P8)		
<b>NATHAN</b>	8 (P 2/3)		
<b>DICK</b>			n/k
<b>PAT</b>	8 (P5)		
<b>LEN</b>	8 (P8)		

The research finding, that clients from lower socio-economic classes tend to drop out more frequently from psychotherapy, does not hold true for this sample. The spread of socio-economic class across the three groups is even, although the number of clients where the data is not known (n/k) may skew the results, especially in the drop out section. Whether NS-SEC interacted with cultural background variables through educational upward mobility was at this stage of the client's life difficult to say. Their illness affected their education, for some it had done so for several years. Whether

they would be able to move into or out from their parental NS-SEC remained to be seen. A variation occurred between clients who had been adopted (Liz) whose identification was with their adoptive family, and those fostered (Jack and Belle), who still identified with their birth family.

For some clients diagnostic stressors may interact with NS-SEC. Hattie and Lia were both single parents of young children and were both clients who dropped out. Sam and Len had family employment problems as diagnostic stressors, Sam dropped out, while Len engaged. The dissonantly graded clients are evenly spread amongst the NS-SEC in both AT and DMT, the same goes for clients identified by dissonant themes, group and individual.

Therapist NS-SEC is class 2 (P2) for the art therapist and 3 (P3) for the dance movement therapist. Given the potential class difference between client and therapist this factor will need to be considered as an interacting variable in the individual case studies, although the overall pattern of dissonance does not reveal any effect.

## **Gender**

Gender has been identified as another co-variable with culture (Sue et al 1991). The constitution of gender in the clients was 50% male and 50% female. Both arts therapists were female, co-therapists 1 and 2 male, co therapist 3 female. This meant that the gender balancer of the team in AT was a male and female therapist. In DMT first male and female, after the male co-therapist left two female therapists.

The gender make up of the clients who engaged was evenly split; ambivalently engaged one man and two women. The drop outs were also evenly split. The dissonant clients through grading were evenly split in AT, while there were more dissonant women in DMT. This was also reflected in a differential attendance across the genders in AT and DMT. Some clients attended the art therapy group more often than the dance movement therapy group: Liz (8%), Belle (8%), Lia (21%), Sally (5%) and Jan (33%). These clients were female. The clients who attended the dance movement therapy group more than the art therapy group were Al (8%), Ted (5%),

Jack (8%), Kate (2%), Hattie (3%), Val (3%), Nathan (4%), Dick (21%) and Pat (67%, representing 2 sessions). The clients with a difference of more than 3% were male.

The dissonant group themes in AT and DMT were more represented by female clients, while the individual themes were evenly split amongst the genders. The effect of gender as a variable will need to be considered in the individual case studies.

### **6.3 Stage of treatment as an explanation for dissonance**

The therapeutic community treatment group was a slow open group, where clients left and joined throughout the 18 months of fieldwork. The expected average treatment period was two years, but as was shown in chapter 4.2.1 tables 4 and 5, clients left at various treatment lengths, some with a planned discharge. Others dropped out without agreement or planned ending of treatment. As the group was slow open, it was possible to identify various clients and their grading and themes at the beginning and ending stages of their treatment. For some this could be compared with their grading throughout. The median and mean grading showed variations in ratings for individuals. In AT for Jack (mean 3.7; median 4), Kate (mean 3.56; median 4) and Ted (mean 4.14; median 1.46). In DMT for Cate (mean 2.83; median 3), Belle (mean 2.87; median 3), Hattie (mean 2.2; median 1) and Sam (mean 2.6; median 3). It was possible to study the effect of stage of treatment on the variation and identify whether early or ending stages of treatment affected dissonance, as indicated in group dynamic literature (Nitsun 1996).

In the following section I will compare the ratings between clients in the first six weeks of treatment, in the final 6 weeks of treatment and those of clients who stayed throughout the year. Table 29 shows clients in their first and last 6 weeks of treatment, the number of sessions they were present, non-completion of questionnaires (P), absent (A) and their mean rating.

Table 29 First and last 6 weeks of treatment

Client	First Six Weeks		Last Six Weeks	
	AT	DMT	AT	DMT
CATE			3P, 3A	3A, 3.0
JACK	6P	5P, 3.0		
LIA	6A	6A	6A	6A
KATE	3P, 1A, 2.5	1A, 3.0	1P, 2A, 3.8	4A, 4.5
HATTIE	2P, 2A, 3.0	2P, 2A, 1.0	2P, 4A	1P, 4A, 4.0
SAM	1P, 2A, 3.0	1A, 2.65	1P, 2A, 3.0	1A, 2.65*
SALLY	4P, 2.5	2P, 3.4		
VAL	1P, 5A	1P, 5A	6A	6A
MANDY	2P, 2.5	3P, 2.6		
NATHAN	4P, 2.0	2P, 1A, 3.0		
DICK	1P, 4A, 4.0	3A, 2.6	5A, 1P	3A, 2.6*

\* clients' treatment was 6-8 weeks in total

Mean first 6 weeks: AT 2.2P, 2A, 2; DMT 1.5P, 1.9A, 2.1

Mean last 6 weeks: AT 1.1P, 4A, 1; DMT 0.15P, 3.3A, 2.5

Comparing the mean attendance, non-completion and evaluation ratings of the first and the last 6 weeks with the overall results the following summary table emerges.

Table 30 Summary attendance, completion and mean rating

	First Six Weeks	Last Six Weeks	Overall
<b>DMT</b>	64%	35.7%	70.2%
<b>AT</b>	64%	33.4%	67.3%
<b>Non-Completion of Questionnaires</b>			
<b>DMT</b>	25%	2.4%	33%
<b>AT</b>	40%	19%	46.5%
<b>Mean Rating</b>			
<b>DMT</b>	2.1%	2.5%	3.03
<b>AT</b>	2	1	3.35

This shows a different mean calculation at different stages of treatment.

Did clients show a different pattern of consonance and dissonance in those first and last 6 weeks then they do overall? There are two clients where it is possible to compare their consonance/dissonance patterns of the first and the last 6 weeks with their overall patterns in the DMT group.

TD=Therapist Dissonance TC= Therapist consonance

PD=Peer Dissonance PC=Peer consonance

*Table 31 Dance Movement therapist and peer dissonance first and last 6 treatment weeks*

Client	First Six Weeks		Last Six Weeks		Overall	
	TD/TC	PD/PC	TD/TC	PD/PC	TD/TC	PD/PC
<b>KATE</b>	3:2	0:5	1:1	1:1	12:5	1:11
<b>HATTIE</b>	2:0	1:1	0:1	-	2:3	2:1
<b>One client for whom it is possible to compare her patterns in the last 6 weeks with those overall:</b>						
<b>CATE</b>			2:1	0:3	1:4	0:5
<b>One client for whom it is possible to compare her patterns in the first 6 weeks with those overall:</b>						
<b>SALLY</b>	2:2	1:3			5:1	2:6

Although the sample is small, a difference in patterns emerged; clients showed a difference in the first and last 6 weeks in comparison with their overall pattern.

Therapist dissonance in the last 6 weeks was less frequent for two clients and more frequent for one. In the first six weeks the reverse was the case. Peer consonance was higher than overall for one client, for the others the level was similar.

In AT the poor completion rates for two clients meant that the rates in the first 6 weeks were the only ones available, so were the same as the overall rates. The dissonance pattern for them and two peers is presented in table 32.

*Table 32 Art therapist and peer dissonance first and last 6 treatment weeks*

Client	First Six Weeks		Last Six Weeks		Overall	
	TD/TC	PD/PC	TD/TC	PD/PC	TD/TC	PD/PC
<b>KATE</b>	1:1	2:0	2:0	0:3	5:2	1:7
<b>HATTIE</b>	Same as overall		No data		0:1	2:0
<b>CATE</b>	Same as overall		No data		1:1	0:2
<b>SALLY</b>	1:0	0:2			5:1	2:6

In this small sample of 25 % of clients in DMT and 12.5% of clients in AT there was a different pattern according to stage of treatment. This was taken into account when selecting clients for individual case studies, while studying variations in dissonance over time. The effect of absences, joinings and leavings will also be considered as an aspect of group dynamics in section 6.5 of this chapter.

#### **6.4 Diagnosis and previous treatment history as an explanation for dissonance**

In chapter 4 I discussed the literature of research into young people’s attrition rates from psychotherapy and showed how diagnosis might interact with cultural background variables to affect attrition. I analysed the diagnostic and treatment profiles of the clients to ascertain whether diagnosis was a factor in client continuation or attrition. Both diagnosis and the severity of a client’s condition can influence their ability to engage with therapy. The table of codes below indicates both the nature of the clients’ diagnoses, stressors and their treatment history. If clients have a history of repeated inpatient treatment and a variety of treatments, they are classified in the NHS as severe and enduring. Those who received treatment mainly in an outpatient setting are defined as mild to moderate. Given emphasis of the young people’s unit, the nature of the clients’ problems would be either classified as moderate or severe. In table 33 I have indicated these factors

Table 33 Attrition, client diagnoses and treatment history

Client	Engaged	Ambivalently Engaged	Drop Outs
<b>LIZ</b>	BPD,S,D / SA,A/ severe		
<b>CATE</b>		BPD,S,AD / PS, BS, SA / severe	
<b>AL</b>	D, PD / BS, SP / moderate		
<b>TED</b>	D, AP / moderate		
<b>BELLE</b>	D, S, ED / SA, PEA, F / severe		
<b>JACK</b>	PD, AD, DD, S / BS, PS, F / severe		
<b>LIA</b>		BPD,S,AD,DD / BS, YC / severe	
<b>KATE</b>	OCD,S,D / PS / moderate		
<b>HATTIE</b>		BPD,AD,S,D / SA,YC / severe	
<b>SAM</b>			AP,BPAD / BS,FE / severe
<b>SALLY</b>	BPD,S,AD / severe		
<b>JAN</b>			BPD,S,ED / PS / severe
<b>VAL</b>			n.k
<b>MANDY</b>	AP,ED / PS,BS,SP / moderate		
<b>NATHAN</b>	BPAD / PS / moderate		
<b>DICK</b>	n/k		
<b>PAT</b>	D,ED,OCD / PD,BS / severe		
<b>LEN</b>	AP / PS / moderate		

The clients who ambivalently engaged or dropped out were on the severe and enduring end of the spectrum. All but one had a diagnosis of personality disorder / borderline personality disorder. The two clients diagnosed with bipolar disorder were evenly split between the one who continued in treatment (more on the moderate end of severity) and the one who dropped out, on the severe end. Those who continued in treatment were more mixed in their diagnoses, evenly split between moderate and severe problems. There is no identifiable difference in psychodynamic stressors between those clients who continued in treatment and those who left.

The diagnostic comparison between consonant and dissonant clients is presented in table 34. The summary in percentages indicates that the incidence of depression, self-harm and obsessive compulsive disorder is higher in the sample of dissonant clients. There are no clients with bi-polar affective disorder in the client-therapist dissonant sample.

The clients who used dissonant themes are mostly those who continued in treatment, with the exception of Hattie and Sam. Their diagnoses, stressors and severity of symptoms are more varied. Differences in diagnosis in the dissonant sample between AT and DMT are in the areas of eating disorders (not present in AT). There is a higher incidence of alcohol dependency in AT and of depression in DMT. The diagnosis variable will thus need to be taken into account in the individual case studies.

*Table 34 Diagnostic incidence overall client sample- dissonant sample*

Diagnosis	Overall	%	Dissonant clients			
			AT	%	DMT	%
<b>D</b>	6 in 16	37.5	2 in 5	40	7 in 8	87.5
<b>S</b>	8 in 16	50	4 in 5	80	5 in 8	62.5
<b>ED</b>	4 in 16	25	0 in 5	0	2 in 8	25
<b>AP</b>	2 in 16	12.5	1 in 5	20	1 in 8	12.5
<b>BPD</b>	7 in 16	43.75	2 in 5	40	3 in 8	37.5
<b>OCD</b>	2 in 16	12.5	1 in 5	20	2 in 8	25
<b>AD</b>	5 in 16	31.25	3 in 5	60	3 in 8	37.5
<b>BPAD</b>	2 in 16	12.5	0 in 5	0	0 in 8	0
<b>PD</b>	1 in 16	6.25	0 in 5	0	1 in 8	12.5

## **6.5 Group and unit dynamics as treatment variables affecting dissonance**

The themes of absences and the ‘blame game’ were identified in chapter 5 as of cross relevance to AT and DMT as particularly affected by group and unit dynamics, rather than simply being an expression of client – therapist dissonance. It is possible to study the effect of therapist and co-therapist absence on grading, and look at whether the theme of absences coincides with the citing of other themes or whether particular clients are mentioned in relation to absences. Peer dissonance may have an effect on client – therapist dissonance, especially in a group therapy context. If the ‘blame game’ theme is used in relation to particular clients or the (co-) therapists, timing and study of the participant observation notes may give some indication in what affected its use.

The analysis of chronologies is a frequent technique used in case studies and may be considered a special form of time series analysis (Yin 2003). It enabled me to see which themes were identified by therapists and clients at certain times. I could also identify whether certain themes cluster at particular times or can be linked to certain events over time. One of the themes I particularly wanted to look at within the chronology is the 'blame game' theme, because it was identified as a particular expression of dissonance in chapter 5.

### **6.5.1 Chronology of absences, leavings and breaks.**

The chronology notes therapist and client absences, as well as unit interruptions of treatment due to a change of programme or closure during festivals. The arts therapies groups had regular breaks related to unit residential or activity weeks, where no arts therapies groups took place, as well as breaks due to staff annual leave and unit closure during festivals. Clients received notice of these breaks in advance, but client absence and staff absence due to illness tended to be without notice. The chronology triangulates questionnaire and focus data together with the participant observation notes to indicate what was happening in sessions and in the unit.

The dance movement therapist and art therapist were present throughout the year (December 1998 to December 1999), with some absences. The co-therapists varied, with a dramatherapist being present as co-therapist 1 in DMT and AT until 12 May 99, when he stopped working for the Trust. The other two co-therapists were nurse therapists, co-therapist 2 was in the AT group from the beginning of the research until 24 November 1999 and co-therapist 3 in the DMT group from 1 September 1999.

The grading was affected in different ways by therapist and co-therapist absences. If the arts therapist was absent, the session was rated higher than the mean grade when the therapist was present. The sessions taking place before a therapist's absence were rated considerably lower twice in AT (once marginally so) and both times in DMT. This suggests that the anticipation of absence is worse than its actual occurrence, where the session is rated higher than the mean. The rating on return varied, so may be interacting with other factors affecting the session. The grading was not affected by

the co-therapists absences, but there was a significant increase in non- completion of questionnaires and a refusal to meet for a focus group. Co-therapists 1 and 2 left after prolonged absences due to illness and family circumstances, while the arts therapists tended to notify the clients in advance. The art therapist was only once unexpectedly absent due to illness.

The chronology indicated over the fieldwork year the following pattern of treatment interruptions, the asterisk indicates the 'blame game' theme:

December, January. Group composition: Liz, Ted, Belle, Cate, Al and Jack.

Pattern: Art therapist absence – Absences Al and Jack (incl. Cate hospitalised after overdose) - \* (towards Al and Jack by Belle) - Festival break-Refusal of focus group post break- Liz attends college (only present in the arts therapies groups outside term time) - Lia joins for one week, then leaves; Jack leaves after many absences.

February, March, April. Group composition: Ted, Belle, Cate, Al.

Pattern: Sam and Kate join- Sam absent and co-therapist 1 absent – \* (towards Sam by Belle, Ted and Kate) - Residential week- Belle in hospital after overdose- Refusal questionnaires / focus groups - \* (towards self by Cate and towards therapists by Ted and Kate) - Sam leaves – festival break - \* (towards therapists and Al by Belle, Kate and Ted; towards Hattie by therapists) – Cate leaves

May, June. Group composition: Ted, Belle, Al

Pattern: Jack and Lia rejoin, Al leaves, Sally joins - \* (towards therapists by Belle)- co-therapist 1 absence and leaving – Lia and Hattie have many absences – refusal questionnaires and focus group- staff concerned that clients absent and harm themselves instead of mourning the loss of co therapist 1 - Jack and Lia many absences- \* (towards Lia and Jack by Belle and Kate)

July, August. Group composition: Ted, Belle, Jack, Lia, Sally

Pattern: Kate leaves and Jan joins in July- August summer break has a different activity based programme instead of the normal therapy programme at the unit - breaks in the arts therapies groups - Jan and Lia leave

September, October. Group composition: Ted, Belle, Jack, Sally

Pattern: Belle absent in hospital after overdose, new DMT co-therapist -\* (Ted blames Lia for Belle's overdosing, towards the therapists by Sally), co therapist and arts therapists absent- activity week (instead of residential week due to staffing shortage) - \* (towards Sally and Ted for withdrawal by therapists) – Ted and Sally absent (Belle still in hospital)-refusal questionnaires and focus group- \* (towards therapists by Sally)- half term break-Nathan and Mandy join- Belle returns

November, December. Group composition: Ted, Belle, Jack, Sally, Nathan, Mandy

Pattern: co-therapist 2 ill and absent until leaving – DMT prepares for 4 week absence- Nathan and Belle absent, Dick joins (was due to come at the same time as Sam and Nathan) - residential week break- art therapist absence (two nurse therapists facilitate the group, one locum covering for co-therapist 2) - \* (towards the art therapist for being away and towards the locum by Ted, Belle and Sally, towards the dance movement therapist by Ted, Belle, Sally, Dick and Mandy) - refusal questionnaires and focus groups - \* ( towards clients for scapegoating locum by therapists) – Len and Pat join – DMT 4 week break starts - good bye to researcher – Festival break

### **6.5.2 Analysis of chronology, including co-variation of themes**

The occurrence of absences in the groups and breaks due to festivals, residential or activity weeks can be seen to affect dissonance patterns in the group. The 'blame game' theme often accompanies such events. The 'blame game' needs to be studied from a variety of perspectives. One perspective for understanding this form of dissonance is the psychodynamic one, object relations in particular. The Kleinian concepts of projection, denial and splitting (Jenkyns 1996), together with the concept of scapegoating (Schaverien 1992, 1996, 2000) provide a complementary explanation to that of cultural dissonance. Splitting and projection are associated with the paranoid schizoid stage of development (Segal 1964) and indicate an inability of the

individual to integrate positive and negative experiences from the care giver. Denial can be a defense mechanism accompanying these processes (Jenkyns 1996). Scapegoating is understood as a group dynamic related to a group splitting off unwanted feelings, denying their existence and projecting them on one individual to be expelled from the group (Scaverien 1996). These psychodynamic explanation can relate to individual, group or setting dynamics. Sometimes the 'blame game' is an individual client projection, i.e. Belle's projection onto male clients. However, the gender aspect also affected the group dynamic. This will be discussed further in the case studies. At other times the 'blame game' is an expression of group dynamic scapegoating, i.e. Sam and Lia. The breaks caused by staff leavings / absences and unwanted replacements were projected and expressed in the scapegoating of the locum therapist. The acting out of Belle through taking a life threatening overdose upset both clients and therapists. The resulting anger and guilt were denied and first mutually projected onto each other, then projected onto Lia.

The clustering of themes with the 'blame game' gives further meaning to its occurrence and what is expressed. In dance movement therapy the clients aimed the 'blame game' at therapist interpretation and a lack of connection between movement and talking. The other theme most frequently accompanying absences and the blame game in DMT was people not joining in (D12-), particularly aimed at Jack and Al (occasionally Ted and Sam). Lia was the only woman blamed for being unhelpful by several clients. They felt that her 'outside the group' contacting of others contributed to Belle taking an overdose. Both women and men joined in the 'blame game' here.

In art therapy several themes accompanied absences and the 'blame game'. The first was strong undercurrents left unaddressed (A17D-), identified by both clients and therapists. Other accompanying themes were boundary issues for the therapist and lack of group connection (A7-) and interpretation (A13D-) for the clients. Another accompanying theme was the art being for real and expressive (A2+). This helpful aspect of the session continued to operate in the presence of the unhelpful themes. Lia, Jack, Nathan and Al were blamed by their peers for hindering a session. Staff members identified Kate, Lia and Hattie as unhelpful in blocking a session.

The chronology shows that, as part of the interacting variables affecting client – therapist dissonance, group dynamics, especially staff and client absences and leavings, need to be considered in the case studies.

## **6.6 Researcher presence and its effect on dissonance**

The “in between position” as participant observer felt a privileged one in gaining an insight into both staff and client perceptions of sessions (especially in the post session focus groups). I was able to experience my own process in the therapy groups.

The chronology of me achieving my in between position needs to be considered, as it took some time. I had initially negotiated with the staff and client group in the young people’s service that I would have a three month period of participant observation in the groups, before implementing other instruments such as questionnaires and interviews. Clients and staff felt the interviews should be held after clients had been in the unit for three months, so that they also had time to settle before being asked about their perceptions of their problems and treatment. I asked for permission to be present as participant observer in both the therapy groups and the staff reviews. When I asked the clients whether they held reviews they agreed that I could also come into their room after a session, where they met to digest what happened over a drink and cigarette.

In the initial observation period the AT and DMT group were on different days. The two unit dramatherapists facilitated a ‘creative’ group. The music therapist saw outpatients for assessments and individual treatment. However, in August of that year one of the unit dramatherapists left due to chronic illness and the unit introduced a new timetable, where the dramatherapist co-worked with AT and DMT. Both groups moved into the same day, thus creating a special ‘arts therapies’ day within the therapeutic community programme. The client group also changed over the summer, of the initial group of six, only two remained and four new people joined during September / October. I decided to extend my initial participant observation period by another three months, so that the new clients could be acclimatised by the time I introduced the session questionnaires and interviews.

This allowed me more time to establish my 'in between' position as participant observer. I struggled to find a position in the group that was neither client, nor therapist, while drawing on both identities to make sense of both my own and the group's process. At the end of each day, when writing my participant observation notes, I also wrote a section on my own process, which I took to clinical as well as academic supervision.

I found that at the end of the day I was often emotionally churned up. My usual role of therapist in being able to work with those emotions with the clients was not open to me, but counter transference reactions in relation to both clients and therapists were very present. The time before the introduction of the questionnaires and interviews proved crucial to enable me to experience the impact of the participant observation and set up suitable support systems. The latter included weekly therapy and fortnightly clinical supervision, in addition to the academic supervision. Personal therapy allowed me to process my own issues which arose from the participation in the therapy groups, the clinical supervision allowed me to process the impact I had on the group dynamics.

The impact of my presence was strongest in the beginning and ending stages. My presence was inevitably a part of the group dynamics. This could be raised in the therapy groups and worked with as part of the normal process. However, I found that clients would also raise issues outside the group in the focus groups. I needed to reflect on that through clinical supervision and, where appropriate, reintroduce themes back into the group via my personal painting, moving or reflections. I could only do that through the medium, as interpretation of group dynamics would have placed me firmly in the role of therapist. Taking part in the image making meant that my images were part of the client and staff reflections in the therapy group, as well as the staff focus group review, where they reviewed the images of all who had been present. What I said about my image became thus part of the group process review, as did the moving and reflection part of the dance movement therapy group. The clients never reflected on either my images or moving in their focus groups.

Occasionally, focus group material spilt over the boundaries of the session. I would use clinical supervision to identify and process such issues. My supervisor helped me to reflect if and how, as a participant observer, it was possible to reintroduce those themes through my movement and image work back into the therapy group. Having been employed in the trust as a dramatherapist prior to the research proved initially problematic, because staff knew my professional identity and would ask for my interpretation / comments or even if I could facilitate / co-facilitate in staff absences. Initially, clients would only leave a chair next to the therapist free for me, but over time different seats would be available. I wrote in my participant observation notes: "I was interested that in the staff review no reference was made to my comments in the group. It seems more possible to be a participant observer; it has taken 4 months to feel like that."

After the initial three months participant observation I brought a palm top recorder into the review sessions to establish them as slightly more formal focus groups, using the questionnaire as a semi structured format to question staff and clients. They still used the reviews as they had done previously, but the recorder and particular questions helped to establish my separate role as witness and recorder in these groups.

The potential intrusiveness of my role needed extra consideration. The timing of interviews, especially if clients were having a difficult time emotionally, could be problematic. I might arrange to see a client and then find that they would not come that day. This was potentially an ethical problem, as the research should not impede client treatment. The same problem occurred when going into the client room after sessions if a client was upset. I always asked permission to enter and consent for the focus group, but it took time for clients to refuse me entry. Similar reactions occurred with the questionnaires; instead of refusing to complete them, a client might put a blank in the envelope. Time was needed to establish a relationship where clients could say no to me. When new clients joined and I explained the research aims and methodology, it was often an opportunity for others to ask questions again.

The continuity of the work remained problematic throughout the fieldwork year. This was due to breaks for residential activities (excluding arts therapies groups) and the

continued staff and client turnover. New clients joined at regular intervals. As I mentioned in the chronology, two additional staff left during the research period, after the initial staff turnover. I found interruptions to the therapy were an inherent unit dynamic, in line with a common pattern in the NHS where high staff turnover rates are often related to re-structuring and low staff morale (Johnson and Larkin 1995). I adjusted the research methodology and analysis to the clinical circumstances. This meant studying attrition, the effect of absences, group and unit dynamics more explicitly than initially conceived.

My own cultural background as an English second language speaker and first generation migrant was occasionally commented upon by clients, usually in the form of teasing about my accent or phrasing (as they also did occasionally with the art therapist, though never at the same time). When the music used in DMT was Germanic the clients teased that that would be my preferred music and disparaged it (as they did with one of the clients, Sam, but again not at the same time). The experience was of being singled out and kept at a distance. This was more likely to occur when new clients joined the group. I also needed at that time to re-establish the 'in between' position again.

Being teased was one of the dynamics in being with the group. They would tease each other and the unit therapists more than the arts therapists. Greater familiarity and more frequent contact played a role in this. In my 'in between' position I was considered fair game too. This could mean being singled out for a roughly kicked ball in DMT, teased about my accent, choice of clothes / music, my images in AT. In the focus groups my tape recorder was a regular object of teasing. It became hidden when the clients did not want to talk (like my pencils, which could disappear when they did not want to complete the questionnaires). If I said that it was "ok to say no" they tended to reappear.

When I started the individual interviews with staff and clients, I needed to keep the sessions separate from the interviews; otherwise the sessions of the day might affect the overall reflections. The semi structured format helped, because I made clear that I was asking the same questions of everyone. I needed to establish the confidentiality

of the material, including the audiotapes. As I mentioned, several clients would absent themselves for an interview if they felt it would be too intrusive at that time. This meant that I saw clients not always at three months after starting, but at different intervals. Giving them the repeated possibility to say no was important to establish continuity of therapy, as well as some element of trust, steering clear from the authority positions / transferences experienced in relation to the therapists.

As the effect of therapy interruptions became a part of studying dissonance, so the effect of my presence became a part of understanding the group dynamics. I needed to consider the material of the focus groups as part of the overall group dynamics, as well as a method of data gathering. Whether the questionnaires, interviews and focus groups aided the therapeutic process by introducing further reflective devices beyond reflection in the therapy groups is a point to consider. Given the client themes of over interpretation / being obliged to draw something meaningful and a lack of connection between movement and talking, the potential impact of further reflective devices could be considered both helpful and hindering. This made the clients' ability to refuse them even more imperative. Establishing a relationship where that could happen was crucial. The privileged 'in between' position of the participant observer felt a very responsible one; the therapist and researcher code of ethics to 'do no harm' working in parallel.

## **6.7 Methodological considerations**

This chapter identified variables to consider as interacting factors affecting dissonance. Looking at them in isolation from each other is necessary to identify their relevance. The methodological difficulty is that they do not act independently, but interact with others. Many researchers have attempted to isolate single client variables that have a prognostic relationship to therapy outcome (Clarkin and Levy 2004). Pre-treatment client variables have a plausible impact on the therapy, but as soon as the therapy begins, the client variables are in a dynamic and ever changing context of therapist variables and behaviour (Stiles et al 1998).

A major interest in the study of effectiveness centres on how certain contextual and individual difference variables moderate the effects of treatment (Zane et al 2004).

“Psychotherapy is a highly complex interchange in which a large number of factors interact, any one of them could significantly influence outcome. Clients differ along many dimensions... Similarly therapists vary.....Service provision also varies in important ways...” (Roth and Fonagy 2005: 17)

Various client, therapist and treatment variables have been identified that affect client – therapist dissonance. The case study method is necessary to look in depth a how these interact for the individual client. Replication across cases can then inform generalisability.

Participant observation and focus groups proved a very useful method to study client and therapist perceptions of treatment. The ‘in between’ position of the researcher, as long as it was contextualised within the group dynamics, was an excellent method to study the individual in a group context. These methods contextualised the individual questionnaires and interviews taken at one moment in time. Triangulating the various data sources allowed the study of variations for individual clients and the effect of setting dynamics over time, especially therapy interruptions in various forms.

Studying the variables affecting attrition remained a methodological difficulty, due to the lack of data for triangulation. Medical records lack the necessary data and, as the majority of clients did not respond to follow up, this remains a weakness in the methodology. Using Sam as a case study aims to address this shortcoming.

However, given that the majority of clients who dropped out came from a specific diagnostic category different from him, which has been shown to have a higher incidence of drop out (Gunderson et al 1989, Shea et al 1990), a change in design for future research will be discussed in chapter 8.

However, Kate’s and Sam’s cases that the mismatch of expectations can create additional dissonance in the early stages of treatment.

## 6.8 Chapter findings and conclusions

### Variables affecting attrition

- The client-therapist dissonance as expressed through attrition does not identify any particular within group demographic details leading independently to a client dropping out of treatment. However, the client who is a member of a visible minority, self identifies differently from how others perceive him. He experiences others perception as discriminatory and drops out of treatment. His story will be considered as one of the case studies to ascertain whether and /or which other factors interacted with the demographics to lead to his dropping out. His diagnostic picture is different from the other clients who left.
- Diagnosis and previous treatment affected attrition. All clients who dropped out are on the severe and enduring end of the spectrum and all but one have a diagnosis of (borderline) personality disorder. These may be co-morbid with a variety of other diagnoses. However, some clients with that diagnostic picture remained in treatment. It will be interesting to try and ascertain which factors interacted with the diagnosis to enable treatment retention.
- The two clients in that diagnostic category with additional stressors of single parent with young children both dropped out of treatment. That may have been one interacting factor. There is not enough data for these clients to enable the study of other interacting variables.

### Client and therapist variables affecting dissonance within treatment

- Within group heterogeneity variables that could influence client- therapist dissonance within the sample of clients who remained in treatment were: migration history, the influence of a surrounding rural or urban community and religion. Religion, nationality and skin colour were used by clients and

therapists to self differentiate ethnically and culturally. The effect of English as a second language in a therapist and client group who are fluent in English may be negligible in this sample, but needs to be considered as a difference factor.

- Gender difference in attendance of AT and DMT, a factor not shown by research to effect outcome in psychotherapy (Lambert et al 2004), indicates a potential gender factor affecting dissonance related to the medium. Similarity in age between client and therapist may interact with therapist experience to affect the difference between the AT and DMT. These will need to be considered as interacting factors.
- There is a different diagnostic picture for those clients who are dissonant in DMT than in AT, so this factor may interact with that of gender. Clients who suffer from eating disorders and / or depression are more dissonant in DMT, while there is a higher incidence of alcohol dependency in AT. There is a higher incidence of depression amongst the women, so this will also be considered as interacting with gender. Regretfully the higher incidence of alcohol dependency in AT can not be studied in the case studies. The one client who was in treatment long enough refused to be part of the research, and the others dropped out, so the required data are not available.
- Class shows no affect on attrition, but may affect dissonance in clients who remained in treatment. Arts therapists and clients in this study are both mainly downwardly mobile, the therapists due to choice of career, the clients due to their mental health problems. The nurse therapists tended to be upwardly mobile. These figures can not be contextualised for the professional groups, but makes therapist value systems in their choice of career an area for following up existing research (Gilroy 1996, Grainger 1995).

### Treatment variables affecting attrition

- Stage of treatment effects dissonance. Clients in their first and final six weeks of treatment show different dissonance patterns with the therapist. Given the variations related to stage of treatment, clients were selected for case studies who were in treatment for longer than six months. The variation over time is a variable that can be included.
- Treatment interruptions in the form of therapist, co-therapist and client absences affect dissonance and will be considered as an interacting variable in the individual case studies. The particular dissonance themes co-appearing with absences are the 'blame game', over interpretation and a lack of connection. Non-completion of questionnaires and refusal of focus groups proved an additional expression of dissonance and will be considered as part of the individual treatment stories.

### Methodological considerations

- Individual interviews need to be kept separate from sessions. The semi structured format allows for separating retrospective interview material from direct daily experience of therapy. Timing needs to be responsive to clients' needs and where necessary adjusted.
- The effect of the researcher presence needs to be incorporated in the study of group dynamics. The effect of additional reflective devices like questionnaires, focus groups and interviews also needs to be considered as part of the group dynamics. The clients' ability to say 'no' to any of these research interventions at a given time is important to the continuity of therapy and the ethical maintenance of 'not doing harm'
- Participant observation and focus groups are a useful method to study client and therapist perceptions of treatment. The 'in between' position of the researcher, as long as it is contextualised within the group dynamics, is a good

method to study the individual in a group context. The methods contextualise the individual questionnaires and interviews taken at one moment in time. Triangulating the various data sources allows for the study of variations for individual clients and the effect of setting dynamics over time, especially therapy interruptions in various forms.

## **Chapter 7 Five case studies**

### **7.0 Chapter overview**

Yin (1994) stipulates that the logic underlying the use of multiple case studies means that each case must be carefully selected. This is in order for the case study material to predict similar results (literal replication) or to produce contrasting results for predictable reasons (theoretical replication).

This chapter will provide a rationale for the selection of the cases. It will provide evidence from the data sources for that case, as well as referring back to previous analyses in chapters 4 to 6 in order to indicate patterns of dissonance and consonance. The chapter will then explore the interacting client, therapist and treatment variables, previously identified as relevant. The client variables identified were: age; gender; class; cultural background; diagnosis and previous treatment history. The treatment variables were related to certain setting and group dynamics: these included areas such as absences and treatment interruptions. The stage of treatment proved relevant in relation to dissonance patterns at the beginning and end of treatment. The chapter will also consider the effect of the arts modality for different genders in relation to this area. Therapist variables identified were cultural background, age/gender/class and therapist experience. The theoretical orientation of the unit and arts therapists was psychodynamic. Other areas of interacting variables considered relate to this: how the orientation influences therapists' perceptions of the efficacy of arts therapies treatment, along with how this matches or mismatches the explanatory framework the clients use.

In the final stage of the case study analysis, I will look at replication across cases. This is in order to identify the interacting variables which affect client-therapist dissonance in their perceptions of the efficacy of arts therapies group treatment. This will include the consideration of the role of cultural back ground variation.

## 7.1 The rationale for case selection

The selection of the cases depended on the data sources available for those clients, the duration and stage of their treatment (see chapter 4) and the possibility of literal or theoretical replication across data sources, both within a case and across cases (Yin 2003). Cases selected were those clients who engaged for longer than six months and where sufficient and varied data were available for triangulation:

- Ted and Belle engaged throughout the research year and were at similar stages of their treatment. Their treatment in the community started approximately 4 months before the questionnaires and interviews were implemented. Ted was in the community for three years, Belle two and a half years. The research covers the first half of their treatment.
- For Sally the 7 months of treatment and research was the beginning stage of her treatment. She stayed in the community for two and a half years.
- Kate participated in the treatment and research for 7 months. It was a complete treatment from start to end, her case could be used to look at stage of treatment in comparison with the above three cases.
- Sam was one of the clients who dropped out after 3 months. His was a case for theoretical replication, as he was a client from a visible ethnic minority background.

Three female and two male clients, of both similar and different class from the therapists, were selected. In terms of engagement, four clients who engaged and one who dropped out were included (no multiple data sources were available for other drop outs). The stage of treatment was monitored for clients who were in the first half of their treatment period (Belle, Ted, Sally). Theoretical replication might be possible for the clients who underwent brief treatment (Kate) or who dropped out (Sam). The diagnoses and prior treatment varied across cases. Both the psychiatric and psychodynamic understandings were compared with the client's and therapist's perception of suitability for the problem identified. In addition, the research considered their perceptions of the role of arts therapy in the efficacy of the treatment received. I have used the term 'treatment' though the term itself carries cultural

biases: these will be discussed in the analysis. Staff turnover, absences and other treatment interruptions will be discussed in relation to the chronology of dissonance, with the therapist being seen as an interacting treatment variable. All data sources were available for Liz, Cate and Mandy. They were not selected for case studies for the following reasons. Due to many absences, the data was too thin for Liz and Cate. Mandy joined late in the fieldwork period; hence she was only in the first four months of her treatment.

The therapists in this study are an art therapist and a dance movement therapist. Although age and experience of the therapist are not 'proven' to affect outcome, some studies have shown that experience and age of therapists can be an issue in attrition and engagement in therapy (Dembo et al 1983, Atkinson et al 1986, Beutler et al 2004). I have added these as potentially interacting variables alongside the cultural background variables. Dembo et al (1983) showed that clients aged 18-30 working with a therapist in the same age range showed less distress and isolation post treatment than they did with therapists more than 10 years older (see chapter 3). The dance movement therapist is in her thirties, whilst the art therapist is in her fifties. Dembo et al do not discuss how age may interact with therapist experience as a contributing issue. Atkinson et al (1986) showed this to be a factor facilitating engagement, whilst Beutler et al (2004) showed that the range related to therapist experience may affect outcome. At the time the research took place, the art therapist had more than 10 years experience, 5 years in the young people's service. The dance movement therapist was newly qualified and had started the group in the young people's service three months before the research period started.

The art therapist was a woman in her fifties. She self-identified ethnically as Northern European white and culturally as Norwegian / Jewish. She was a first generation migrant, whose parents and grandparents were born in Norway. She identified her religious orientation as Jewish, that of her parents as Norwegian Lutheran. She maintained contact with other Norwegians in the area. She lived in the city, and spoke both English and Norwegian with her children (English first language, Norwegian second). The Norwegian identity was maintained through language and contact with family and friends in Norway and the UK; the Jewish identity through

connections with the local synagogue and the husband's family. The art therapist was, due to her husband's occupation, in the same socio-economic class as her parents (2). She did her first degree in art and art history as a mature student in the UK and trained at the University of Hertfordshire as an art therapist during the 1980's. The training was psychodynamic in orientation, with an emphasis on the centrality of the art making process. The art therapist saw progress in terms of the client's independence being developed and being able to get on with daily life. She saw the transition from parental home to independent living as the important trigger to the distress, re-evoking earlier abandonment issues in their parental relationships. She looked for expressivity in the art as a sign of progress.

The dance movement therapist was a woman in her late thirties. She self identified ethnically as Caucasian white British; culturally as Western European. Her family had been born in the UK for the last three generations. She identified herself as not having a religious orientation and that of her parents as Church of England. English was the first and only language spoken at home. She was in the same socio-economic class as her parents (3). She trained as a dancer and dance movement therapist in the UK. Her DMT training was at the Laban centre during the 1990's. A strong psychodynamic orientation, combined with an emphasis on movement analysis, was part of her training. She stressed the importance of group therapy in so far as the client difficulties were manifested in forming relationships. She looked for an ability to form relationships in DMT as a sign of progress. Other signs of improvement were that clients were able to make sense for themselves and integrate unbearable feelings.

## **7.2 Case study Ted: the boy from the country**

Ted was 23 years old when he joined the community and remained in treatment for three years. He joined in the research period of initial observation at the same time as Belle. He had been referred for depression and panic attacks. The unit assessment did not identify any other stressors, although staff saw his problems as related to his childhood. His dominant mother had been replaced by his dominant girlfriend and Ted suffered from low self esteem. Ted himself said that his depression and panic attacks were caused by doing what other people wanted him to do, while he himself

did not know what he wanted. He left school after his GCSE's and became a car mechanic. His father was an electrician and his mother a housewife (NS-SEC 6 for all). A few years ago he moved out of the parental home to live with his girlfriend. She was still working as a hairdresser, but he had been off work for three years becoming increasingly withdrawn and housebound. This meant that he lost his job. Ted had lived and grown up in one of the small villages in region F, and was still living there with his girlfriend near his parents. His treatment prior to coming to the community consisted only of drug treatment.

When Ted was asked how he felt treatment could address his problems he described that having a structure to his day, talking about his problems, finding solutions and a change in medication had all been efficacious. He felt that DMT gave him confidence by doing things seriously with other people. He could not say what he found useful in art therapy. The unit staff identified DMT as particularly useful to him, because they saw him channel his frustrations non-verbally. The art therapist felt it was useful for him to express his dissatisfaction and anger in words. The art therapist also felt that his use of the art medium changed over time. Initially he could not relate his feelings to the image, but over time he was more able to do so. Ted felt he had changed during treatment. He had relaxed more and was more able to communicate with people. His aim for treatment was growing independence and re-employment.

Ted's ethnic and cultural background were both self-identified as English. He was one of the 50 % of clients who made no distinction between ethnicity and culture and one of the 66% of clients who used nationality as the deciding factor. Both parents and grandparents were British born and he grew up in a rural community. Neither he nor his parents had a religious affiliation. This made him one of the minority of 6.4% in the young people's service to do so, although the fact that 67.7 % of clients' religion is unknown makes that figure questionable. Ted completed his statutory education, but did not enrol in higher education. Within his peer group that made him one of the fifty percent in a lower economic class than the therapists and other clients. Unlike the majority of clients and therapists, he was neither upwardly nor downwardly mobile.

Table 35 Ted: summary cultural background variables

<b>Ethnic / Cultural background</b>	TED: English / English
	ATH: N. European white / Norwegian- Jewish
	DMTH: Caucasian-white-British / W. European
<b>Religious orientation self / parents</b>	TED: none/none
	ATH: Jewish /Norwegian Lutheran
	DMTH: none / Church of England
<b>Migration history in three generations</b>	TED: no
	ATH: yes, first
	DMTH: no
<b>First / second languages</b>	TED: English / English
	ATH: Norwegian / English
	DMTH: English / English
<b>Urban / Rural place of residence</b>	TED: rural (one move within same area)
	ATH: urban (many moves)
	DMTH: urban (many moves)
<b>Reinforcement surrounding community</b>	TED: yes
	ATH: yes
	DMTH: yes

### 7.2.1 Ted's pattern of dissonance in AT and DMT

Ted attended 85.5% of the dance movement therapy group and 80 % of the art therapy group. This was higher than the average attendance of the engaged clients (71.6 %) and drop out clients (47.6%).

Ted's grading of sessions was also higher than that of his peers. His mean grade was 4.1 for DMT and 4.15 for AT, his peers' mean was 3.03 DMT and 3.35 AT. He also graded higher than the therapists (mean 2.96 AT and 3.53 DMT). When the art was expressive and for real and there was contact between people, he found art therapy sessions useful. When there were absences and / or the session felt too long it was unhelpful. In the focus groups his themes were the same, but others were added. This could be influenced by the fact that other people formulated them and he did not contradict them. Additional useful focus group themes were that a session was relaxing, and that there was enough time to paint and talk. Art as a distraction was also felt to be useful. Absences were not mentioned in the focus group, but other themes were identified to make a session unhelpful: a lack of group connection, timing being problematic (often related to the balance between talking and action, i.e.

too much talking made the sessions feel too long), feeling obliged to draw something meaningful, over interpretation and a dislike of staff and fellow clients.

In dance movement therapy he provided a greater variety of themes to qualify his grading. Useful factors were again connecting with other people in the group, expressing feelings through talking or movement, having fun and using certain structures such as kicking the ball “to let off steam”. Hindering factors were a lack of structure and / or direction, balls being out of control, absences and people not joining in. Additionally unhelpful factors were that feelings were blocked or the physical space was too small (connected to the ball being out of control). In the focus group clients initiating and moving to get rid of stress were added. As in art therapy, unhelpful factors were more varied and identified with greater frequency in the focus groups. Additional factors were a lack of connection between movement and talking. Repeated in a group context were the use of certain structures, i.e. the ball being out of control, absences and dislike of staff and fellow clients.

Table 36 shows Ted’s questionnaire grades and the comments in his own words.

*Table 36 Ted’s grades and comments in AT and DMT*

*Art therapy*

<b>Grade</b>	<b>Comments</b>
<b>1</b>	Ok, , don’t know
<b>2</b>	Ok, ?, sitting down for 1.5 hours, need a coffee break and time in loo
<b>3</b>	Ok, but a bit too long
<b>4</b>	not too bad
<b>5</b>	ok (10 times), very well (3 times), very sexy (once). Comments: being able to talk and show how I was feeling, explained how I felt in pictures, seeing tits, showed how I felt using art, drawing what was on my mind, using art to show how I was feeling (5 times), working together as a group. More people? (3 times), not seeing penis.

### *Dance Movement Therapy*

Grade	Comments
1	it did not go well, dick all useful, like shit. Reasons: Having a wanker have a go at me, the group being 1.5 hours too long, what is the point of this group, Belle being in hospital
2	not used
3	?, Ok, not being able to hit someone
4	Ok, moving fast and as a group, breaking the light. The length of the group unhelpful, sitting down for half an hour, could use video or keep fit tapes to help come up with ideas
5	Ok (5 times), very well (6 times). Useful :It was a good laugh, working as a group, kicking the ball, it brought up a lot of feeling, using movement to change how I was feeling, helping others, being able to move to show feeling and to get in touch with feeling. Unhelpful: need more people to join in, more people, especially staff who can not be bothered to come in, need bigger room, more people needed, people sitting in the coffee room!

Ted attended 5% more DMT than AT sessions. Over time it showed that the issues concerning timing (sessions too long, needing a break) issues were raised nearer the beginning of the treatment. The absence of people was felt later. Ted gave more detail in his comments on the DMT group throughout the year. The art therapy low grade comments had question marks, indicating that it seemed difficult for him to articulate the reasons for finding a session unhelpful.

In dance movement therapy Ted tended to grade high, showing a consistent pattern of consonance with occasional incidents of dissonance. In DMT there were four, in AT five incidents throughout the year. In DMT he was first dissonant in February (six months into his treatment), when the clients were asked to create their own symbolic space in the room. He put a question mark in his questionnaire and was not present in the focus group. From the participant observation notes it can be seen that in the group he asked “what is the point of this, usually we move how we feel?” In mid March he was dissonant again; angry at the co-therapist who he felt had a go at him. Belle was in hospital after an overdose. The next week he was dissonant again. He said “it was crap as there is too much going on at the moment. The only good thing was the distraction”. In the afternoon most clients did not attend the art therapy group and visited Belle in hospital. The staff focus group felt that the clients were very angry and divided and scapegoat Sam as a reaction. Ted’s last dissonant DMT session was in July (he was also dissonant in AT at this time). It seemed to be a reflection of overall discontent with the unit expressed through absence rather than being able to articulate it. The research continued until the end of December. In that period he was

absent one week and did not complete a questionnaire the following week. The other weeks he was present and consonant.

The unhelpful comments about the sessions tended to involve comments on timing and absences. It was not easy to ascertain why a group felt too long for him. The question marks and Ted's asking 'what is the point of this', can be seen to indicate confusion and / or anger. The blame game was never focused on the DMT per se, once on the co-therapist and once generally on all staff "as they give you groups, but do not tell you what to do with them".

In art therapy the dissonant sessions were spread out over the year of the research period. The first time was early in December, when the research started. He felt the group needed more breaks. In February he was dissonant again, with the rest of the group. This was the week before a residential and the clients discussed in the focus group their fears of constantly being with each other and the staff. Ted would not be there, as he needed a small operation in hospital. His next dissonant session was mid May, when there were visitors. He put question marks, did not seem sure why the group did not feel ok, but asked Belle in the focus group whether she was taking the piss out of him. She responded that she was taking the piss out of the staff. He was absent several times in June and July in DMT and AT. It seemed to be a reflection of an unspoken sense of discontent with the unit. Mid July was his next dissonant session in AT. He gave no reason for his low grade, nor did he attend the focus group or articulate discontent within the session. Post summer break in November he was again dissonant, graded the session 1, but gave no reasons in the questionnaire. He expressed irritation with the art therapist's interpretation in the focus group. In his high grading during these months for both DMT and AT, he frequently mentioned missing people and wanting more people to join in (the latter especially in DMT).

With the exception of blaming the co-therapist, where he felt "got at", Ted did not use the 'blame game' theme. He did not disagree with other clients when they mentioned it in the focus groups. He initiated expression of discontent at the art therapist's interpretation once.

Changes over time indicate that in the first six months of the research Ted showed greater dissonance than in the second six months. Moreover, the dissonance with the art therapist was more pronounced. It continued into the second half of the year and started earlier than with the dance movement therapist. Ted rarely expressed direct dissonance via the blame game, only once with the male co-therapist in DMT and once in the focus group with the art therapist. After the first incident with the co-therapist, the co-therapist said in the staff focus group that Ted was upset that he needed to admit Belle to hospital when she took an overdose. He was additionally upset that he had not gone on the residential week with the others; had felt isolated and alone. His therapist dissonance interacted with the group dynamics at that time.

However, it may also be that in the expression of anger certain people are more likely to be scapegoated; Ted quarrelled with Sam for not washing up the bowl. This was backed up by staff perception that Ted's anger was generally present, looking for an outlet. His AT comments about tits and penis also seem to indicate an element of sexuality in this. Another interacting factor may be the use of the medium. When the DMT group did not move much, this possibly meant that Ted was not able to use the movement to express his anger. The fact that he graded higher and was more able to express hindering factors in the focus group than in his individual questionnaires, may be linked to his identified problems of doing what people want and finding it hard to identify and express his own needs.

### **7.2.2 Interacting client, therapist and treatment variables**

Ted's greater dissonance in AT was affected by the interacting client – therapist variables of migration history, ethnic self-identification, nationality and language. Treatment variables included the relationship with certain peers, treatment interruptions including staff turnover and the arts medium.

Ted's relationship with Belle occasionally affected his therapist dissonance. This was clear after her hospital admission in March and when he checked with her whether she had a go at him in May. This 'pairing' (Bion 1961) was more prevalent in the first six months. His attachment in the second six months was more general to the group. He

frequently expressed a wish for more people to be present and actively involved, especially in DMT. He blamed Lia for Belle's readmission to hospital after another overdose. Sam was the other client with whom he directly expressed anger, at the same time as the group scapegoated both the art therapist for her foreign accent and Sam for his different choices in music and clothes.

Two factors, which influenced Ted's dissonance with the art therapist and dance movement therapist were the absence and leaving of co-therapists. CO-TH 1 left after being co-therapist in both the art and dance movement therapy groups, and CO-TH 2 left the art therapy group. The greater dissonance with the art therapist could thus be argued to have been caused by the twice occurring loss of the co-therapist. Ted regularly commented on the absence of people (peers and staff) and once Ted stated that 'staff not bothering to come in' felt an unhelpful aspect of the session. These sessions were not graded particularly low though. Confusion seemed more around as a theme when a session was graded low. Also, the absence of people was much more frequently articulated in relation to the dance movement therapy group.

The role of the medium was an interacting treatment variable. It could be seen psychodynamically to influence Ted's greater dissonance. I will look at this under ethnographic explanations too, but would like to consider the issue of resistance as a possible explanation for Ted's difficulty with certain interpretations. His frustration in DMT with too much talking and too little movement, could be considered a resistance to thought, the movement a mere acting out / abreaction. However, the more direct irritation with the art therapist seems to be connected to not understanding, the question marks a sign of confusion, rather than resistance. The question marks were more frequent in art therapy and directly linked to low grades. The divergent understandings between him and the art therapist about how he uses the art may be a further variable affecting dissonance.

Ted preferred DMT to AT. Linking this to the medium, he seemed to find it more difficult to give meaning to images and found DMT a better way to channel his frustrations. Given how he understood his diagnosis and identified problems the more direct physical expression in dance and movement may have facilitated easier

expression in a direct, rather than metaphorical, form. He expressed difficulty with the issue of interpretation and frustration with the lack of movement in DMT. He was particularly dissonant with the art therapist about the interpretation of images. He valued being able to express what he felt through the images. His emphasis was more on expression than understanding. The greater emphasis on group interaction in DMT might have been experienced by him as more directly useful, he valued everyone joining in and doing things together as useful in the sessions.

The similarities in the perception of efficacy between the client, art therapist and the dance movement therapist were that each cited symptomatic causes related to psychiatric diagnoses. The client discussed how these affected his daily living; not being able to get up, go out, go to work. He saw the underlying causes to his distress as doing what other people wanted him to do (relational, possibly psychodynamic, but not necessarily related to parental relationships). When asked “which people?” he said “in general, rather than particular people”. The art therapist saw the early parental relationships as the underlying cause for all clients (psychodynamic explanation).

The dance movement therapist saw them as different for each individual, but for Ted as the difficulties in his relationships with his parents and his partner (psychodynamic explanation). Ted saw the treatment as effective because he found it easier to go out, easier to communicate with people and his panic attacks had decreased in frequency (a mixture of psychiatric and psychodynamic frameworks). In his treatment he saw medication and talking to other people as appropriate ways of addressing his difficulties. The dance movement therapist stressed the importance of group therapy as the difficulties were in forming relationships. She looked for that in DMT as a sign of progress, as well as the clients being able to make sense for themselves and integrate unbearable feelings. The art therapist saw progress in terms of the client’s independence being developed and being able to get on with daily life. She saw the transition from parental home to independent living as the important trigger to the distress, re-evoking earlier abandonment issues in their parental relationships. She looked for expressivity in the art as a sign of progress. Ted saw the efficacy in DMT as being able to do things together with others and taking it seriously. In the interview he was not sure about the art. The interview took place in the fifth month of

treatment. His chronology showed that he started to articulate the usefulness of expressivity in art more during the second six months (months 10-16 of his treatment).

The dance movement therapist was nearer to Ted in age, but less experienced than the art therapist; age and experience affecting dissonance is not clear in Ted's case.

Ted's differences in cultural background were in terms of nationality, religion and language with the art therapist. These variables were the same for him and the dance movement therapist. I wonder whether these differences may be particularly relevant for a client who identifies as English for several generations and whose contact experience with people of a different background may be limited (rurally based in one place throughout his life, in a community with little diversity- see 4.1.2). The irritation with interpretation may be due to a difference in perception of underlying causes; the emphasis on relationships with people in general is congruent. The art therapist stresses the parental relationships more, while the dance movement therapist incorporates peer relationships (more consciously acknowledged and thought about by Ted). The impact of the cultural variables on the medium may be relevant; direct or indirect artistic expression may have relevance for clients in their preference of dance / movement over art.

### **7.3 Case study Belle: I can't trust anyone**

Belle was a 20 year old young woman who arrived at the unit at the same time as Ted and stayed for two and a half years. She was referred for depression, self-harming and an eating disorder. Other stressors the unit identified in their assessment were sexual, emotional and physical abuse in her birth family, as well as being fostered in adolescence. Belle received previous treatment in child and adolescent inpatient psychiatry, in acute inpatient psychiatry and was still receiving drug treatment.

In the interview, when asked why she was in the unit, she said after 6 months that people piss her off and she is too wound up to sleep. Initially she said the problems started aged 14, but would rather not say why. Later she stated "people say it is the

abuse from childhood”. The unit staff articulated the abuse by her brother and her subsequent period in the inpatient adolescent unit as precipitating factors. They felt this had affected her ability to trust and to make sense of her experiences. The dance movement therapist cited her difficult relationship with her parents, two family members abusing her. The art therapist cited family relationships as problematic. Both the arts therapists mentioned her acting out as part of Belle’s way of relating to people, particularly the self-harming incidents.

Belle said that she “really does not have a clue” what type of treatment might be useful to her. She found the individual time with her key worker most useful. This clashed with the dance movement therapist’s emphasis on the usefulness of group therapy. The art therapist felt that Belle was able to come back to the unit after acting out and hospitalization was really useful to her. When talking about the arts therapies as part of her treatment Belle said that she hated it in the beginning. After 6 months of treatment she preferred art therapy to dance movement therapy; she did not like to get up and do things in DMT, “in art everyone gets on with their own things”. In the follow up interview later, she felt that the expectation to do something, to express what she felt, was really inhibiting. It reinforced her feeling unable to express herself. She felt she enjoyed it more now she was able to relax. Belle could not see any aims for her life, she expressed that she had become used to the way her life was now and could not see the possibility of change.

When referring to her ethnic and cultural background Belle referred to her birth family. She self-identified ethnically and culturally as English. She identified her mother as Irish born, when she was asked where her parents and grandparents were born (one set of grandparents were born and resident in Ireland). This had however not influenced Belle’s self-identification. The language spoken at home was English; the home was urban without a significant Irish neighbourhood to identify with. She was raised a Roman Catholic, with a Roman Catholic mother and Methodist father. This made her one of the minority 2.8% in the young people’s service, of the 32.3% of clients with a known religious affiliation. Emotional identification with her cultural background might have been difficult, due to the abuse suffered. Non reinforcement of the community or parent might have been another factor. The fact

that her religious orientation linked her more with her mother's Irish background than with her father's English non-conformism, was for her not connected to her ethnic / cultural self-identification.

Her father was a factory worker, her mother a receptionist. She herself had worked as a waitress in the past, but was now unemployed. She had not completed her statutory education, fairly common for clients with her longstanding history of mental health problems. Her own SEC was 8, her parents' 7. This placed her, with Ted and half the clients in a lower socio-economic class than the therapists and other clients. There was no sizable discrepancy with her family's SEC due to her mental health problems.

*Table 37 Belle: summary of cultural background variables*

<b>Ethnic / Cultural background</b>	BELLE: English / English
	ATH: N. European white / Norwegian- Jewish
	DMTH: Caucasian-white-British / W. European
<b>Religious orientation self / parents</b>	BELLE: Roman Catholic/RC (M)-Methodist (F)
	ATH: Jewish /Norwegian Lutheran
	DMTH: none / Church of England
<b>Migration history in three generations</b>	BELLE: Irish grandparents, mother first gen.
	ATH: yes, first
	DMTH: no
<b>First / second languages</b>	TED: English / English
	ATH: Norwegian / English
	DMTH: English / English
<b>Urban / Rural place of residence</b>	BELLE: urban (many moves)
	ATH: urban (many moves)
	DMTH: urban (many moves)
<b>Reinforcement surrounding community</b>	BELLE English yes, Irish no
	ATH: yes
	DMTH: yes

### 7.3.1 Belle's pattern of dissonance in AT and DMT

Belle attended 51% of the dance movement therapy group and 59 % of the art therapy group. This was lower than the average attendance of the engaged clients (71.6 %) and higher than the drop out clients (47 %). This was due to several periods of absence from the unit after overdoses and hospital admissions. Her mean grades (2.9 for DMT, 3.5 for AT) were lower than those of her peers (mean 3.03 DMT and 3.35

AT), lower than the dance movement therapist (3.53 DMT) and higher than the art therapist (mean 2.96 AT).

In AT the art being expressive and real and contact between people in the group made a session useful to her, while absences and problematic timing made a session unhelpful. The additional frequently mentioned themes in the focus groups was relaxing as useful, once having enough time to paint or talk was felt to have contributed to the usefulness of the session. Hindering on more than one occasion were a lack of group connection, over interpretation and a dislike of self and others. A lack of focus and feeling obliged to draw something meaningful were an occasional hindrance.

In DMT connecting with other people in the group, being able to sleep in a session and the use of certain structures was experienced by Belle as useful. Unhelpful were the use of other particular structures, absences, people not joining in and the blame game. The balance in the focus group between helpful and hindering factors was similarly distributed, but different factors emerged. Expressing feelings, clients being able to initiate, having fun and moving to get rid of stress were added to the useful factors. In unhelpful factors; a lack of structure and a lack of connection between movement and talking were added. The same unhelpful themes were mentioned, both more often, excepting the absences.

Table 38 shows Belle's questionnaire grades and comments in her own words.

*Table 38 Belle's grades and comments in AT and DMT*

*Art therapy*

<b>Grade</b>	<b>Comment</b>
<b>1</b>	crap, art therapist is a knob, hating art
<b>2</b>	not used
<b>3</b>	People being open, having ideas suggested, having a laugh, anger at co-therapist for sexual interpretation of image
<b>4</b>	being able to prat around, express myself, relaxing, therapist is a prat
<b>5</b>	Relaxed, having fun, doing what I wanted

*Dance Movement Therapy*

<b>Grade</b>	<b>Comment</b>
<b>1</b>	load of shit, crap. I feel like shit, unhelpable and a miserable cow. Therapist and co-therapist are prats
<b>2</b>	I was in an arsy mood and could not be bothered
<b>3</b>	Everyone joining in and trying. Balls being out of control. Kicking /hitting the ball and letting out frustration
<b>4</b>	Enjoyed it, a lot of activity. Pace gained speed and everyone joined in. people missing. Sleeping for 10 minutes at the end, walking with my eyes shut, relaxing
<b>5</b>	Al and Jack away, having an idea that people liked, people sulking and not joining in (otherwise enjoyable session)

Belle attended 8% more AT sessions than DMT, which meant she missed one more session of AT than DMT. In AT the strong dislike of staff and self, as expressed in the ‘blame game’ theme, occurred on one occasion before an overdose and period of hospitalization, but that was not repeated during the second time this happened. In DMT more dislike of other clients and the therapist was expressed via the ‘blame game’ throughout.

In AT Belle showed dissonance first when the therapist was absent, four months into the treatment. The following time in February, Belle expressed anger at the co-therapist. In the focus group the clients expressed their fear of living together in the upcoming residential week. The staff focus group commented on the scapegoating of the art therapist for her accent and Sam for his cultural difference.

The next dissonant session was before a 3 week break in May, when new clients were present in the group. Belle watched, but did not paint. In the focus group she told Ted (who asked her why) that “she wanted to take the piss out of the staff “(in her questionnaire she said that “the art therapist is a nob”). She was again dissonant in June when visiting new clients were present. In the questionnaires she blamed herself and felt “unhelpable”. In the focus group she blamed a change in medication, but also expressed irritation with the art therapist for talking ‘positive crap’. One of the other clients mentioned missing the co-therapist 1. The staff focus group felt that the clients’ acting out (cutting etc) was due to co-therapist 1’s leaving.

These four dissonant sessions occurred during the first six months of the research. Belle had a period of absence due to an overdose after the February dissonant session. The dissonant sessions tended to alternate with consonant sessions. The comments in December showed her irritation with the therapist, but she graded the session high because she was able to switch off. At the end of February after the art therapy group Belle said in her questionnaire that she hated art, the co-therapist was felt to be perverse for making a sexual interpretation (during the session Ted showed magazine images of naked people, he and Belle giggled over them. Co-therapist 2 remarked on Ted's drawing of invisible naked people covered in glue).

March showed a consonant session after her return post hospital admission, she stated that the session went well, but gave no reasons. There are no focus group data as the clients opted not to discuss the art therapy group. The next consonant session was post break. She stated she felt more able to paint and enjoyed messing about with the paint (and not having to clear up). After the dissonant sessions in May and June with new clients, July saw another consonant session where she felt she had fun and the session was relaxing.

After the August break she was absent due to another hospital admission after an overdose. She was absent from the unit for a further six weeks after discharge from hospital. Her return was marked with a consonant session. She stated in the focus group that it was good to be back and see friendly faces. She also felt able to use the art to express herself. In December she was again consonant and stated this was due to the fact they did something as a group; she enjoyed the group painting.

Dissonance in DMT occurred for the first time in May, the same time as in the AT. There were visitors. She felt DMT was hard and experienced the therapist and co-therapist as patronizing. She had not wanted to say goodbye to Al who was leaving the unit. Two weeks later she was again dissonant in DMT in advance of a residential week, but Belle felt she herself was in an 'arsy' mood. At the end of June she was dissonant in DMT and AT. There were visitors, she had a change of medication and was worried about an upcoming review. In the focus group she said that she

experienced all staff as using emotional blackmail. The next dissonant session was not until six months later, the last DMT session before a 4 week break.

Consonant sessions occurred in December, due to a stated relief that Al was absent. She found his presence inhibiting as he did not move. The following week she graded the session high, apparently consonant, but stated that it was boring. The staff focus group felt that the clients were resistant. The week after that she still graded DMT high and said it was good to move. The difference between her grading and comments could be ambivalence. The next highly graded session was in March, she was irritated with Al for not joining in, but said she enjoyed DMT. She felt more able to play, like a playful child. The last consonant session in DMT was in early June, she graded the session high because she liked to use the musical instruments. However, she was sad she had just sat there, did not move, although she had wanted to pace up and down. In the focus group she said DMT was shit. Again, this seemed to indicate ambivalence.

After her prolonged absence post summer break Belle did not complete any more questionnaires for DMT . She was present in one focus group where DMT was discussed but did not take part in the DMT discussion. She was more concerned with one of the client's recent cutting. She then chose not to attend any other focus groups until after the DMT group had entered its four week Christmas break.

Over time a pattern emerged in DMT and AT. Belle often indicated ambivalence through a contrast in grades and comments. The blame game in either questionnaires or focus group acted as an indication of therapist and / or peer dissonance. Sometimes it was an expression of anger at the therapists for absence or introducing new members. Sometimes the male group members who sat out and watched carried the transference projection of the abusive male. Although AT dissonance was expressed earlier than DMT dissonance, in the focus groups the blame game indicated an earlier ambivalence about DMT. In December Belle's discomfort about her body and being watched while moving, was focussed on the inhibiting effect of Al and Jack not joining in. In AT the absence of the therapist seemed to have evoked rejection, as well as a sense of loss. In February, fearing the enforced intimacy of the residential week,

she openly expressed anger at the art therapist and her co-therapist. The group expressed their discomfort and fear in a scapegoating of difference in the art therapist's accent and Sam's different cultural choices. Belle said in the focus group that she experienced the DMT as 'being in a huff'. The session notes mentioned an upcoming absence of the DMT and anger in the group by Belle that the dance movement therapist insisted on drawing attention to absent clients. The art therapist was again blamed in April, having "talked a lot of shit" and interpreted "images which meant nothing". Belle was also angry at the co-therapist for interpreting sexual imagery. This angry blaming seemed a projection on the therapists of her unwanted (denied) sexual feelings. In May and June the pattern of dissonance and consonance was similar in AT and DMT, both occurring when new clients were present for the day, as well as linking feeling bad to absences of staff. Mid May there was an extra dissonant session with the DMT, but Belle blamed herself for being in a bad mood, possibly owning rather than projecting her emotions..

The hospital admission and consequent absences post summer break made consistent comparison difficult. Belle did not complete any more DMT questionnaires until December, while she continued to be forthcoming on art therapy, all consonant. Just before the long DMT break Belle expressed herself dissonant with the DMT in her questionnaire (the only one completed for DMT since the summer break). She did not say why she was angry, but expressed irritation with the dance movement therapist's interpretations in the focus group. When the art therapist and co-therapist 2 were absent during this time and two other members of staff facilitated the group, Belle commented that it felt strange, she missed the art therapist, "as I would just have been able to shout at her if I was angry".

### **7.3.2 Interacting client, therapist and treatment variables**

The interacting factors influencing dissonance for Belle are her diagnosis and treatment history, as well as cultural background variables (migration history, ethnic self-identification and religion). These client variables interact with setting and group dynamics, cross gender relationships and absences in particular, as well as treatment

interruptions. Replication across cases between her and Ted may give some indication about class, age and therapist experience.

Belle had many treatment interruptions, sometimes they were due to the setting, therapist and co-therapist absences for example, but they were also due to her overdosing incidents resulting in admission to hospital. Her long and frequent absences from the group meant that she maintained better contact with her peers (who often saw her outside the community and visited her on hospital) than with the arts therapists, who would not see her if she did not attend the groups. However, peer dissonance might have been an issue affecting therapist dissonance for Belle. In the blame game theme, questionnaires and focus groups she mentioned Al and Jack as an inhibiting factor in DMT (as they watched and did not join in). Excepting Ted, Belle was mostly dissonant with other male clients. Sam was derided for having the wrong taste in music, clothes and possessions in the focus groups. This may be attributable to more than gender or a psychodynamic explanation as this seems to be part of group scapegoating and coincides with art therapist dissonance and scapegoating.

The psychodynamic understanding of Belle's problems relate to early abuse and consequent problem to form trusting relationships. The latter would be problematic with peers as well as authority figures, as both father and brother were active in the abuse. Her dissonance with male peers can, in a psychodynamic framework, be explained by her history. Being watched by people who do not participate, especially male (she does not mention it when female peers sit out and watch) can be understood as an objectified watching by a male. Her anger at the male co-therapist when he interprets sexual imagery may be a reflection of this same dynamic. The self-hate is common in abuse survivors who tend to blame themselves for the abuse having occurred. Her cutting and eating disordered behaviour may be a reflection of hating her body, which would make an arts medium that requires embodiment more difficult than one with an external form of expression. The difficult feelings could be projected on others, such as male clients and co-therapists.

The absences of therapists evoke anger, which seems to indicate some form of attachment despite therapy interruptions. Nevertheless absences could negatively

influence forming a trusting relationship. Her ambivalence, as expressed in contradictory grading and comments, may be a further expression of this.

In the interview Belle said about the arts therapies treatment that she hated it initially. After 6 months of treatment she preferred art therapy to dance movement therapy. She linked the reason for this to the medium. She did not like to get up and do things in DMT, in AT everyone got on with their own things (more individual in the group than group-as-a-whole orientation). In the follow up interview she felt that the expectation to do something, to express what she felt was really inhibiting as it reinforced her inability to express herself.

Both therapists and the client shared the view that traumatic familial relationships affected Belle's ability to relate. She said that people piss her off, but she could not tell them. It is interesting to note that in the December focus group (16 months into her treatment) she reported having missed the art therapist 'as she would be able to shout at her'. The arts therapists (AT and DMT) felt that her acting out behaviour was her way of relating to people and that she found it hard to trust. Efficacy of the overall treatment for Belle would have been that she found it easier to go out and have friends. Belle could not say what would be appropriate treatment for her difficulties, but felt individual time was most effective for her. This might conflict with the dance movement therapist's stressing the importance of group therapy. The stronger group orientation and the embodiment nature of DMT might have influenced the greater client – therapist dissonance.

After the first six months Belle felt she had not got anything out of the arts therapies. Getting better would mean being able to hold down a full time job and go out with friends, "being a normal person". Her hopelessness about her situation might be reflected in her overdose and subsequent absences. She did however return and showed a greater client-therapist consonance with the art therapist. Her failure to complete dance movement therapy questionnaires might reflect her "not being able to tell people when they piss me off". However, earlier she had been able to do so, first in the focus groups with support from peers, then in the questionnaires.

In AT questionnaire comments she stated that she experienced sessions as relaxing and even cites feeling useful that she was able to express herself. In DMT the helpful factor was “having an idea that everyone liked”. Relaxation was not mentioned, but she commented that being able to sleep was useful. This could be seen more as a shutting off than relaxation; the fact that the high grade was qualified by ambivalent comments in the focus groups and questionnaires seems to underpin this explanation. She expressed hostility towards the therapists, fellow clients and herself in even measure (in AT therapists three times, self twice; in DMT, therapists 3 times; self three times; fellow clients four times). The incidence of self and peer blame was more frequent in the DMT group. Her difficulty to trust might have played a role in this, especially in DMT. She noted therapists’ absences with greater frequency in the AT group, possibly indicating greater attachment.

The greater dissonance with the dance movement therapist can be explained by Belle’s difficulties with the medium (being witnessed and having to use embodiment to express her feelings), as well as the group orientation within DMT. Belle’s diagnostic history and severity of problem may have offered difficulties in engagement for a less experienced therapist. The closer age may not ameliorate that difficulty.

Belle’s sense of alienation and distrust can be psychodynamically explained by past experience, but it is interesting to note that she came from a mixed cultural background which remains unrecognized. She may be more comfortable as the daughter of a first generation migrant with the first generation migrant therapist. A minority religion and lack of identification with one side of her cultural heritage, as a potential alternative to the abusive one, does not seem to have been open to her. Her sense of self loathing diffusely connects to many factors that can not be causally linked, although culture as a contributing factor to a problematic identity formation could be argued. This could be expressed as dissonance in the form of scapegoating of difference as expressed towards the art therapist and Sam. On the other hand this allows for a greater capacity of articulating anger towards people, one of her stated problems. In articulating missing the art therapist she values the fact that she is able to express anger towards her. Difference may provoke scapegoating, but also a

greater ability to relate; the ambivalence about the own difference leading to a greater ability to express both negative and positive emotion in the attachment relationship.

#### **7.4 Case study Sally: Lashing out**

Sally was a 17 year old woman who started her attendance in the community in May (the fieldwork covered the first 8 months of her treatment), and stayed for two and a half years. She was on probationary discharge from a secure unit for the first six months, with a condition of daily attendance, if she was not to be returned there.

Sally was diagnosed as suffering from borderline personality disorder (BPD), self-harming and adjustment disorder. The unit identified no other stressors in this early stage of her treatment, which was still considered to be an extended assessment period while in transition from the secure inpatient unit. Previous treatment received was drug treatment, as well as receiving in and outpatient child and adolescent psychiatric treatment.

In the interview she said she attended the unit because she had nowhere else to go and needed to do something during the day. She also needed to get things off her chest.

“I needed something after hospital, having been there so long. I needed a step that was in between hospital and the outside world. I couldn’t just leave and go to college or a job. I just can’t cope. I want to kill myself. Now being in a rational state I can see that people do not want me to do it, but sometimes I get into a state where I think they all want to do it as well, so there is nothing to stop me. When I am in one state of mind, I cannot remember being in another one. When I am happy I cannot remember being sad or vice versa. I can remember what it was like, but not imagine that I will ever go back to that”.

From her previous treatments she felt the anti depressants and cognitive behaviour therapy had helped. People physically stopping her from harming herself were part of that help. In the unit she found seeing people outside groups useful, also being able to phone someone outside hospital. When discussing the arts therapy input she felt it was

a way of letting people “sort of” know what she was feeling. She considered that it was sometimes harder to create an image than to say it.

The unit staff felt that the arts therapies were a less threatening way for people to relate to others, as well as connecting with their own emotional life. The art therapist felt that Sally was able to illustrate some of the dramatic feelings she had about herself. Co-therapist 3 felt that Sally was able to get some of her frustration and self hatred out about a particular incident that happened to her very powerfully in the movement, more so than in image making. The dance movement therapist fluctuated, and Sally had no particular things to say about DMT in the interview. Her comment about not being able to remember one state of mind when she is in another might have been related to this. In the questionnaires she frequently mentioned the kicking of the ball to express feeling as helpful. Occasionally a structure sparked off negative associations (guided imagery, following in movement). In the health diary she mentioned that DMT felt good at the time, but later she felt guilty about having fun. When asked what she expected from the treatment she focussed on wanting to stop cutting and killing herself, and needed to “learn to cope with people”.

While she was at the unit Sally lived with her father, a policeman, and her mother, a disabled ex-nurse. Her parents’ SEC 5 was lower than the therapists’ SEC 2 or 3, one of the 67 % of the sample for which this was the case (as were Ted and Belle). Her non-completion of her education was a concern to her. She lived with her parents in a small village in region F and said she would find it difficult to return to school there, as “everyone knows my history”.

Sally’s self-identification was white English for culture and ethnicity. Her parents and grandparents were born in England and she had grown up in a rural area with little diversity. English was her first language and the language spoken at home. She and her parents did not follow a religious tradition. She said of her parents that they were christened Church of England, but non-practising. This made her one of the 6.4% of clients who self classified as no religion, out of 32.3% whose religious affiliation was known. She had not completed her secondary education due to her mental health problems, one of the 35% of the sample for which this was the case.

Table 39 Sally: summary cultural background variables

<b>Ethnic / Cultural background</b>	SALLY: white English / white English
	ATH: N. European white / Norwegian- Jewish
	DMTH: Caucasian-white-British / W. European
<b>Religious orientation self / parents</b>	SALLY: none /none (christened CofE)
	ATH: Jewish /Norwegian Lutheran
	DMTH: none / Church of England
<b>Migration history in three generations</b>	SALLY: UK born for three generations
	ATH: yes, first
	DMTH: no
<b>First / second languages</b>	SALLY: English / English
	ATH: Norwegian / English
	DMTH: English / English
<b>Urban / Rural place of residence</b>	SALLY: rural small town
	ATH: urban (many moves)
	DMTH: urban (many moves)
<b>Reinforcement local community:</b>	SALLY: yes
	ATH: yes
	DMTH: yes

#### 7.4.1 Sally's dissonance pattern in AT and DMT

Sally attended 95% of DMT sessions and 100% of AT sessions. This was higher than the engaged clients (71.6 %) and drop out clients (47%). As stated, she was on probationary discharge from a secure unit for the first six months, with a condition of daily attendance, which might have influenced her higher attendance rates. However, when the probationary condition was lifted after 6 months her attendance continued to be high for the last two months of the research.

Sally's mean grade of 3.3 for DMT and 2.9 for AT was higher than the grading of her peers for DMT (mean 3.03 DMT) and lower than them for AT (mean 3.35 AT). She graded lower than the dance movement therapist (3.53 DMT) and the same as the art therapist (mean 2.96 AT).

Individually (in her questionnaires) she valued the art being central and expressive (“explaining things using art” and “using the art to show what I was feeling”) as well as using art as distraction. A lack of group connection, feeling obliged to draw something meaningful and a strong dislike of self, staff and others were experienced as unhelpful experiences during the sessions. In the focus group absences, problematic timing and too much larking about were additionally mentioned as unhelpful. Additionally useful was a relaxing session and that there was enough time to paint and talk.

In DMT her individual questionnaires valued connecting with people, having fun and the use of certain structures (“kicking the ball against the wall, because it let out some feelings” was mentioned four times). Other structures like guided imagery (“imagining a field brought back bad memories”) and following (“it made me paranoid”) were felt to be unhelpful. Absences were consistently noted as a hindering factor. In the focus group expressing feelings, being able to initiate and moving to get rid of stress were added to helpful factors. Absences and blaming absent clients and therapists tended to be discussed more frequently in the focus group than the individual questionnaires.

Table 40 gives Sally’s grades and comments in her own words.

*Table 40 Sally’s grades and comments in AT and DMT*

*Art therapy*

<b>Grade</b>	<b>Comments</b>
<b>1</b>	Session was crap, not a lot to nothing useful, everything was unhelpful myself was unhelpful. No one talking about their pictures and being talked to rudely was unhelpful. The session upsetting me was unhelpful.
<b>2</b>	Not used
<b>3</b>	Session was reasonable. It was interesting hearing what others thought my reasonable pictures meant but it was unhelpful not to be able to draw a picture with meaning. Session was not too bad. Doing a picture which didn’t mean anything was useful but it was unhelpful that people were trying to make something of my picture - it bugged me.
<b>4</b>	Not used
<b>5</b>	The session was ok. It was useful to explain things using art. It was useful to be able to use art to show how I was feeling.

*Dance movement therapy*

<b>Grade</b>	<b>Comments</b>
<b>1</b>	Session did not go very well. Nothing was useful. Imagining a field was unhelpful, because it brought back bad memories
<b>2</b>	Session was frustrating. Maybe kicking the ball was useful-don't know. DMTH was unhelpful, because she annoyed me
<b>3</b>	not used
<b>4</b>	Session went mostly quite well.. kicking the ball was useful, because it got out some feelings. Nothing specific was unhelpful
<b>5</b>	Session was ok. Connecting with other people in the group was useful but it was unhelpful that Lia was not in the group.

Sally attended 5 % more AT than DMT sessions, but that meant that she only missed one session of each in the fieldwork period. Given her contract, she might have needed a different way of expressing choice than the other clients, who were more able to ‘vote with their feet’. Sally’s rate of non-completion of questionnaires is compared with that of the other case study clients in table 41. Her rates were higher than the other clients. When issues of choice and/or confusion were around she might have chosen not to complete a questionnaire where others chose to be absent.

*Table 41 Non-completion of questionnaires*

	<b>Non-completion questionnaires</b>		<b>Absences</b>	
	DMT	AT	DMT	AT
<b>TED</b>	4/33	7/33	4/33	6/33
<b>BELLE</b>	1/33	4/33	16/33	13/33
<b>KATE</b>	1/19	6/18	5/19	4/18
<b>SALLY</b>	8/19	11/19	1/19	1/19
<b>SAM</b>	0/6	1/6	1/6	2/6

Sally started the art therapy feedback with two non-completions. The first week she was absent in the focus group, but present the second week. The focus group discussed that the art in art therapy was expressive and that they missed co-therapist 1, who was felt to “spice things up a bit’ in his presence. Sally contributed to the discussion about DMT, but not on AT. The following week she was consonant, felt able to explain things using art. The staff focus group felt she was very open and

showed a lot in her imagery. Two weeks without questionnaires and focus groups followed.

At the beginning of July Sally was openly dissonant for the first time. She said that she felt thick as she could not get her drawing right and worried about Jack and Lia feeling bad. In her questionnaire she said she felt crap and saw herself as unhelpful. The following week she graded the AT session high, but gave no comments. She did not attend the focus group, so no reasons behind the grading could be ascertained. The staff focus group was concerned that her self-harming seemed to be escalating. The summer break was due to start. It might have been that Sally anticipated this with relief due to experienced pressure. Her high grade might have been related to that. She did not paint or talk in the AT group.

After the summer break she was dissonant. She was upset at Belle's admission to hospital, and felt AT was "crap". She complained that the therapist talked to her rudely. The participant observation notes elucidated that the therapist commented on the silence for the last half hour, the clients not wanting to discuss their images and the art therapist asked Sally about her image. Sally's questionnaire seemed to indicate being upset at having been asked, although other clients who would not discuss their images were felt to be unhelpful. The defense mechanisms of denial and projection might provide a psychodynamic explanation

This session was followed by several weeks of alternating non-completion of questionnaires and sessions graded 3. The triangulating of comments and grades indicated Sally's ambivalent whether she wanted to depict, or wanted other people to see meaning in her images. During the middle of this period of non-completion she hit a crisis period. She walked out of the DMT group threatening to throw herself in front of a train. The group followed her half way to the railway line, where they persuaded her to return to the unit. The staff focus group commented on her red image stating HELP and wondered whether the crisis was a response to being included in the group. The client focus group did not refer to the incident.

The following week Sally was the only one present in the focus group. She articulated ambivalence about staff questions. On the one hand she felt that they were intrusive; on the other hand she found it hard to ask for help. Nevertheless she wanted the staff to respect her privacy. In the following focus group the clients discussed the new timetable and Sally said she was pleased with the introduction of individual time, as it was sometimes uncomfortable to talk in groups. When visitors attended the next week the clients asked not to have a focus group. Sally graded the session low, and she commented that everything felt unhelpful.

During November unit staff changes were announced. Sally was upset about this in the sessions. In the focus group she said “something bad happens every week during the arts therapies day”. After a break for the residential week the focus group discussed that it felt weird to be without the art therapist with two unit staff facilitating the AT group. The clients expressed their dislike at the new locum staff member. Sally and Belle knew her from the adolescent unit.

During the last month of the research she did not complete three of the questionnaires, but graded one session high. The clients did a group painting (at Sally’s request). She said in the focus group that it was good to do something as a group. She said that she was “pissed of” by Nathan, but did not give a reason. During the session there were a lot of references to Christmas (clients were decorating, organizing presents and lunch). Nathan had mainly been witnessing, but sprayed a Star of David in the group painting. This was not commented on in the session. The group did comment that it was the researcher’s penultimate session and asked she “was not really foreign was she?” There was a lot of joking around this and around the sexual imagery in the painting. The art therapist’s accent was also joked about.

In the final week Sally did not complete a questionnaire. She said in the focus group that it was good to be able to say goodbye to the researcher and that she had enjoyed the playing around with Belle in the AT group.

In dance movement therapy Sally started the first week by grading the session 3, but included no comments in the questionnaire to explain this grade. She was not present in the focus group. The following week she said in the focus group that walking around made her feel able to connect to people somewhat. She also said that she was not sure what the group was about. She had wondered whether to join in or not, but was glad in retrospect that she did not join in much. She did not complete questionnaires the following two weeks. Clients requested not to have a focus group during these same two weeks. The week before the residential Sally was dissonant. She commented that she found the relaxation unhelpful. She imagined herself in a field, which brought back bad memories.

After the residential she had two consonant weeks. She commented in the first week that kicking the ball let out some feelings and said she really enjoyed going out for a walk and playing with Kate. Kate left the next week. Sally did not complete a questionnaire, nor did she attend the focus group. The staff focus group commented that Kate not coming back to say goodbye might have been upsetting to Sally.

After the summer break Sally was dissonant. In the questionnaire she did not comment, but in the focus group she said that she was pleased not to have been asked to join in the movement (she sat and watched). She wondered though, whether might have got more out of it if she had been asked. The clients discussed their concerns for Belle who had been admitted to hospital after an overdose. Sally said that all the groups felt crap at the moment. The next week she was absent. This was followed by two weeks of non-completion and another absence. The first week of non-completion Sally said she could not see the point of 'all this wobbling up and down'. She did not want to comment on her absence. The staff focus group expressed frustration about her 'dramatic absence' and thought it might be related to the fact that she was coming up towards the end of her probationary period. After a break in the arts therapies groups (activity week), Sally did not complete a questionnaire. She walked out mid way during the DMT group to go to the railway line. She did not complete a questionnaire and the client focus group did not discuss the incident.

The next week Sally arrived late and stayed outside the DMT group waiting. In the focus group she said she heard laughing and felt staff were hard on her, because they would not allow her in (she blamed the dance movement therapist for enforcing the rule about not coming later than 10 minutes after the group has started). She had not asked to come in and said she found it hard to ask for help. The following week Sally re-attended, participated in the DMT group and was consonant. In the focus group she said she was pleased with the new timetable, both the inclusion of individual time, but also the shortening of the DMT group by 15 minutes. She felt DMT was good this morning “considering how I hate it. Sometimes I get this burst of energy; I might now not join in again for a month”. In the questionnaire she said kicking balls helped her to let out some feeling. The staff focus group commented that she seemed motivated today.

After the half term break new clients were visiting. The clients asked not to have a focus group. Sally did not complete the questionnaire. The following week she said in the focus group that DMT was all right, joining in the movement stopped her from walking out. She said in the questionnaire that she enjoyed the relaxation this time, but the structure used of clients walking behind each other made her feel paranoid.

The following two weeks took place prior to a residential week. The first week the clients negotiated that the DMT group was used for talking. They said they wanted to talk about their concerns, because there was so much staff turnover. They felt that there was no space for their concerns (the dance movement therapist announced that there would be a four week break over December, as she was on annual leave). Sally graded the session high and said it was good to be able to talk and that the session could be adapted. The following week there was no focus group at the clients’ request and no questionnaires were completed. Sally asked the researcher in the session whether she really needed to leave and cried when the response was affirmative.

The residential took place the following week. Several staff were absent on return. The client focus group discussed the new locum member of staff as bossy and unlikable. The DMT session started late due to a crisis meeting focused around Sally

being late and missing the community meeting. Sally said she was angry, but did not want to discuss reasons. Later she says she had planned to be absent today, woke up wanting to go, but was then late. The next week Sally was dissonant. She felt the session was frustrating and that the dance movement therapist had annoyed her. She said in the focus group that the dance movement therapist was twisting their words. Sally had left the DMT session and then returned. All clients left the session early.

The next week was the last DMT session before the four week break. Two new clients joined and two members of the unit staff were off sick. In the client focus group the clients discussed the staff-client hierarchy. Sally commented that “staff always get what they want. They may listen, but only implement it 6 months later when you may no longer want it“. The clients commented on the researcher’s leaving and discussed where she fitted in the hierarchy. Sally said “she is one up from us, but one down from the staff“. She did not complete a questionnaire.

Summarising changes over time the picture is as follows. During the first month Sally shows ambivalence in DMT and consonance in AT. She completes only 50 % of the questionnaires and is watchful in the focus groups. Her only comment about DMT is that she is not sure what it is about. The second month she completes a few more questionnaires, showing alternating consonance and dissonance. This alternating can fluctuate quite quickly, between morning and afternoon within one day. Her health diary shows that she is not always clear what causes the fluctuation, but her comments seem to indicate reactivity to peer’s moods by feeling that she is stupid, resulting in self hate and cutting as release.

She tries to use the art and movement at times, expresses some sense of release if she does, but often alternates this with withdrawal and self blame. Before the summer break the absence / leaving of clients and staff seem to evoke both loss and relief.

After the summer break she appears to hit a crisis period over September, the upcoming end of her probationary period may have a part in this. Her grading and comments indicate alternating dissonance and ambivalence, the blame game factor appears in both the focus groups and her questionnaires. It is interesting to note that

the non-completion diminishes for DMT (from 5/11 in the first three months to 3/7 in the last three months), but increases for AT (4/7 in the first three months and 5/8 in the last three months).

She fluctuates between consonance and dissonance at the same frequency in DMT and AT, but the blame game factor is more frequently articulated in DMT. In the focus group once for AT, 4 times for DMT (two times before the four week break).

#### **7.4.2 Interacting client, therapist and treatment variables**

Sally's interacting variables affecting client-therapist dissonance are diagnosis and cultural back ground as client variables; arts medium, group dynamics / effect of peers and treatment interruptions as treatment variables; therapist variables of age and experience, as well as cultural back ground variables (differences in the area of migration history, ethnic identification, nationality, language and religion).

Diagnosis is an important interacting client variable in the alternation between consonance and dissonance. However, other factors need to be taken into account to explain the differences between DMT and AT. Having fun and playing is easily converted to guilt and self hate in DMT. In AT the issue of meaning of the imagery, particularly what she does and does not mean to express and can be witnessed by others, causes a conflict. This may be expressed as dissonance with the therapist.

Peer relations are one of the interacting variables causing dissonance. Quantitative analysis of Sally's grading of sessions shows that her mean grade (3.3 for DMT and 2.9 for AT) is higher than the grading of her peers for DMT (mean 3.03 DMT) and lower than them for AT (mean 3.35 AT). It is interesting that she reverses the mean of her peers who generally rate AT higher than DMT. She grades lower than the dance movement therapist (3.53 DMT) and the same as the art therapist (mean 2.96 AT). There is more dissonance with the art therapist in the qualitative themes.

Sally is occasionally peer dissonant in her grading, but overall tends to be peer consonant. Peers' states of mind can affect her positively (Kate), but also negatively (Jack, Hattie, Nathan). She is more AT dissonant than her peers (with the exception of Ted, but he graded higher than his peers, as opposite to her lower). She worries about Lia when she is absent.

Peer dissonance is not used as a substitute / displacement to therapist dissonance. Sally can articulate dissonance directly with the dance movement therapist and indirectly with the art therapist, by complaining about her interpretations. The only time she is simultaneously client and therapist dissonant is in December. Foreign origins seem to be connected to this dissonance: Nathan's Star of David combined with comments about foreign accents and origins in relation to the art therapist and the researcher. Absences and leavings played a role. Sally expressed upset at the researcher's leaving. She was also dissonant with the dance movement therapist before her four week break. An increasing attachment may lead to dissonance here and the issue of 'foreignness' used as a vehicle for its expression.

Sally's dissonance patterns can be looked at from both an individual psychodynamic and a group dynamic perspective. From an individual psychodynamic perspective Sally is seen to have a problematic relationship with peers, exacerbated by bullying at school. She has spent a lot of time in adolescent in-patient facilities. The problematic attachment pattern can be seen to be echoed in her engagement with the unit, both staff and peers.

Sally's mentioning the useful effects of group interaction (feeling she can contact some of her peers when she needs help) indicates, together with her leaving home to live by herself after the first six months of treatment, that growing independence may help her to turn more towards her peers than parental figures. Her dissonance can then be explained as part of the adolescent acting out against parents in order to create distance and separation to leave home. Her change in September leading up to crisis point can be explained psychodynamically. The anger previously turned on herself now starts to be turned towards the therapists (including unit staff therapists),

articulating and expressing emotion previously realised in self-harm. However, this does not explain the difference between AT and DMT.

The role of the medium is an important interacting variable in the therapist-client dissonance for Sally. Quantitative analysis of her ratings shows that she prefers DMT to AT. The possibility of abreacting and play in DMT seems to be part of this grading. Although she says in her health diary that she feels guilty about having fun, that playful element is important to her. In AT she feels more often a strong dislike of herself, her peers and the therapists. The role of interpretation could be seen to influence that process. She is very ambivalent about the art therapist interpreting her work, although she can find it more acceptable from peers.

The more direct physical expression in dance and movement may facilitate greater ease of expression as it can be seen as direct rather than metaphorical expression. However, in her health diary, Sally uses metaphorical expression and images to express how she feels. The difficulty may then arise from the overt interpretation and expectation experienced as coming from the therapist.

Sally stresses the need for a transitional space between hospital and life back at home and return to school / college. She does not know the reasons behind her wish to kill and cut herself. She feels that group support is one of the main benefits from the treatment provided. She feels that letting people know about her distress and self-harming is progress for her. Art therapy is an aspect of that being able to let people know what she is feeling. In the interview she can not articulate anything she gains from dance movement therapy. The contrast between the quantitative and qualitative data is interesting here. It may be that DMT provides short term relief, which is reflected in the post session questionnaires, but that AT assists in the longer term by encouraging her to express what she is feeling in both images and words, not in abreaction or distraction (as in the DMT play).

In contrast the unit staff speculate that the parental relationships, especially that with her mother, have precipitated some of the self-harming behaviour. They feel that DMT helps her to express some of her frustration and self loathing and gain some

relief that way. In art she can illustrate some of the dramatic feelings she has, but staff members feel that the more direct expression in DMT is of greater benefit. Sally, in the questionnaires and focus groups, sees both as potentially of use to her, but expressivity in art is accompanied by ambivalence about how it is interpreted. She echoes both Belle and Ted in this. Her previous treatment included AT, so some of her ambivalence about this may be incorporated in her current dissonance. Cultural factors may also play a role, particularly the rural nature of the community in which she grew up.

Sally's background is similar to Ted's and she grew up in the same regional, rural community. Her lack of familiarity with cultural diversity may make it additionally difficult to tolerate interpretation from someone 'foreign'. Sally's greater tolerance of peer interpretation might make her more accepting to the interpretations of a therapist closer to her in age. However, like Belle, the severity of her problems might be expected to lead to greater dissonance with a less experienced therapist. The triangular relationship of arts medium – therapist- client (Schaverien 2000, Jones 2005) intimates interacting variables affecting dissonance. The variables include the effect of the rural community and diagnosis on the client – therapist axis; therapist interpretation on the therapist-arts medium axis; direct vs. symbolic expression and the group-as-a-whole versus individual-in-the-group orientation on the client-arts medium axis.

### **7.5 Case study Kate: Keeping control**

Kate was a 19 year old young woman who started treatment at the unit in January and completed treatment in July of that same year. She was one of a minority of clients who completed treatment in less than one year, Al being the other one in a sample of 18. She therefore was in the research throughout her treatment.

Kate lived alternately with her father, a graphic designer and her mother who was a teacher. She herself was a student. Her parents' SEC placed her in social class 2 and 4 alternately, a similar socio-economic class to the therapists

Kate was diagnosed as suffering from depression, self-harming and obsessive compulsive disorder. Other stressors the unit identified were parental separation. Previous treatment she had received was drug treatment. In the interview in early May, Kate said she was referred to the unit by her GP because of depression and obsessive compulsive disorder. She felt that was something within her she was prone to. She also saw circumstances, what was happening at the time, as contributing to her distress. She mentioned that her parents' divorce was rather messy and that she was abused a few years previously. She felt that she probably would have become ill some time anyway, but that the circumstances kick started it.

The unit staff identified family disruption, a lack of intimacy and trust, her parents' divorce and abusive relationships with peers as her difficulty. The dance movement therapist related her difficulty to the way she dealt with her parents' divorce by bottling up her feelings and compartmentalising things. This was echoed by the art therapist's feeling that Kate's progress might be a freeing up process, as previously "she had to go through all these rituals; boxes and boxes before she could draw".

Kate felt that the type of treatment she received at the unit, the whole combination within the group programme, was useful. She had found cognitive therapy and hypnotherapy useful in the past. She saw arts therapy as part of the whole programme, but more as a distraction and relaxation: "I don't see them having anything to do with solving my problems but they are a good way of escaping for a little while".

Kate self identified as Irish / British. Her father's parents were first generation Irish migrants. She grew up rurally with reinforcement from the British side of her heritage. She felt others saw her as English / British, but she herself stressed the Irish inheritance additionally. She identified herself as Christian, giving her parents' religious traditions as Church of England (mother) and Roman Catholic (father). This made her a member of a 1.2% minority of the young people professing a religious affiliation (32.3%).

Table 42 Kate: summary cultural background variables

<b>Cultural background variables</b>	
<b>Ethnic / Cultural background</b>	KATE : Irish-British/Irish-British
	ATH : N. European white / Norwegian- Jewish
	DMTH : Caucasian-white-British / W. European
<b>Religious orientation self / parents</b>	KATE : Christian/RC (M)-CofE(F)
	ATH : Jewish /Norwegian Lutheran
	DMTH : none / Church of England
<b>Migration history in three generations</b>	KATE ; one Irish grandfather, mother 2nd gen, mother UK born but grew up in USA (1-18yrs)
	ATH : yes, first
	DMTH : no
<b>First / second languages</b>	KATE: English / English
	ATH : Norwegian / English
	DMTH : English / English
<b>Urban / Rural place of residence</b>	KATE :small town (many moves)
	ATH : urban (many moves)
	DMTH : urban (many moves)
<b>Reinforcement surrounding community</b>	KATE : English yes, Irish no
	ATH : yes
	DMTH : yes

### 7.5.1 Kate's dissonance in AT and DMT

Kate's grade of 3.2 for DMT and 3.6 for AT was higher than the grading of her peers (mean 3.03 DMT and 3.35 AT). It was lower than the dance movement therapist (3.53 DMT) and higher than the art therapist (mean 2.96 AT).

In her art therapy questionnaires Kate valued contact between people in the group and strong issues being allowed to surface as well as art as a distraction. Absences and over interpretation were experienced as unhelpful. In the focus group she valued a session being relaxing, the art being expressive and central and having enough time to paint and / or talk. In contrast, a lack of group connection, problematic timing and a dislike of others were considered to be additional hindrances.

In her DMT questionnaires Kate valued space to talk, expressing feelings, having fun and the use of certain structures such as relaxation and confronting people by walking up to them. Hindering factors included the fact that certain structures might have been useful to her, but upsetting to others; absences, people not joining in and a dislike of others. In the focus group additional emphasis was placed on connecting

with others and being able to initiate as useful. A lack of structure and connection between movement and talking, in the absence of an acknowledgement of difficult feelings, were discussed as hindering.

In table 43 Kate's comments are given verbatim.

*Table 43 Kate's grades and comments in AT and DMT*

*Art therapy*

<b>Grade</b>	<b>Comment</b>
<b>1</b>	not used
<b>2</b>	I think some people were pissed off with the continuous 'japes and jollities' but I enjoyed them. ?.....?
<b>3</b>	Analysing things which meant nothing
<b>4</b>	?...?, making a mess because it was fun discussing when dad was ill, sort of closure. Having plenty of time to look at everyone's art work was interesting. The long silence at the beginning was felt to be boring, feeling sad because N had not stayed for the art group
<b>5</b>	not used

*Dance movement therapy*

<b>Grade</b>	<b>Comment</b>
<b>1</b>	Nothing was useful, everything was unhelpful and the world can go fuck
<b>2</b>	It was ok, I was a bit intimidated by the flying balls and elastic etc. Some people got a bit hurt
<b>3</b>	It was ok, useful to say how I felt, but someone's self-righteousness was unhelpful. All right, dunno what was useful or unhelpful. Ok, relaxation useful, but E's farting was unhelpful and the fire alarms pissed me off.. A bit slow at the start, but it got better ; just having fun was useful, unhelpful was that it was rather exhausting
<b>4</b>	Just playing games was distracting and relaxing, Fun Fun Fun !!! Joining in at the end was fun, it was unhelpful that it was cold outside and that AL and HATTIE did not join in.. I found walking up to people, then going round them useful because it was a confrontational position but I learnt not to feel confronted. I was sad that SALLY did not feel able to join in. Relaxation was lovely, but it was unhelpful that the relaxation made SALLY upset
<b>5</b>	Talking seriously, then acting like a kid was very good. It was so much fun and a change from normal things. Good to be uninhibited and to forget myself for a while. Nice not to care what people thought- I felt I could have run around naked without being embarrassed!!!

Kate attended 2 % more DMT than AT sessions. The majority of absences were in the last six weeks of attending the unit. She completed fewer questionnaires for art therapy than dance movement therapy. She did not complete one DMT questionnaire while attending the session, for art therapy this increased to 6 in 20 sessions attended.

These occurred throughout her stay in the unit, alternating with consonant and dissonant sessions, not clustered in particular stages of the therapy

The first dissonant session in art therapy was after a month in the unit. She stated that “they (*the therapists*) are reading too much into it” (*the images*). The following dissonant session preceded a residential week, when the clients joked about Sam’s choice of music (“uncool, for 13 year olds”) in DMT and made fun of the art therapist’s accent. After the residential Kate was again irritated with the art therapist’s interpretations. She commented one week that there was too much “analyst babble” and refused to share her work the following week. After that she consistently graded art therapy higher. She seemed to be more able to express herself in her images, once remarking that it felt good to talk about her father’s illness, achieving a sense of closure over that episode in her life. She was once more dissonant at the end of June, when there were visitors present. She said in the focus group she had thought about not coming in as she dreaded the visitors being there ‘and things were quite tough anyway. She felt the art therapist was speaking ‘positive crap’.

In her last six weeks, in preparation for leaving, she missed three weeks out of the possible six. The last week she was present she was very positive about the DMT session with Sally, but felt that when Jack and Hattie joined for the AT session, their ‘negativity’ took some of the morning’s pleasure away.

Kate was dissonant in DMT the first session she attended, stating that she felt intimidated by the use of props: balls flying around and the use of elastic. The “blame game” came up before the residential week, when she complained in the focus group about Sam’s choice of music, and Ted’s farting. She enjoyed the relaxation, but felt disturbed by the fire alarms. After the residential she stated there was too much “blah blah”, too much talking and not enough moving in DMT. She found it unhelpful that Al and Hattie refused to join in. In March there were several weeks where “the groups felt shitty, and no one cares” (Belle had been admitted to hospital after an overdose). She said the session felt better when the dance movement therapist was absent. These were the last dissonant sessions in DMT according to her questionnaires. In the focus groups she still expressed negative feelings about too

much talking in DMT, not wanting to show her work in AT (in the same week at the end of April).

She stated AT and DMT were better than expected at the end of June, as she had been dreading the visitors' presence. She had felt pleased that she had been able to initiate ideas in DMT and felt it was releasing to put them into practice. During May and June she graded DMT consistently higher. In her last six weeks at the unit she missed three out of the six sessions. Her final DMT session she and Sally were the only clients present. The dance movement therapist suggested a walk. Earlier in the year, in March, Kate felt this to be unhelpful "as it is not what we normally do". Now in July, at the end of her stay in the unit, she found it very useful, enjoyed the serious talking that took place during the walk, followed by playing in a children's paddling pool ("felt really fun, playing like a kid and not caring what anybody thought").

Summarising changes over time. Initially in AT she was more irritated with the lack of structure and the therapist's interpretation, later she emphasized expression of feelings as positive and expressed an interest and engagement with other clients' work. In DMT after an initial engagement she became angry with other clients and the therapist, then started to relax and enjoy playing. She also expressed engagement with what was happening to other clients. It seems that she became more emotionally engaged in DMT and appreciated emotional expression as useful.

Over the first four months of her attendance she showed more dissonance, the last three months more consonance. Initially the rough use of props in the DMT session disconcerted her. The fact of various clients observing and not joining in the movement was experienced as unhelpful. Too much talking and not enough movement added to the unhelpfulness of DMT. In AT she expressed more direct dissonance with the therapist and her interpretations.

The "blame game" recurred throughout her stay, while low grading of sessions occurred only in the first few months. In DMT this concerned the behaviour of her peers, their not joining in or playing too rough. In AT it was more directed at the therapist's interpretation. It is also interesting to note the greater frequency of non-

completion of AT questionnaires. The first cluster of these was during the first six weeks of her stay in the unit (three out of the 6 non-completions occurred during that time). The clients chose not to have a focus group for two weeks during that period and when there was one Kate commented that the therapist interpretation “made me cringe”. The next non-completion was after the residential week break. In the focus group she complained that several clients did not join in during DMT. She said in the focus groups that all groups “felt shitty”, AT was ok as a distraction. The next non-completion was during the period she felt that there was too much talking and “analyst babble” and she did not want to share her work in AT. The final non-completion was towards the end of her stay.

### **7.5.2 Interacting client, therapist and treatment variables**

The client variables for Kate are diagnosis and perception of treatment, ethnic self-identification as a third generation migrant interacting with treatment variables such as the arts medium(symbolic vs. direct expression, individual-in-the-group vs. group-as-a-whole interpretation) and treatment interruptions. Therapist variables of age and experience, as well as cultural background can be looked at across the other case studies for replication.

The peer dissonance in DMT may be related to her diagnosis interacting with the nature of the medium and group dynamics. She frequently comments that peers not joining in the movement is felt to be unhelpful. It may be being watched is experienced as threatening, because of her past experience of abusive peer relationships. The rough use of props is also felt to be intimidating in the beginning. Later she mentions that a particular ‘confrontational’ structure meant she was able not to feel confronted. Her feelings about her peers not joining in change from anger to sadness. While she felt threatened in the beginning, she now sees it as a difficulty for the individual concerned. In art therapy the only peer related comment she makes is that it was helpful to have enough time to look at everybody’s artwork. She is aware of peers’ irritation at her “joking about”, but enjoys it anyway.

Her self consciousness at being watched in DMT may be linked to the experience of being objectified in a sexual abuse situation. Engaging in play diminishes her self consciousness and provides her with a sense of fun. Being able to play without worrying what people think of her related also in part to not caring that someone might notice her self-harm scars.

Her dissonance with the art therapist's use of interpretation can be seen as resistance / denial from a psychodynamic point of view. Her preference for cognitive therapy and hypnotherapy could be interpreted as an expression of wanting to stay in control (as enacted in her OCD symptoms). The fact that her images may have a meaning beyond what she meant to express might make her feel out of control. The art therapist's sense of Kate's problem reflects this. The therapist stated that the parents' split caused her to develop OCD rituals to try and maintain a sense of control when stability disappeared.

Kate's interview description of the arts therapies as a bit of escapism could also be seen as defensive. In later questionnaires she stresses the value of people connecting and being able to discuss strong issues (her fear at her father's heart attack and near death was an example). Given her emphasis on group connection, fun and play, the more direct group-as-a-whole interaction in DMT may have allowed for that more than the mostly individual-in-the-group orientation of AT.

However, Kate's difference in perception may have made it difficult for her to make use of the arts therapies as a symbolic medium. This reflects the literature, which states that those clients with OCD with strongly incongruent treatment perceptions are more likely to drop out (Hansen et al 1992). Kate found the overall treatment in the unit helpful. This might have helped her retention in treatment, while finding the arts therapies component of less use. She replicates the other clients who complain about interpretation though, as well as Ted's difficulty with symbolic expression / preference for direct impression. He did not drop out either, even though panic disordered clients with depression from lower income families show higher drop out rates too (Grilo et al 1998). Belle and Sally, who each show aspects of a (borderline) personality disorder, as well as high initial hostility, remained in treatment too. This

is in contrast with the research findings that clients with that presentation have been shown more likely to drop out (Hilsenroth et al 1995). Kate's higher dissonance in the first four months, followed by greater consonance in the last three months may indicate a conversion of values more akin to those of the art and dance movement therapist. The fact that initially she saw psychodynamic stressors as her parent's separation and the sexual abuse suffered as part of the cause of her problems may have provided a bridge.

Kate's ethnic identification as a third generation migrant does not seem to have led to greater consonance with the first generation migrant art therapist. This does not replicate my hypothesis about Belle. Identification by others may play a role here. Kate's English identity would be reinforced by a surrounding homogenous rural community. Her identification towards a Christian religion, less contentious than the Roman Catholic minority identity of Belle, integrates the different cultural identities of her parents and is not perceived as different by others. For Kate the abuse happened outside the home rather than inside it, making identification potentially less conflicted.

## **7.6 Case study Sam: belonging nowhere**

Sam was an 18 year old young man who started treatment at the unit in January and left in March, dropping out after two months of treatment. He returned the semi-structured questionnaire used for the interview after dropping out. He did not want to be interviewed. Sam's parents ran a business (language school), which had been going through some difficulties. This explains why unit staff identified it as one of his stressors. He still lived at home with his parents (now reunited after a period of separation) and was a university student (one of 50% of the client sample engaged in higher education). His parents' employment placed him in SEC 4, slightly lower than the therapists 'SEC 2/3.

Sam's psychiatric diagnosis listed anxiety, panic attacks and bipolar affective disorder. The unit identified family employment problems and bullying at school as additional stressors. He had previously received drug treatment and adult in and

outpatient psychiatric treatment. The bipolar affective disorder applied to only 2 out of 18 clients. It is interesting to note that the diagnosis of psychosis applied to two clients whose cultural background was ethnically and culturally more mixed than that of the other clients. They were the only second generation immigrants of two parents born outside the British Isles. Both were male; the diagnosis of psychosis is used more for young men from ethnic minority backgrounds (Littlewood and Lipsedge 1997, Fernando 1998). Sam's secondary diagnosis was anxiety and panic disorder (like Ted).

Sam's account of his diagnosis differed from that of his file. His reason for attending the unit was that there were lots of emotions inside him. OCD tendencies first brought him to hospital. He felt that these were due to strong emotions stemming from being bullied at school and a strong relationship with his dad. As he completed the questions as a questionnaire it was not clear what he meant with the latter. It may be that he is referring to the marital break up and his separation from his father when he accompanied his mother to Brazil. He felt therapy was appropriate for his problems. He mentioned his diagnosis as depression (not bipolar disorder as stated in his medical file). He felt cognitive behavioural therapy had helped him gain some control over his obsessive compulsive symptoms. He expected "normality" as a result from the treatment. Arts therapies were seen to aim for self expression and freedom of repression. It is unclear how he reconciled those objectives with his wish for greater control. His valuation of being more in control as progress resulting from treatment remained unclear. His definition of normal could not be queried either, because of the lack of face to face interview data.

Under the question about his ethnicity and culture he wrote "never mainstream English". Sam self-identified ethnically as Indo-Brazilian and culturally English / Brazilian. He was the only client who did not identify himself as British or English ethnically, although all clients were British born. Sam's mother was Brazilian, his father British born of Indian migrant parents. He grew up in a city, had moved frequently during childhood and felt different from the communities he lived in. When asked how he was seen by others he said as a "Paki". He spoke Portuguese as a

second language at home. He identified his religion as Roman Catholic, the same as his mother. His father's religious tradition, if any, was not known.

*Table 44 Sam: summary cultural background variables*

<b>Ethnic / Cultural background</b>	SAM: Indo-Brasilian / English-Brasilian
	ATH: N. European white / Norwegian- Jewish
	DMTH: Caucasian-white-British / W. European
<b>Religious orientation self / parents</b>	SALLY: Roman-catholic / Roman-catholic(M)
	ATH: Jewish /Norwegian Lutheran
	DMTH: none / Church of England
<b>Migration history in three generations</b>	SAM; 2nd gen(father 2 <sup>nd</sup> /mother first gen )
	ATH: yes, first
	DMTH: no
<b>First / second languages</b>	SAM: English / Portuguese
	ATH: Norwegian / English
	DMTH: English / English
<b>Urban / Rural place of residence</b>	SAM: urban(many moves)
	ATH: urban (many moves)
	DMTH: urban (many moves)
<b>Reinforcement local community:</b>	SAM: no
	ATH: yes
	DMTH: yes

### 7.6.1 Sam's pattern of dissonance in AT and DMT

Sam attended 83% of dance movement therapy and 67 % of art therapy sessions. Given the short period of engagement this meant that he attended one session less art therapy than dance movement therapy, because of an afternoon hospital appointment

Quantitative analysis of Sam's grading of sessions showed that his mean grade of 2.6 for DMT and 3 for AT was lower than the grades of peers (mean 3.03 DMT, mean 3.35 AT). It was also lower than the dance movement therapist (3.53 DMT), though slightly higher than the art therapist (2.96 AT).

Despite his low grading of DMT he mentioned more useful elements in his qualitative comments than unhelpful ones. He mentioned connecting with other people in the group 3 times and once being able to initiate and once to have fun. On the unhelpful side he identified a lack of connection between moving and talking ("the talking was quickly washed out by music and superficial playing with the ball") and the failure of

people to participate in as unhelpful. He attended two focus groups and again mentioned people not joining in as a hindering factor.

His art therapy questionnaires showed more differential shading between useful and unhelpful factors. Individually he valued the art work being central and authentic, as well as connection between people in the group. A lack of group connection and being expected to draw something meaningful was experienced as unhelpful. In the focus group the clients said it had been helpful that the session was relaxing. Sam mentioned different factors than the others in the focus group, he commented that “everyone seems very individual, not positive or negative, that is just the way it is”. The other three clients present (Kate, Belle and Cate) did not comment on this, just said “it was good to have a rest”. It seemed difficult to acknowledge the felt lack of group connection. When discussing the AT group Sam stressed the expressiveness of the art, while the others grumbled that the therapist had read too much into the images. In the second focus group he attended, Sam said DMT was ok, although he did not really need it as he was ok with his body. Kate said it was fun and Hattie that it was crap. In the AT session itself Sam expressed regret that people were not sharing their images (the others agreed it was difficult at the moment). Kate had enjoyed pairing off with Belle for face painting.

Although Sam seemed to have more connection to his peers in the second focus group, when he was absent in the next focus group Kate, Ted and Belle comment disparagingly on his pink bike and choice of music. The focus groups seemed to highlight the lack of peer connection and his difference.

In table 45 Sam’s comments are quoted verbatim, showing his grades and comments in his own words.

Table 45 Sam's grades and comments

*Art therapy*

Grade	Comment
1	Not used
2	The session was ok, but did not resolve any of my problems- or get anywhere with them. It was useful that someone appreciated my work by saying "you put a lot of work into it". Unhelpful aspects: I don't think that something one draws has to represent anything very black- but since we adopt this line of exploration- I feel that I am obliged to draw something 'meaningful'.
3	The session went well, weird music and happy. It was useful that everyone joined in on one big project-all getting on with our bit of harmony. It was unhelpful that some people did not share their work with us, not everyone trying-no sense of trying together
4	Session was ok, drawing was useful, nothing was unhelpful
5	Not used

*Dance Movement therapy*

Grade	Comments
1	Not Used
2	I liked that fairly promptly we all got involved throwing the beanbag around-participating with each other-everyone-no holding back. AL's talking about being annoyed at not finding it easy was unhelpful. The session went well-there was no tension in the air. It was useful that we interacted-doing a movement for others to follow-explaining games to each other etc. My tiredness was unhelpful – I do not think I have a problem with DMT- I play a lot of sports etc
3	The session was ok. My talking at the beginning was useful, it made me realise stuff about myself-but I realise this is meant to be DMT, unsure how I might move-how my self expression in this might have been ? It was unhelpful that it (the talking) was quickly washed over by music, the ball playing seemed superficial. The session was nice. Useful was messing around in my house, like old times. It was unhelpful that some people were not participating.
4	Not used
5	Not used

Sam attended 4 AT sessions. In the first session he was dissonant. He queried why he had to draw something meaningful and could not quite see the purpose of the art. He valued the art therapist's acknowledgement of his efforts. In the focus group he

commented that everyone seemed very individual, he “does not want to make a value judgement about that”, but wanted to raise the issue. The other three clients in the focus group did not comment. The second session he was consonant and found the drawing useful. In the focus group the clients discussed how it was difficult to share their work at the moment. The following week Sam was absent. In the focus group the clients joked about his choice of bike and music.

There was a sense of him not fitting in and he did not take part in the following residential week. The last session he attended he enjoyed the group painting, but regretted “some people not joining in and sharing their work”. After the residential week there was no AT session as all clients went to visit Belle in hospital. Sam was absent. He did not return to the group.

In DMT he started dissonant. Although he enjoyed everyone joining in, he disliked Al’s critical reflection. He then graded the sessions higher for a couple of weeks, but continued to wonder what it was for. He stated he liked the interaction, but could not quite see the use of it for himself. He liked “creating a house, it reminded me of making dens when I was younger”, but he felt it was unhelpful that no one wanted to visit each others’ houses. He found the lack of group interaction unhelpful. He attended the session before the residential week and was dissonant again. He felt that he was “ok with his body, ok with explaining games”. He linked him finding the session unhelpful to feeling tired. He was absent from the residential week, but attended the DMT session the following week. He found it useful that he could talk about himself at the beginning, but felt that no one really listened to him. He could not see how to continue the work he started through the movement, felt the games were superficial and that his words had been washed over. The other clients graded the session lower than his 3 and were preoccupied with Belle’s admission to hospital. They chose to visit Belle in the afternoon and did not attend the AT session. Sam went home and did not return to the arts therapies’ groups. He left the unit and continued his attendance in adult acute psychiatry.

Looking at Sam’s comments and the way they developed during the short time he was in the unit, the following picture emerged. He was not clear why he was asked to

paint and move, but willing to go with it. He strongly looked for connection with his peers. He wanted the group to draw together. The therapist was not mentioned in his comments. Only once did he mention her as someone from whom expectations came to “draw something meaningful”, but also as a source of appreciation. She recognized that he had “put a lot of work into it”. There was no comment on the dance movement therapist, more on the medium, wondering what it was for. He was in agreement with some of his peers in the early stages, but not in the later stages. This might have reflected a progressive sense of alienation / lack of connection.

### **7.6.2 Interacting client, therapist and treatment variables**

Sam’s dissonance is affected by treatment variables; group dynamics (especially peer relations) and the arts medium. His client variables of diagnosis and stressors interact with his cultural background variables, while potentially the therapist background variables influenced the therapist not to intervene.

Sam seems to be out of tune with his peers. Their disparaging comments on his taste may in part be due to the felt necessity to be “cool”/ fit in with youth culture. However, his ethnic and cultural difference from his peers seems to reinforce the differences in taste. The difference may possibly be reinforcing Sam’s fear of a repeat of past bullying experiences, as well as repeating a sense of alienation from the surrounding community. He feels he is seen by others as a ‘Paki’. The peer dissonance can be looked at from both a psychodynamic as an ethnographic explanatory framework.

Sam is an only child of culturally mixed parents. When they separated, his mother took him to Brazil. His sense of alienation may be a repeat of their experience. His statement that he never felt ‘mainstream English’ seemed to indicate a sense of not being able to belong. This experience was repeated in the unit in his sense of difference from his peers. His school experience of bullying may have caused him to think this was repeated in the unit group (his difference is joked about by his peers and their disparagement of his music may have reinforced the fear).

When reflecting on why he attended the unit he mentioned containing a lot of emotions inside him. They related to the bullying at school and his strong relationship with his father. The dance movement therapist had a sense that he felt isolated in his world. Things began to go wrong when his parents separated which led to a change in the countries where he lived. She felt that since the whole family came to England there were a lot of difficulties in the relationships within the family.

His parents' separation may for Sam have fostered the belief that differences can not be bridged. Sam experienced alienation in Britain, but also in Brazil. It might have produced a sense of not being able to find a place where he can belong for himself. Sam said he 'went strange' when he accompanied his mother to Brazil during the separation, he is worried he might "go strange" again.

The staff (arts therapists and co-workers) picked up on his alienation in the staff focus groups, but did not raise it within the arts therapies' groups. The fact that the therapists did not raise the scapegoating within the therapy groups may have reinforced Sam's isolation. These parental figures were not able to help him bridge the alienation either, or protect him from bullying about his difference.

He may have re-experienced his sense of alienation in relation to the treatment. He did not seem sure what was expected of him in the arts therapies, recognition of effort was appreciated, but the felt expectation of drawing something meaningful was experienced as unhelpful pressure. He did not really know what to make of the function of DMT, he could not see it symbolically, merely functional. The therapists' emphasis on symbolization does not seem to be understood. Although he saw the arts therapies as aiming for self expression, he could not see how this related to understanding (the connection between words and movement) and felt irritated by the interpretation of his images.

Sam showed a great wish to connect with his peers, but neither the group nor he were able to achieve that. His difference was commented on by his peers, both in perception and his preference in music and consumer goods. He was made to feel this when his music was not used in the DMT group and he expressed different

perceptions in the focus groups. He experienced this strongly as a lack of group connection.

For Sam the peer dissonance may have been as great a factor as therapist dissonance. The dissonance with the latter seems to be located in a miscommunication as to what is expected of him. This may have reinforced his sense of not belonging / not being wanted / being discriminated against. As he completed the questionnaire on his own it was not possible to question him (he had chosen not to meet the researcher for an interview, but completed the questionnaire by himself). It was not possible to ascertain in how far he felt being seen as a “Paki” extended to his experience in the unit as well. There seemed to be more connection, comments and higher grading for his relationship with the art therapist. Recognition of mutual difference in nationality and language may have been a factor in developing potential consonance. In a group context where he experienced a lack of group connection this was not sufficient for him to be able to engage. The fact that these issues (the group not connecting, his music not being chosen and his tastes criticised by his peers) were not addressed in the group by any of the therapists, despite the fact that they were aware of a potential scapegoating dynamic, did not allow for possible resolution in the therapy group. The staff focus groups mentioned several of these dynamics, but did not address them in the arts therapies groups.

## **7.7 Chapter findings and conclusion: replication across cases**

The findings from the case studies are:

### Interacting variables affecting early dissonance and drop out:

- The case study of Sam showed that the interacting variables affecting his attrition were current peer dissonance and past experience of bullying (psychodynamic stressor) interacting with a difference in cultural background variables of ethnic self-identification and a racist identification from others. The consonant relationship with the art therapist did not compensate for the peer dissonance; the combination of psychodynamic and sociocultural factors leading to a sense of not belonging. Treatment

interruptions formed the trigger for his leaving. The stage of treatment was also an interacting factor: Kate's and Sam's cases showed that a mismatch of expectations can create additional dissonance in the early stages of treatment. Kate's case showed that an initial mismatch of therapist and client expectations concerning the use of the medium, could be adjusted over time. Diagnosis as a factor in attrition was not evident in Sam's case, although his and Kate's case replicated for OCD and client-therapist dissonant expectations of treatment (Hansen et al 1992).

- Diagnosis of BPD was identified in chapter 6.4 as a factor influencing attrition. Hattie, Lia and Cate were ambivalently engaged before dropping out; Jan only stayed for a short time; Sally and Liz stayed. The co-morbid client problems may be an important factor. The ambivalently engaged clients all had alcohol and drug dependency problems, while the ones who stayed did not. However, Jan's co-morbid problems are similar to those of clients who stayed. Sally's case study may provide some insights. She showed rapidly fluctuating patterns of dissonance, with a strong ambivalence about being noticed and / or 'helped'. She does show a strong attachment to both peers and therapists and is upset when they are absent / leave. This does complement both the psychodynamic and psychiatric understanding of the diagnosis. Sally's contract with the unit to be obliged to attend for 6 months helped her to remain in the unit. A crisis occurred when the end of the contract came, but her attendance remained constant. Extra 'holding' for clients with this diagnosis in the early stages of treatment, whilst envisaging ongoing treatment support (Liz remained longer than any other client in the unit) is currently recommended for treatment of clients with these type of 'complex needs' (White et al 2001).

Client variables affecting dissonance in ongoing treatment are:

- Diagnosis

Diagnosis was one of the important client variables interacting with gender and treatment variables to create client-therapist dissonance, with cultural background variation as moderating factor.

Diagnosis in the current evidence based practice climate is often taken as a prescriptive variable, one that prescribes a certain treatment as opposed to competing treatments. Roth and Fonagy's (2005) critical review of psychotherapy research is based on using diagnosis as a predictor, so are the guidelines of the National Institute for Clinical Excellence. This does not do justice to the complexity of clients' problems.

Table 46 provides an overview of these diagnoses for the clients concerned, it is an abstract from table 9 in chapter 4, expanded with some of the clients' own identification of their problems.

*Table 46 Final summary of case study diagnoses*

<b>Client</b>	<b>Diagnosis</b>	<b>Stressors</b>	<b>Treatment history</b>	<b>Dissonance</b>
<b>Ted</b>	D, AP		DT	AT
<b>Belle</b>	D, ED, S	SA, PEA, F	DT, CAP(in), AAP(in)	DMT
<b>Sally</b>	BPD, A, S	BS	DT, CAP(in and out)	AT
<b>Kate</b>	D, OCD, S	PS, SA	DT	ATand DMT same
<b>Sam</b>	BPAD, AP, D, OCD	PS, FE, BS	DT, AAP(in and out)	Peer, DMT

Ted, Kate and Belle replicated for depression, Sam and Kate for obsessive compulsive disorder. Kate, Sally and Belle self-harmed (cutting for all three, repeated suicide attempts for Belle and Sally). Replication for anxiety and panic occurred across Ted and Sam. Sally's diagnoses of borderline personality and adjustment disorder and Sam's diagnosis of bipolar disorder is not replicated.

Clients with the diagnosis of depression were more dissonant in DMT (chapter 6.4). In the case studies Ted is not dissonant in DMT, but Kate and Belle are. However, their co-morbid diagnosis of self-harm and the stressor of sexual abuse proved more dominant in affecting their dissonance in DMT. This interacted with the embodiment aspect of the medium. Male clients sitting out watching, created dissonance within the triangular relationship of client-therapist-arts medium. Group dynamics did affect this interaction and will be looked at under treatment variables. Client age may have interacted with the diagnosis, younger clients with higher hostility are more likely to be dissonant (Hilsenroth et al 1995); Sally and Belle did fit this profile, Kate did not.

Kate's severity of problems was more moderate and recent, she had not received inpatient treatment (either adolescent or adult), unlike Belle and Sally. Ted was the other one of the sample whose severity of problems was more on the moderate side. He and Kate showed higher grading than the other clients, maybe indicating a greater ease in engagement, although higher dissonance was present for them too in the early stages of treatment.

Sam and Kate's obsessive compulsive symptoms seemed to interact with expectations concerning treatment (Hansen et al 1992), which made it difficult for them to see the use of the arts therapies. Length of treatment meant that Kate was able to adjust, while Sam did not. All clients were more dissonant in the early stages of treatment

#### Interaction of treatment variables with client variables:

- Treatment interruptions, group dynamics / peer dissonance and the arts medium in its group-as-a-whole or individual-in-the-group orientation proved important in affecting dissonance.

Treatment interruptions affected dissonance for the four clients who remained in treatment too. Residential weeks, co-therapist's departure and therapist absence increased dissonance. If the interruption was anticipated, clients showed dissonance before the break. If the interruption was sudden, dissonance occurred after the break.

Group dynamics, in the form of the presence and absence of particular clients, did not affect AT and DMT equally; the presence of certain male clients made DMT a more dissonant experience for Belle and Kate, especially those who chose to sit out. In AT therapist interpretation was another way of becoming seen / self conscious, this occurred across genders. Occasionally the ‘difference’ of clients like Sam and Nathan, as shown through the medium (choice of music or imagery), made them a target for peer dissonance. In AT this was at times a displacement of therapist dissonance, at other times in both DMT and AT a sign of general group disaffection (“all groups are shitty”). Greater dissonance was also present when new clients joined the group.

The group dynamics interacted with the nature of the arts medium. The AT group was more individual-in-the-group in orientation (clients talked, individually created images, then talked again about their individual images). When there was a change to group painting or pair face painting (clients’ request or initiative), the exclusion of those clients who chose not to take part was commented upon. The same happened when clients chose not to show their work in the group. The DMT group had a similar format of talking, moving and reflecting on the movement through discussion. The movement was always in interaction with others, even if a client chose to sit out, they became an ‘audience’ to those who moved. This meant the DMT had more a group-as-a-whole format. Both the AT and DMT were psychodynamic ‘process’ group in theoretical orientation (Burlingame et al 2004).

#### Therapist variables affecting dissonance:

The group therapy research literature advocates more research on the effect of therapist gender, training and experience, adherence to a particular theoretical orientation and co-leadership (Burlingame et al 2004). Experience was reflected in reducing drop out (Stein and Lambert 1995). Both arts therapists were postgraduate trained and drop out occurred equally across the two therapies. The only variable was the differential attendance. This did not reflect the art therapist’s greater experience. More important factors here were staff turnover of co-therapists (twice in AT, once in

DMT), treatment interruptions and gender factors in preference for the medium interacting with diagnosis.

Therapist age and experience were not shown to be interacting variables. Clients with more severe problems were not more dissonant with the less experienced therapist. Whether co-therapy ameliorates experience has not been researched and given the turnover of co-therapists was impossible to ascertain in this study. Therapist cultural background was shown to interact with clients whose ethnic and cultural identification was white English-British and who had grown up in a rural community which reinforced that identity, with little experience of those from different backgrounds. Sally and Ted both showed this pattern in their dissonance with the art therapist. This may interact with a relationship to the arts medium that prefers direct expression of feeling, rather than symbolic expression, leading to greater irritation with the interpretation of images as symbolic representations.

Whether separate individual cultural background variables play a greater role than others or whether class and culture interacted in early drop out (Grilo et al 1998), are areas for further study. The teasing comments on accents and nationality may indicate that language and nationality may play a role. Migration history affects the individual's ethnic / cultural identification, but this interacts with other experiences such as abuse and discrimination, possibly diagnosis. Within a white majority group religion was not a unifying factor; Sam's Catholicism did not make him feel a sense of belonging with Belle or Kate. Not having any religion was not a unifying factor either. Whether it can create greater dissonance with a religious therapist may be an issue to consider. It is interesting to note that the religious art therapist was dissonant with the two non-religious clients in the case studies. The participant observation notes do not give any religious content to the interpretation of imagery, so the general emphasis of direct expression versus symbolic expression is a more valid conclusion.

## **Chapter 8 Conclusions**

### **8.0 Chapter overview**

This chapter discusses the research findings in relation to the original hypothesis, the questions this raised and their implications for practice. It then critiques the research methods and provides recommendations for further research.

In chapter 3.2 I stated the hypothesis and main related questions for this research:

“Intragroup cultural background differences of therapist and client will adversely affect client – therapist consonance in their perception of the efficacy of arts therapies’ group treatment”.

I wanted to look at the consonance between therapist and client about the meaning of the arts therapy group, what in the sessions do they think is useful, what is not? Does this relate to clients continuing or dropping out of therapy and if so how? Is dissonance affected by cultural identity, if so which variables play a role? Which treatment variables affect client-therapist dissonance and how do these interact with client and therapist variables?

As part of the methodological critique in the second half of the chapter I will reflect on researcher assumptions (Luborsky et al 1999, West and Talib 2002). The methodological critique will discuss strengths and weaknesses. The need for further research, including conceptual and methodological issues to be addressed, concludes this chapter.

### **8.1 Client-therapist consonance in their perception of the efficacy of arts therapies group treatment**

My research demonstrates that clients and therapists agree that a session is useful when the art is central, when clients are able to initiate and when the group helps people to interact. These findings provide confirmation from a client perspective of

the arts therapists' views discussed in the literature review and show that the issues can be appreciated on a conscious level over time. The literature review showed that most of the research highlighted the therapist perspective on useful aspects of arts therapies sessions. These were the empowerment function of the art (Byers 1998, Springham 1998), the reduction of dependence (Skaife & Huet 1998) and the role of art making in the development of group cohesion (Kymiss et al 1996), mostly as unconscious processes. However, Casson's research into client perspectives also showed the importance of client empowerment (Casson 2004). My research shows that stage of treatment needs to be considered as an interacting variable for client – therapist consonance in longer term therapy. Two factors that may play a role here are helpful group processes, and therapist-client value conversion. Casson's clients stressed the importance of group cohesion, attachment and interpersonal learning (Casson 2004), processes which only occur in group therapy over time. Gilroy's (1996) research in the transformation of values in an art therapy training group could be followed up by research into the actual value conversion process between clients and therapists, as well as between clients.

My research demonstrates therapist and client agreement about unhelpful group processes. These are identified as an imbalance between talking and art making, absences and an occasional lack of structure. The literature review showed that therapists identified similar unhelpful processes in art therapy groups, such as those related to therapist initiated structures (Skaife and Huet 1998; McNeilly 1983, 1990, 2006), an imbalance between flexibility and structuring (Carr and Vandiver 2004, Rust 1994) and an imbalance between talking and painting (Skaife and Huet 1998). The research reveals that absence unhelpfully connects to the value of group interaction. In a cohesive group the absence of group members and a break in treatment are experienced as attacks on the group from a group dynamic perspective (Nitsun 1996). I show in the case studies that setting dynamics and client diagnoses interact with this experience of absence. However, clients and therapist perceptions may differ on what constitutes an attack, as will be further discussed in 8.2. The lack of structure (client experience) or focus (therapist experience) may connect to a group dynamic of 'taking the piss' (Greenwood & Layton 1992, Sarra 1998). I will return to this when discussing the findings for dance movement therapy and the generalisability

of this finding to the other arts therapies. Springham's contention that an exclusive focus on art making may collude with the denial of relationship (1998), will also be considered as an aspect of dissonance in 8.2.

This research shows that in dance movement therapy clients and therapist agree that connecting with people, having fun, client initiative, therapist structuring and expressing feelings contribute to a session being useful. The literature identifies self-expression, integration, symbolic work, synchronicity and cohesiveness as useful therapeutic factors in Chacian DMT groupwork (Schmais 1985, Karkou 2006). Not evident in this DMT literature is the usefulness of fun, structuring and client initiative. However, the non-directive authentic movement orientation in DMT grouptherapy does stress client initiative (Whitehouse 1979, Levy 1988). The value of client initiative may also connect to the importance of empowerment, as identified in art therapy (Byers 1998, Springham 1998) and dramatherapy (Casson 2004). There is a further need to look across to other arts therapies research for (client identified) valuing of fun in dramatherapy (Casson 2004) and childlike play in music therapy (Amir 1999). The latter two may interact with the 'taking the piss' group dynamic (Greenwood & Layton 1992, Sarra 1998), identified with psychotic clients as a means of deflating interpersonal tensions. Peer dissonance may thus be expressed through or within play. However, the release and distancing from problems that can be experienced in play can in itself be a helpful factor too.

My research shows that the clients and therapist agree that a lack of connection between movement and talking, people not joining in, absences and the use of certain structures (those that lack containment and create a sense of unsafety) are unhelpful. As discussed in 2.5, group structuring in dance movement therapy is handled differently whether the therapist is creative movement, interactive or psychodynamic in orientation (Karkou 2006). The debate within art therapy about structuring also related to the orientation of the therapist. My research shows that structuring contributes to a session being experienced as useful or unhelpful. I will discuss this in greater detail in 8.2, as structuring can contribute to client therapist dissonance, in 8.4 implications for practice and 8.6 the need for further research. I propose that structuring as part of arts therapy training and practice requires further research and

reflection, which must go beyond therapist theoretical orientation. If and how therapists adhere to the model taught or to the orientation of the setting is an issue that needs further research in the arts therapies, as it is in psychotherapy (Roth and Fonagy 2005).

I established that in both DMT and AT groups peer dissonance and a consequent disliking of self or others are felt to be unhelpful. The research clarified that across the two arts therapies the congruent / consonant emphasis is on expression, on connecting to others and on being able to initiate / do your own thing as the most useful aspects of arts therapies group treatment. Having enough time to paint and talk and a relaxing session is especially important in art therapy; while fun, play and certain therapist structured interventions that allow for contained expression make DMT useful. Arts therapies' research in the other modalities suggest that my findings may be generalisable (Casson 2004, Benjamin 1983, Amir 1999). My findings can be contextualised with those from psychotherapy research on the therapeutic alliance. The research shows that support, attention to client experience, reflection and exploration, facilitation of affect and accurate interpretation are beneficial (Roth and Fonagy 2005). The area of verbalised interpretation in the arts therapies is a complex one, I will explore this in 8.2 and 8.3.

The literature review outlined that consonance and dissonance between client and therapist depends on how each perceives the clients' problems and what constitutes efficacious treatment and progress. Over time the interaction between client and therapist can modify these expectations, but they can also contribute to ongoing dissonance and potential drop out.

My research identified the following consonance and dissonance in this area.

Arts therapist perspectives on signs of progress:

- The development of client independence
- Improved expressivity in the art
- Improved ability to develop relationships

- clients being able to make sense for themselves and integrate unbearable feelings
- Unit staff felt that the arts therapies were a less threatening way for clients to relate to others and to connect with their own emotional life

Dissonant client perspectives:

- Arts therapies aim for self expression and freedom of repression, this clashes with a wish to control symptoms
- Arts therapies as escapism “I don’t see them having anything to do with solving my problems but they are a good way of escaping for a little while”
- The use of the arts form as index or symbol
- An inability to express related to experiencing therapist expectation to do so
- Individual orientation vs. arts therapies group interaction aims

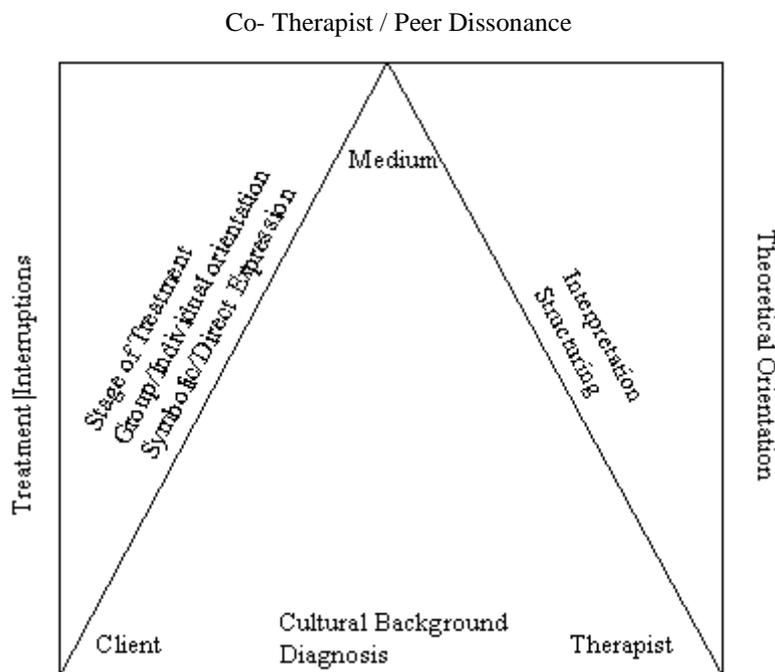
Consonant client perspectives:

- the arts as a means to play
- connecting with others in the playarts therapies for expression
- relaxation
- communication with others
- growing independence

I will look at dissonance in greater detail next. Client-therapist consonance findings are that expression and interconnecting with others are the most useful factors in arts therapies groups. The ability to initiate for clients fits the process orientation of the groups. The structuring of those groups can facilitate either consonance or dissonance, depending on a variety of factors. The emphasis on expression may be consonant, but the understanding of this expression may create dissonance with the psychodynamic values of the therapists. If the therapist stresses the symbolic nature of the medium (arts as symbol), while the client stresses direct expression (arts as index), dissonance may result. A variety of interacting factors may influence dissonance which I will represent in an image (figure 1), followed by discussion of the variables and their implications for practice in 8.3.

## 8.2 Client-therapist dissonance on the efficacy of arts therapies group treatment

My hypothesis that intragroup cultural background differences between client and therapist would create dissonance in their perception of arts therapies' group treatment proved invalid. Interacting client, therapist and treatment variables created dissonance, of which cultural background variables were a part. I have presented the interacting variables along the triangular arts therapies relationship axes in figure 1. The treatment variables are represented along the sides of the square representing the setting. I will discuss how dissonance can occur on any of the axes of the diagram and interacts with the other factors along the axes.



**Figure 1 Client-Therapist dissonance**

### Dissonance within the arts-therapist-client relationship

The triangular relationship between client and therapist, client and medium, therapist and medium interacts with the different variables along its axes to create dissonance. The client-medium axis emphasises how the clients experience the medium. It

contains the factors of stage of treatment, group-as-a-whole or individual-in-the-group orientation and symbolic or direct expression (arts as symbol or index).

Early and ending stages of treatment are accompanied by greater client-therapist dissonance. In the early stages this can lead to client drop-out and in the ending stages to many absences and premature termination. A therapist may regard a departure as premature, while the client simultaneously feels that s/he has attended for the optimum length of treatment. This divergence remains a phenomenon to be explored (Lambert et al 2001). A psychodynamic understanding of separation anxiety may play a role. Client and therapist individual variables such as diagnosis and cultural background variation interact to give form to this dissonance. The 'taking the piss' dynamic can be more present at a group level. Greater peer dissonance as a result of an anti-group reaction to defend against separation (Nitsun 1996), creates a greater need to defuse interpersonal tensions (Greenwood & Layton 1992).

In the early stages of treatment dissonant expectations about the use of the medium can clash. A client expectation of the arts as distraction or relaxation diverges from the therapist expectation of the arts as symbolic expression. This clash creates self consciousness in the clients through therapist interpretation and the effect of an audience, realised in clients sitting out and watching (Jones 2005). The client variables of gender and diagnosis interact with the stage of treatment and the symbolic or index use of the medium. Springham's (1998) finding that an exclusive focus on the arts can be a denial of relationship provides an interpretation for the need to 'take the piss' as an avoidance of interpersonal tensions at this stage (Greenwood and Layton 1992). However, in the early stage of treatment particularly, this may provide a much needed relaxation and connecting with others through play and / or art making to build group interaction and cohesion. In the ending stage of treatment this pattern may recur (Nitsun 1996), but may need a different intervention, more in line with the standard arts therapies psychodynamic intervention to address resistance. Stage of treatment thus needs to influence the flexibility of structuring (Carr and Vandiver 2004, Rust 1994).

The pilot stages' finding that clients do not differentiate between the different arts therapies media is not born out by the findings of the main study. The difference between the media is experienced through a more group interactive focus in DMT and a more individual-in-the-group focus in AT. The exception to this is when the clients initiate group interactive painting. The group interactive form of structuring in the arts therapies influenced client preferences for a particular medium. A second factor influencing the preference for the medium was its possibility for direct or symbolic expression. The literature review showed a discussion in the arts therapies about the symbolic communication through the arts form. Images may be considered indirect communications about the way clients construe the relationships in the therapy session (Springham 1998), whether diagrammatic or embodied (Schaverien 2000). This understanding of the arts as sign (Karkou 2006) can clash with a client understanding of the arts as index (Pavlicevic 1997). The generalisability across the arts modalities may be open to debate here. The understanding of the arts as index stems from music therapy, while the semiotic interpretation is articulated within art therapy. There may be a difference for performance arts modalities like dance, drama and music from visual art. This is an area that needs further research. However, as an implication for practice I propose that all arts therapists consider the possibility of arts as index, as well as arts as symbol. The findings of this research show that the potential for inaccurate or mistimed interpretations is increased when client and therapist diverge in their perceptions of the arts as symbol or index.

The therapist-medium axis indicates that structuring connects to a therapist expectation of directive or non-directive interventions, often combined with a group process approach that aims to facilitate client independence. The findings of this research are that a more directive structure is useful to clients, if it leads to a sense of safety and containment. A non-directive approach can be experienced as empowering in being able to initiate and "do your own thing". Client-therapist dissonance occurs through a lack of safety in a directive structure or a lack of focus in a non-directive one. The arts therapies' current trend towards flexibility (Carr & Vandiver 2004), eclecticism (Karkou 2006) and adaptation to the clients' needs (Huet 1997, Skaife and Huet 1998) can allow for adaptation to stages of treatment and client variables where this is needed.

Another aspect of structuring is the balance between talking and the arts expression. Clients and therapists were consonant about the importance of arts expression and talking in an arts therapies session. I found that dissonance occurs in the balance between the two. A lack of connection between talking and moving, or too much talking, creates dissonance. If there is not enough time to talk, the therapists perceive that feelings remain unexpressed or blocked. However, the clients perceive the talking as blocking their ability to use the medium as a distraction. The clients value distraction as it allows them to relax and “get away from their problems”. The theoretical orientation of the therapists can provide a constraining factor on their ability to respond flexibly to clients. A psychodynamic understanding of resistance may lead the therapist to reinforce an interpretation that the clients are not ready to hear. The psychodynamic concept of resistance is defined as the client being unwilling / unable to become conscious of unconscious motivations (Segal 1982). If a unit co-therapist is present, the theoretical orientation of the setting interacts with that of the therapist. The findings of this and other research emphasise the value of play and fun in the arts therapies (Amir 1999, Casson 2004). This can counteract the view of distraction as resistance. The therapeutic value of play (Winnicott 1985) provides an alternative conceptual arts therapies framework which, in interaction with stage of treatment and client diagnosis, provides a more flexible therapist response.

The client-therapist relationship axis was the main focus of the research. Client diagnosis and client-therapist cultural background differences are the variables to address on this axis. I will conclude this section with the findings, after a discussion of their interaction with treatment variables. The effect of treatment variables are represented in the square in figure 1. Peer dissonance influences client-therapist dissonance in a group treatment context. Dissonance with particular peers, who sit out of the group interaction and watch, interacts with the relational stressor of past sexual abuse, especially in a mixed gender group. A self consciousness about scarring can create dissonance in being watched for clients who self-harm. Past experience of bullying makes peer dissonance harder to tolerate. The psychodynamic understanding of current difficulties in the context of past relationship patterns, provides an explanation for this dynamic.

This research has shown that inter-group cultural background variables of ethnicity and nationality can contribute to peer dissonance and drop-out. It can also create intra-group dissonance in the area of religion. The arts medium can facilitate indirect expression of peer tensions, potentially leading to scapegoating. This type of scapegoating interacts with the group dynamic of new clients joining the group or clients taking an audience position to others. There may be implications for structuring, as the dynamic is more likely to occur when group-as-a-whole interaction is required.

This research highlights that treatment interruptions are an interacting dissonance factor in their own right. There is a high level of staff attrition in the NHS. This research shows that the way the arts therapies are perceived or used by the setting influences client-therapist dissonance within the therapy group. The setting's use of the arts therapies as an intake assessment and the perception of arts therapies as a less threatening way of relating increased client-therapist dissonance. The use of the arts therapies as intake may be appropriate, but it increased group dissonance in the early stages. The early stage of arts therapy treatment already shows higher dissonance levels as, contrary to the setting expectations, arts therapies are not experienced as a less threatening way of relating. The treatment interruptions resulting from the intake assessments of new clients and the residential weeks exacerbated those dissonance patterns. This research has shown that the scheduling and expectations about arts therapies treatment within the setting impacts on client-therapist dissonance patterns.

The effect of therapist experience and level of training may need to be taken into account regarding art therapy dissonance, because non-art therapists would facilitate the group in the art therapist's absence. The phrase 'familiarity breeds contempt' may have held true for a group that had been part of the unit for many years. The newer dance movement therapy group was not held in the therapist's absence. The more non-directive process orientation of the art therapy group structure may have contributed to the unit staff feeling this was within their expertise. The clients commented that a session could be useful in the therapist's absence, if the co-therapist was still present (although in anticipation they always graded low, indicating a difficulty in being told about the absence). It was, however, considered to be very

unhelpful when once both therapist and co-therapist were absent and two other unit staff stepped in. National arts therapies registration through the Health Professions Council should make this type of practice impossible, but research or audit may be needed to indicate where and if this practice still continues.

Another treatment variable on the client-therapist axis is that of diagnosis and severity / chronicity of problems. Chapters 6.4 and 7 indicated that severity of problems / chronicity of symptoms and a diagnosis of (borderline) personality disorder almost invariably led to drop-out, especially in combination with addiction problems. An adaptation of approach to enable this client group to stay has been indicated by recent NHS practice developments (White et al 2001). A history of sexual abuse creates greater dissonance with the dance movement medium, especially in a group interactive mixed gender context. The effect of OCD symptoms and incongruent treatment expectations interact. The perception of a need to control the symptoms can be experienced as incongruent with the emphasis on expression in the arts therapies. However, the case studies also showed that diagnosis per se as a determining variable is not verifiable. Depression seemed to be creating higher dissonance in DMT (chapter 6.4), but it was shown that combinations of diagnosis and stressors caused this, rather than one diagnostic category alone. Co-morbidity and stressors need to be considered when using diagnosis as a pre treatment given.

On the client-therapist axis the research also shows that therapist and client cultural background variables interact to affect client-therapist dissonance. Clients, whose ethnic and cultural self-identification was white English-British for more than three generations and who had grown up in a rural community which reinforced that identity and had little experience of people from different backgrounds, were more dissonant with a therapist who was a first generation migrant, with a different nationality, religion and first language. This dissonance interacts with that of the client-medium axis, when the client prefers direct to symbolic expression. The effect of audience needs to be considered in relation to peers. This preference interacts with the third axis interpretation of symbolic meanings. Socio-economic class, therapist age and experience could not be identified as interacting factors.

On the basis of one case study in the research it is suggested that inter-group ethnic /cultural difference is a factor influencing peer dissonance and drop-out. The peer dissonance can be expressed through the medium in the choice of music or imagery and easily be lost in a group dynamic of teasing. Therapist consonance will not outweigh this peer dissonance if it interacts with diagnosis / stressors of bullying and an experience of discrimination prior to coming into the group. Group dynamics will interact with the cultural background differences in that the peer dissonance / teasing may be a displacement of therapist dissonance. Alternatively, it can be a displacement from general dissatisfaction with the group onto those who are perceived as different. Youth culture may disguise wider cultural differences in its emphasis on 'being cool' in the choice of music, clothing etc.

Teasing may be a difficult group dynamic to address if the therapist's cultural difference is affected too. Therapist difference in nationality, language / accent and cultural choices were targets of teasing in the arts therapy groups. The reluctance of the therapist to address this was present in both the AT and DMT groups, whether the therapist herself was part of an invisible minority or not, and whether clients or therapist were the object of the teasing. "Taking the piss" (Greenwood & Layton 1997) may diffuse interpersonal tensions, but also create the potential for scapegoating (Schaverien 1996, 1999). Staff awareness of scapegoating emerged in their focus groups, but the therapists did not address these differences in the therapy groups. It is not clear from the findings whether, if they had been addressed as recommended in CST, drop-out could be prevented.

It is important to note that, as discussed in the literature review, the over diagnosis of psychosis for young men from visible minority backgrounds ( Fernando et al 1998, Littlewood and Lipsedge 1997) and the higher attrition in psychotherapy for BME clients, is coinformed by this research. It has not been possible to show whether the sample accessing the psychotherapy at the unit was representative of the hospital population. The lack of Trust monitoring procedures at the time of the research results in a lack of data to assess / audit the access of BME clients..

### **8.3 Implications for practice**

The above findings have implications for arts therapies group practice. Hypotheses can be formulated whether the application of certain findings might also be relevant to individual practice. The findings impact on five areas of practice:

- overcoming early dissonance
- liaison with the setting
- ‘structuring’ the medium
- use of interpretation.
- therapist reflexivity

#### ***Overcoming initial dissonance***

This study has shown higher rates of dissonance in the initial and ending stages of therapy. Arts therapists do consider the difficulties around engagement with and endings in group therapy within a groupdynamic framework (McNeilly 2006). However, this research indicates that the arts therapies may have particular medium related difficulties in the early stages. A comparative study would need to be done to ascertain whether this early engagement difficulty is greater in the arts therapies than purely verbal groupanalytic psychotherapy. In the arts therapies groups a difference in perception about the efficacy of the medium and whether it is meant for direct or symbolic expression has been shown to create client-therapist dissonance. For those clients who remain in treatment adjustments in expectations can be accommodated, but for some it may contribute to early drop out.

Clients with certain diagnoses have been shown to be at higher risk of drop-out, particularly clients with a diagnosis of (borderline) personality disorder and / or addiction problems are at greater risk of attrition. Severity and chronicity of symptoms / condition is also related to a higher risk of drop out. This reflects the literature (Roth and Fonagy 2005). Diagnoses are shown to be a relative way of categorising clients as there are high rates of co-morbidity and certain stressors such as the experience of sexual abuse impact stronger than the primary diagnosis. The

age range of the clients needs to be taken into account when considering generalisability.

Involvement of the arts therapists in client assessment for their groups might help them to address differences in expectation in preparation for the group. They are then in a position to adjust the structuring of the medium to accommodate early problems. In a slow open therapy group format accommodation of new clients may need particular attention by the therapist. Increased dissonance among the existing clients may mean that they are not in a position to accommodate changes for the benefit of newcomers. Different ways of structuring the medium and adjusting the use of interpretation may provide a bridging function.

### ***The impact of the setting***

Treatment interruptions need careful consideration when the arts therapies are provided by staff external to the unit (as is regular practice when an arts therapies department is part of a trust). Co-therapy can be useful to interconnect the arts therapies with the group programme as a whole. However, with high staff turnover prevalent in the NHS (Johnson 1995) and the proliferation of part-time arts therapies posts, continuity and stability of treatment are compromised. This research compared different unit practice with art and dance movement therapy groups in the therapist's absence. The findings show that unit staff taking on the art therapy group results in greater dissonance for the clients. Although therapist age, training and experience were not shown to effect dissonance in this study, when nurse therapists without art therapy training facilitated a session increased dissonance resulted. However, the dissonance was decreased when the nurse therapist was the existing co-therapist. This may be a part of the equivocal evidence for the effect of therapist training and experience on efficacy (Roth and Fonagy 2005), but merits consideration for practice.

### ***'Structuring' the medium***

The findings show that in their nature the arts are an active medium, which rely on therapist intervention to influence the form in which they are offered.

Therapist determined structuring can be in contradiction to the process orientation of arts therapies groups (Waller 1990, 1993; McNeilly 2006, Skaife and Huet 1998, Davies and Richards 2002, Holden 1997, Pavilcevic 2003). The process orientation expects a non-directive stance from the therapist (Burlingame 2004). The literature review showed this theoretical dilemma about dependency and authority issues in the group. Related dilemmas are whether the symbolic meaning takes precedence over the working through of feelings through the artistic medium and whether verbal interaction dominates over art making (Skaife and Huet 1998). In this research offering media alone for individual image making and sharing has been shown to have a different impact on dissonance from group interactive painting. Skaife and Huet quote McNeilly (1983) when considering that increased structuring by the therapist may be transference avoidance. However, the emphasis on theoretical orientation does not allow for consideration of the clients' perspective beyond resistance / transference, nor take into account the importance of different stages of treatment.

In dance movement therapy the structures the therapist offered were shown to directly impact on whether a session was experienced as useful or unhelpful. Within dance movement therapy, as discussed in chapter 2, there is also a continuum between Chacian non-directive work and more direct interventions (like in art therapy between theme based work and non-directive interactive image making). When there is an expectation of group-as-a-whole interaction the impact of non-participating members as an audience can lead to greater peer dissonance and self-consciousness on the part of the clients who are being watched. A therapist orientation of client initiating may see the sitting out as clients exercising choice, or see it in terms of resistance. It may be that the effect of audience on a performance based arts medium needs further consideration beyond these two explanations. This study has shown that gender dynamics and previous life stressors impact on the effect of audience. When assessing an individual in preparation for the group, this needs to be taken into account along with a consideration of boundaries and structuring within the group.

Some clients have difficulty in understanding arts expression as symbolic. The initial dissonance can be related to client fears about the medium. Gilroy's research showed

that in a training group fear reduced over time (1996). Interpretation of images and movement as symbolic evokes resistance in clients, which can be understood psychodynamically. However, greater access to direct expression as efficacious could additionally be considered. Opportunities for more playful exchange and engagement with the medium may facilitate empowerment, group interaction and group cohesion, while at a later stage the more symbolic possibilities of the medium can be explored. Decreased dissonance over time shows that clients become less dissonant to therapist interpretation over time. This may be an aspect of therapist-client value convergence (Tjelveit 1986), or an ability to differ on the use of symbolism while valuing the benefits of expression and interaction. The related issue of interpretation will be considered later. In a climate where there is increased emphasis on short term treatment for complex co-morbid clients, adjustments of arts therapeutic group work technique may be useful to reduce levels of client attrition and widen potential access.

Acknowledging difference may need to become a greater aspect of therapist practice. The research has shown that differences occur in the experience of the medium, the perception of problems and of useful treatment to address those problems, as well as cultural background. The case of Sam shows that difference can be a target for scapegoating, which can be aimed at the client as well as the therapist. Further research may be needed to study the underlying variables affecting therapist resistance / avoidance. I propose that addressing therapist cultural difference may allow those clients, who perceive themselves and are perceived by others as culturally different, to remain in treatment. Cultural competency has not been shown to make an unequivocal difference to therapy outcome (Zane et al 2004), but the case study indicates that it may be a factor in attrition, especially for clients from visible minority groups.

### ***The use of interpretation***

The research findings about early dissonance and structuring of the medium indicate that interpretation of symbolism, whether by experienced or inexperienced arts therapists, needs to be used with care. Experience here is defined as years of practice, but defining experience is one of the methodological problems in psychotherapy

research (Stein and Lambert 1995). Balancing talking and image making / movement in a manner which is experienced as useful by the client and is felt to connect the two, remains a difficult area of arts therapies' intervention. It has been shown to lead to frequent client-therapist dissonance. Whether considered purely as resistance, or a sign of other underlying client internal conflict, is raised as a question through the findings of this research. Maybe these clients are not psychologically minded, often considered a prerequisite for benefit from psychotherapy. However, the research also shows that some of these clients do benefit from arts therapies over the longer term. Further research may indicate whether arts therapies can be a form of psychotherapy that facilitates a client to develop psychological mindedness. However, the current findings show that for some clients the benefit of the arts therapy may be through direct expression and interaction with others, while for others the additional consideration of symbolic meaning may be efficacious. Insisting that the consideration of symbolism is efficacious to all can decrease the benefit from the therapy, as studied through the perception of efficacy. Client based ratings of the therapeutic alliance are better predictors of outcome than therapist or observer ratings (Horvath and Symonds 1991). To be led by client perception may aid the efficacy of the treatment. Rigidified adherence to values, in the form of belief or theoretical orientation, needs to be subjected to self-reflexivity and further consideration of the client's perspective.

### ***Therapist reflexivity***

This study shows that a too rigid adherence to the psychodynamic concept of resistance and an insistence on exploring the arts as symbol, be it movement or an image, may hinder a client in the exploration needed. Psychotherapy research studies the interaction of adherence with therapeutic alliance in interaction with other interventions such as openness to feedback and avoidance of blaming (Luborsky et al 1985, Henry et al 1993). There is a complex relationship between therapist adherence, competence and outcome (Roth & Fonagy 2005). Psychotherapy research has also shown that therapist rigidity is unhelpful (Ackerman & Hilsenroth 2003), while deviation from the model to benefit more difficult clients can be beneficial (Rounsaville et al 1988). Hostile clients with negative pre-treatment expectations

challenge competency. Co-morbidity of different diagnostic category acts as a confounder (Roth and Fonagy 2005). Many of the clients in this study would fall under those classifications.

How training can enhance competence and the role of supervision in that competence (Henry et al 1993) needs further research (Roth and Fonagy 2005). Arts therapies training courses in the UK often derive their identity from their underlying theoretical orientation, whose 'unique' character helps them to attract students. If this unique perspective is taught without reference to other models of understanding, rigidity and a lack of reflexivity in the trainee may be the result. Interpretation of symbolism needs to be considered as an integral part of the clients' understanding of their problem. An understanding of the clients' frame of reference is crucial if all client dissonance is not to be relegated to resistance or a lack of psychological mindedness.

Arts therapists, working as part of a multi-disciplinary team approach, need to consider the effect of the setting's orientation, be it a medical, psychodynamic, learning or other model. When working with co-therapists, staff turnover and treatment interruptions inherent in the setting need to be considered prior to the start of therapy in deciding which model of working to follow.

Therapist orientation in group therapy needs reflection. Whether directly following group process or possibly adjusting this approach to consider different stages of treatment in relation to either group interaction or individual-in-the-group structuring, therapist orientation needs consideration. Adjustment of facilitation according to client diagnosis and their understanding of the problem and its treatment is indicated.

Therapist reflexivity regarding their theoretical orientation, as well as their cultural background is needed to be able to respond flexibly to different clients. Therapists' understanding of their cultural background may help them to be aware of potential blind spots. The latter is especially important to identify areas of resistance / avoidance in order to address potential scapegoating (Schaverien 1996, 1999). Ethnic monitoring of clients and therapists needs to be incorporated into arts therapies' practice. Blindness to one's own and the clients' cultural background, visible or

invisible, can lead to dissonance expressed in the peer relationship resulting in scapegoating and drop out.

#### **8.4 Return to the question: researcher assumptions**

In theory the researcher is not meant to have assumptions about the research during the development of their qualitative research project. They are meant to evolve during the fieldwork and analysis. However, research has also found that the researchers' biases are likely to influence findings. The orientation and identity of the researcher can affect the research outcomes (West and Talib 2002, Luborsky et al 1999).

I started this thesis with a description of my personal and professional journey indicating how this had influenced my choice of topic. Opting for ethnography and participant observation as research perspective and methodology was in part influenced by my MSc in social anthropology. This also allowed me a more distanced stance from the practice than if I had opted for practitioner research. My cultural and ethnic identity made me a member of the sizable staff minority of 'white others'. The fact that my accent identified me as such meant that this could be the target of teasing, as with my assumed choice of music. I described the effect of the process on myself and the group in 6.6. Being thus singled out was at times uncomfortable and at certain times made me concerned that my presence could exacerbate dissonance within the group. At other times it could be beneficial, as it enabled me to raise the issue of difference, where the therapists did not. Often this had to be done through the arts medium in a similar way to that described in reflecting back other group dynamics.

Although the 'in between' position of the participant observer became an accepted part of the group, I found that I needed clinical supervision to reflect on my impact. Therapist reflexivity was needed as a researcher too. I had not anticipated this, when I chose against a researcher practitioner role. When studying wider qualitative research methodology, I found that it emphasized the importance of the reflexive researcher. The setting variables played a role in influencing a mixture of qualitative

and quantitative approaches, taking me even further away from pure ethnography. Whatever my critique of the evidence based practice paradigms (see 8.5), it encouraged me as a researcher to look for ways of triangulating my subjective choices and influences with other types of data to allow both client and therapist perspectives to be noted in their own right.

Completing my own questionnaires and comparing their findings with those of the clients and therapists, it was good to see that they carried the imprint of the in between position. It indicated that my practitioner identity did not seem to dominate my client identity. It was possible to find myself at certain times mentioning the same themes as the therapists, at other times echoing client themes. New findings could then emerge. The really interesting element for me was that certain findings were at odds with my therapist preferences. Prior to this research my previous training had influenced my preferences for exploring psychodynamic unconscious symbolism in the arts form. I also valued verbalisation / discussion of the imagery created in a group dynamic format (Dokter 1994). The research allowed me to gain insight into differing client perspectives of these processes and re-value the importance of expressivity and play.

Initially I assumed I would be able to identify individual cultural variables affecting client-therapist dissonance. Throughout the research process I became more and more aware of the interacting client, therapist and treatment variables. This also influenced the evolving multi-modal methodology. I introduced focus groups in addition to questionnaires and interviews. The participant observation influenced the method of analysis, from isolating individual variables to studying the interaction between them. The interdependence and interaction extended to the values of the setting and how they influenced the client-therapist relationship. The various heterogeneities of client and therapist background, to within arts therapies orientation, to the heterogeneity of values within the psychiatric setting led me to a more post modern and social constructionist perspective on diversity.

I will critique the strengths and weaknesses of the methodology in the following section, but wish to stress the value of participant observation as a research method.

The need for reflexivity is imperative. When that is taken into account however, it provides a very privileged position for accessing diverse perspectives and experiences in therapeutic interaction.

### **8.5 Methodological critique**

This chapter section will provide an analysis of the quantitative/qualitative combination of data gathering and analysis, the multi-modal design, the identification of interacting variables and the use of the natural clinical setting for research. Ethical considerations about the researcher as participant observer will conclude this section.

The data gathering design of questionnaires, interviews, focus groups, participant observation and health diaries was outlined in chapter 3. The strength of the questionnaires was their immediacy and the possibility for triangulation between therapists, co-therapists and clients at the same moment in time. Their weakness was the rating scale for quantitative purposes. During the analysis a rating scale of 10 was proved to be needed for statistical significance. In the design stage this had proved too challenging for some clients (one of the differences between analogue and clinical research studies). A different way of using the rating scale needed to be developed in the analysis stage. The quantitative rating could not be used for the triangulation of the qualitative comments, but were used to delineate the relative importance of the qualitative themes. This was useful within the qualitative focus of the research, but reduced its efficacy as an outcome oriented measure. The focus on client perception per se, rather than triangulating the subjective perception with that of measures to ascertain client change or improvement, made its benefit for outcome questionable anyway, within an EBP context. However, the CST critique of the validity of outcome measures across ethnic groups, excluded that possibility.

Attrition and attendance proved two useful quantitative measures, but a weakness emerged in the lack of detailed monitoring of clients who dropped out of treatment. Follow up was rarely successful. Asking the unit to incorporate the socio-cultural database form as part of its intake assessment would have provided more detailed information on drop outs. This may be easier in the current legislative climate.

Quantitative analysis of diagnosis proved potentially misleading. Diagnosis was shown to be as heterogeneous as cultural identity, comparing client, psychotherapeutic and psychiatric perspectives. This puts into question the potential validity of pure diagnosis based research in EST as critiqued by CST. Co-morbidity and therapy sensitive methods of diagnosis need to be considered for inclusion. This reinforces that as arts therapists we need 'our own kind of evidence' (Gilroy 1996). The collection of data from everyday clinical practice presents such problems as to make it unsystematic for empirical paradigm research. The EBP criteria for research (see 3.10) are rarely implementable in arts therapies settings. The clinical practice setting proved unsystematic. The arts therapies group programme changed between setting up the research and starting. Co-therapists left and group programme interruptions were implemented. The small sample size of this study, typical of much arts therapies research (Odell-Miller 2001) remains a difficulty for purely quantitative designs, although the RCT on art therapy and schizophrenia (Gilroy 2006) provides solutions to this through its multi-centre design. The combination of quantitative and qualitative research methods in single case research (Aldridge 2005) provides further models for practitioner researchers (Payne & Meekums 1993, Lee 1995, Grainger 1991).

The use of focus groups had a real strength in its facilitation of different client perspectives, as well allowing for triangulation of private (questionnaire) and public (focus group) perspectives. Their weakness involved their fluctuating membership and the clients' refusal to have a focus group when the therapy groups were at difficult stages. This could potentially have excluded those moments of the therapy where dissonance was strongest. Focus groups without questionnaires could also have excluded the more private client perceptions. The effect of audience in the data from focus groups needs to be incorporated, as does the ethical issue of therapeutic boundaries, to be discussed later.

Interviews allowed more time with each of the research participants and a further exploration of their perceptions. The methodological issue of retrospective perceptions, taken at a particular time, was addressed by interviewing twice at a three months interval. Clients' avoidance of interviews meant that those times were not the

same for each client, so direct comparisons in time could not be made for some of them. Client premature termination of treatment also meant that some clients only had one interview. Interview data thus had to be used carefully within a case study format, rather than for direct comparison between clients.

The multi-modal design used here has as its strength the variety of perspectives it can generate, as advocated by Crabtree and Miller (1992) for clinical qualitative research. It allows for triangulation of, for example, individual and group perspectives thus addressing the potential skewing of findings through differential power relations. It also allows for the weaknesses of one research method (i.e. the retrospective time frame of the interview) to be compensated for by another (the immediacy of the evaluation questionnaire). It also allows for the weakness of certain forms of data (i.e. the health diary which was only completed by one client) to be replaced (by a study of variations over time through the chronology), so that not the whole design is placed in jeopardy.

This is particularly useful when the research is in a natural practice setting where the researcher needs to be able to respond to changes in the circumstances of the research, rather than control for confounders. The weakness of the multi-modal format is that, instead of triangulating, the different methods may elicit different types of data and the enormous amount of data generated may result in a 'not being able to see the wood for the trees' syndrome in the researcher. The combination of participant observation with focus groups and the evaluation session questionnaires with both focus groups and interviews allowed for very rich data, where therapists, setting and clients could be studied in interaction. Odell-Miller (1999) expressed the need to be able to study group interaction in group therapy, while her research focussed on individual client perceptions. Participant observation and focus groups allowed for that, as well as allowing the researcher an 'in between' position. When theoretical orientation affects both practitioner and researcher (Luborsky 1999, West & Talib 2002, Beutler 1997), practitioner research needs to find methodology beyond that of the reflexive researcher to study particular interactive processes between client and therapist. Applied ethnography may be able to do this, although Yin's critique of its shortcomings concerning subjectivity and time consumption remain valid.

The isolation of variables is a particular methodological problem. As stated in 6.7 variables do not act independently but interact with each other. Pret-treatment variables can have a prognostic relationship to therapy outcome (Clarkin and Levy 2004), but as soon as therapy begins the client variables are in an ever interacting and changing context of therapist variables and behaviour (Stiles et al 1998). The pilots showed in an acute and rehabilitation setting how difficult it was to evaluate the impact of arts therapy in the context of different settings and different individual treatment packages. Whether arts therapies can be considered as related, but different psychotherapeutic interventions (Odell-Miller 1999) is an issue for debate. In the pilots the clients perceived them as interchangeable - analogous. The fieldwork in the young people's unit showed different client perceptions of art therapy and dance movement therapy affected by gender and diagnosis. This may interact with the effect of audience. Jones (2005) discusses the concept of the active witness in the arts therapies, to stand apart and be a part / involved at the same time (Grainger 1999, Schaverien 1992, Aldridge 1996). In addition, the experience for those witnessing in a group context can be therapeutically important (Jones 2005). Jones views this as therapeutically positive. The possibility of 'malignant mirroring' in a group dynamic sense (Nitsun 1996) needs to be further researched as a phenomenon in arts therapies groups. The interacting variable of the changing perception through being an active witness of one's own arts creation was not incorporated in this research. This could be a weakness of the methodology, given the importance of the triangular arts-therapist-client relationship. I think this is an important aspect of the difference between the arts modalities and needs to be a part of modality specific research.

To conclude this section I will reflect on some ethical concerns in the use of participant observation and focus groups in group therapy research. The potential encouragement of discussing therapeutic material outside therapy group boundaries can lead to the psychodynamic phenomenon of 'splitting'. Clinical supervision of the researcher is imperative to allow for reflection on these dynamics and the possibility of reintroducing material through the researcher's participant observation within the therapy groups. Individual client material that indicates risk to the client or to others, which may emerge in either the focus groups or interviews, are subject to the same

code of practice as the therapy practice is subject to. These issues need to be given consideration in the negotiation with the setting and clients in the early stages of the research design and implementation.

### **8.6 Intercultural arts therapies research: further research needed**

Arts therapists need to incorporate an outcome focus in the research they are doing. My research has shown the paucity of demographic details provided by researchers. It would be a small, but very significant, change to include socio-demographic details of clients, therapists and context as a matter of course in research design. The census details and NHS trust requirements currently allow for more reliance on record material since 2000. Details about attrition, diagnoses (within the context of meaning as well as classification) and theoretical orientation of the therapist would allow for systematic monitoring of heterogeneity of the sample. It would comprise a step towards an audit of access for BME clients to arts therapies, models of practice appropriate to BME clients and the identification of necessary adjustments to existing models. This research shows that within group heterogeneity in interaction with other variables affects dissonance. One case study indicates the affect of peer dissonance on intergroup heterogeneity. Further research of variables may allow a study of intergroup differences and identify client, therapist and treatment variables affecting dissonance there.

The literature review showed the need for research into therapist training and its effect on practice. Adjustment of and adherence to the model of practice taught would be a useful area for research in the arts therapies. An audit of clients might provide some insight into the hypothesis that arts therapists work with clients who are less psychologically minded and / or provide a process to develop psychological mindedness. Currently a climate exists of increased demand for 'talking therapies' to address mental health problems. Many talking therapies, however, operate exclusion criteria for clients such as lacking psychological mindedness (psychodynamic psychotherapy), or underlying past relationship conflicts (CBT psychotherapy). If an audit and outcome research showed that, indeed, arts therapies provide efficacious

treatment for such clients, further research to identify the factors influencing that efficacy could help pinpoint which therapy works best for which client.

Dramatherapy models of group work were identified as an area for research and publication. Modality specific research that allows for comparisons between performance arts and visual arts, but also gender and diagnosis affecting preference and / or ability to use an arts therapy would provide clearer referral criteria. The effect of audience in therapy, be it being witnessed by others and / or being an audience to oneself in reflection on an arts media product are two areas for further research identified by this study.

Zane et al (2004) identify at the end of their review of intercultural psychotherapy research methodological and conceptual issues to be addressed. These are the type of research questions asked, the use of analogue studies, the selection of appropriate measures and inter- and intra ethnic comparison designs. Research has also consistently found that socio-economic status, education level and type of living environment, as well as English proficiency co-vary with ethnicity and culture. The other issue that challenges intercultural psychotherapy research is the role of culture. It has often been difficult to incorporate variables directly related to cultural experiences into psychotherapy research. Three conceptual issues have made that difficult. These are the distal nature of ethnicity, the limitations of traditional outcome designs and the lack of conceptual or theoretical approaches to guide research.

Studies of arts therapies training groups (Gilroy 1995, Payne 1995) may provide a basis from which to create analogue studies. Although trainees have shown to be more highly differentiated ethnically than clients, the possibility of studying value convergence processes between therapist and clients might provide a good basis for the design of research with clients. Some American studies do provide a basis for looking at outcome measures cross-culturally. The limitations of traditional outcome measures were discussed in 2.2. and can be even more difficult to address in the arts therapies, whether in a context of arts evaluation or clinical evaluation (Gilroy 2006, Jones 2005). Differences in practice do not exclude the possibility of collaboration

and comparison (Gilroy 2006). This research did not show any effect of socio-economic status or English proficiency, but working with newly arrived migrants in intergroup designs may show an influence of these variables. The effect of the type of living environment is indicated in this research and needs further study. The fact that clients and arts therapists were both downwardly mobile socio-economically is an interesting finding that bears further research into therapist values in their choice of career and how / if this affects their practice.

This research attempted to address the distal nature of ethnicity by studying heterogeneity within the white majority group. The cultural differences approach facilitates the integration of cultural findings with other psychotherapy research. The proposal to include monitoring of heterogeneity as a matter of course would allow that cultural difference approach to be integrated into arts therapies research. Within group heterogeneity as a variable in intergroup designs has become more possible to study since the identification of within group heterogeneity factors through meta-analysis (Zane et al 2004).

Though conceptual and methodological problems for intercultural therapy research remain, I have shown the limits and values of existing research. In this sense my research makes a valuable contribution to the body of knowledge. In addition my research has identified particular research methods as further suitable tools to approach specific research questions in this field. On this basis I propose that my research findings extend the ground from which further theoretical conceptualisation and enhanced therapeutic practice can develop.

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## **Appendix I**

### **Information Sheet for people involved in the research**

#### **Access to and Effectiveness of Arts Therapies**

This piece of research will involve my participation in the arts therapies group's at the Unit for a year.

You will be asked to give your consent to this participation, but are also free to ask me to leave in any given session.

After 3 months I will ask to see people for individual interviews to discuss the attached questionnaire. For the next 6 months you will be asked to fill in a short feedback sheet at the end of each session (the therapists are also asked to fill in the same sheets). All the sheets go in a locked box until the end of the six months. During that time, each person will be asked to keep a health diary for 14 days (I will give out the books).

All this information is given anonymously: no names will be used at any time. Although this may sound a lot; it should not involve too much of your time. 1st 3 months: I participate in the groups.

at 3 months: Individual interviews.

next 6 months: Filling in of feedback sheets at the end of each session and keeping a health diary for 14 days.

at 9 months: Individual interviews.

last 3 months: I participate in the groups and leave at 12 months.

I will be around throughout the year so can answer queries whenever they arise.

Hopefully, one year after leaving, my report will be complete and can then be read by all people who were involved in the research. I hope to find out if / how artstherapies groups are of use to people and how they can be changed to be more useful. I am particularly interested in studying how people's cultural background influences their use of arts therapies' groups.

The information on gender, age and cultural background will be held (anonymously) on a database; protected by the Data registration Act regulations.

I hope you will feel able to participate in this project. All your wishes for confidentiality will be respected and you are free to withdraw at any time. Your treatment will not be affected in any way if you choose not to take part in (any aspect of) the project.

**C. Health Authority**

**Consent by client to Participate in Research project**

I,

of

.....  
.....

hereby fully and freely consent to participate in the research project entitled "Access to and effectiveness of Arts Therapies"

I understand and acknowledge that the project is designed to add to scientific knowledge. I note that I may withdraw consent at any stage in the investigation and I acknowledge that the purpose of the research and the nature of the procedures involved have been explained to me by:

Ditty Dokter

and that I have had an opportunity to discuss these matters with her.

I have received a written explanation of these matters, a copy of which is

attached to this form. Signed.....

WITNESS to signature of client and to fact that he/she has read the document and freely given his/her consent.

Signed.....

(Witness must not be a member of the project team)

I confirm that I have explained to the client the nature and effect of these procedures.

Signed.....

(Member of project team)

Date .....

Place .....

## APPENDIX 2 –SAMPLE QUESTIONNAIRE

Date:

Session Sheet (to be filled in by client and therapist separately)

Art/Music/Drama/Dance Movement (*Please underline as appropriate*)

1. How did you feel this session went?

2. What did you think was helpful?      Why?

3. What did you think was unhelpful?      Why?

4. How would you rate this session?

Unhelpful      1      2      3      4      5      Very helpful

--	--	--	--	--

Put a cross on this continuum e.g.

1      2      3      4      5

--	--	--	--	--

Very Useful

1      2      3      4      5

--	--	--	--	--

Not Great

Any other comments you would like to make about the session?

## **APPENDIX 3**

### **QUESTIONNAIRE USED IN SEMI-STRUCTURED INTERVIEWS**

- 1. How do you describe your cultural and ethnic background? How do others?**
- 2. Please describe the reason you attend the unit and how things are for you at the moment?**
- 3. What do you think caused you to be here? What is your explanation for your situation at the moment?**
- 4. Why do you think your distress started when it did? What do you believe started it?**
- 5. How severe is your distress?**
- 6. What kind of help and / or treatment do you feel is appropriate to your difficulties?**
- 7. What kind of help and / or treatment have you received so far?**
- 8. What results do you expect from your overall treatment?**
- 9. What results have you got so far?**
- 10. What results do you expect from the arts therapies?**
- 11. What results have you got so far?**
- 12. How do your difficulties limit your life?**
- 13. What do you fear about it?**

## Appendix 4

### Socio-cultural Information Form

#### 1 Ethnicity

How would you describe your ethnicity?.....

How would you describe your cultural background?.....

Were you born in this country? Yes/No If no, where?.....

Were your parents born in this country? Both / One / Neither  
If One / Neither, where?.....

Were your grandparents born in this country? Both / One / Neither  
If One / Neither, where?.....

#### 2. Language

Is your first language English? Yes / No

What was the language spoken in your family home? English / Other / Both

#### 3. Place of residence

Past: UK / Other / Both  
City / Rural / Small town

Present: City / Rural / Small town

Number of residential moves in childhood: Many / Few  
In adulthood: Many / Few

#### 4. Do you follow a religious tradition?

Yes – which?.....

Did your parents follow a religious tradition?

Yes – which?.....

#### 5. Gender: Male / Female / Transsexual

6. What is / was your employment?.....

Your Father's employment?.....

Your Mother's employment?.....

7. Employment: Prior to illness and now

Now	Past
1. Employed full time	1. Employed full time
2. Employed part time	2. Employed part time
3. Receiving sickness benefits	3. Receiving sickness benefits
4. Student	4. Student
5. Unemployed	5. Unemployed
6. Voluntary worker	6. Voluntary worker

8. Educational history: level of attainment

Non-completion of statutory education	NS
Completion of statutory education	S
Higher Education	H
Further education	F

9. Current close relationship status

1. Close friendship
2. Single
3. In a relationship
4. No contact with own children
5. In contact with own children
6. Divorced
7. Separated
8. Married
9. Other

10. Current living arrangements (circle appropriate)

1. Alone	7. With parents
2. With young children	8. With partner
3. With friends	9. In temporary accommodation
4. In rented accommodation	10. In group home
5. In own home	11. In a hospital ward
6. Homeless	12. Other

## **Appendix 5 List of Acronyms**

ADMTUK Association for Dance Movement therapy UK  
AT Art Therapy or Art Therapist  
BAAT British Association of Art therapists  
BADth British Association for dramatherapists  
BME Black and Minority ethnic  
BSMT British Society for Music therapy  
CRSG C. Refugee Support Group  
CST Culturally sensitive therapies  
DMT Dance Movement Therapy or Dance Movement Therapist  
DOH Department of Health  
EBP Evidence Based Practice  
Ecarte European consortium for Arts therapies Training and education  
EST Empirically supported therapies  
NSF National Service Framework  
KFD Kinetic Family Drawing test  
NHS National Health Service  
NICE National Institute of Clinical Excellence  
ONS Office of National Statistics  
MDT Multi Disciplinary Team  
RCT Randomised Control Trial  
UK United Kingdom  
US United State  
VCIA roles which are Influential, Active and with Values that are Congruent with the goals in the group