DOI: 10.21277/sw.v2i7.309

SPECIFICS OF ARTS THERAPIES IN EDUCATIONAL INSTITUTIONS COMPARING THE INSTITUTIONS OF HEALTHCARE SETTING

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Abstract

18 arts therapists from educational and healthcare institutions in Czech Republic were interviewed to determine the specifics of therapeutic practice in educational institutions. The results relate to the presence of different professions in the team, their qualification and level of therapeutic competence, understanding the roles and work of arts therapists, the impact of arts on institutions, the depth of therapeutic change, formulation of therapeutic contract, therapeutic goals, organisation of therapy, the therapy room and privacy and assessments/evaluation.

Keywords*: Arts therapies, schools, education, health care.*

Introducing the issue and the theoretical framework

Recently, the results of the first national research of arts therapies (AT) in the Czech Republic were published (Kantor et al., 2016). Its aim was to create a research-based overview of AT, specifically in relation to work environment, groups of clients, theoretical influences, therapeutic principles, assessment/evaluation and other aspects of therapeutic practice (the research used the Karkou-Sanderson methodology, 2006).

The results of the quantitative analysis of the above mentioned research have shown that educational institutions are an important work environment of AT in Czech Republic; having come second after social care institutions. Considering their importance it is surprising how little is known about the specifics of therapeutic practice in educational institutions and this is true not only for the Czech Republic but also for many other countries. Although some titles focus solely on AT in schools (Moriya, 2011; Tomlison, Derrington, & Oldfield, 2012; Leigh et al., 2012; Wilson, 1996; Karkou, 2010), little attention is paid to understanding the specifics of therapeutic practice within different work environments. As a result of these findings, a qualitative part of the research was designed to follow the quantitative. Its aim was to understand how arts therapists work in educational institutions and to map the specifics of this work environment in contrast with healthcare institutions. This paper focuses on the

description of the methodology and results only of the qualitative part. However, we will first explain the basic terminology and theoretical background.

Defining the basic terminology – arts therapies and educational institutions. The term **arts therapies** is an umbrella term for several disciplines that use *"artistic media as vehicles for non-verbal and/or symbolic communication, within a holding environment, encouraged by a well-defined client-therapist relationship, in order to achieve personal and/or social therapeutic goals appropriate for the individual"* (Karkou & Sanderson, 2006, p. 46). In Czech Republic, these disciplines are represented mainly by art therapy, music therapy, drama therapy, dance movement therapy and also an intermodal conception known as expressive therapies (Malchiodi, 2005).

Although in the Czech Republic AT are usually considered to be healthcare professions, they have not yet been defined by law. Therefore, AT are usually performed in combination with other professions such as clinical psychology, medicine, special education, speech therapy, social work, etc. The training programs of AT are often designed as psychotherapy trainings and are rarely affiliated with universities. The professional standards of associations recognise several ways of receiving adequate qualification, however, in reality most therapists do not fulfil them. Moreover, the disciplines of AT differ in history, terminology, theoretical background, client population and other characteristics. This situation brings complications to comparative analyses that are still rare.

Czech **educational institutions** are defined by law of Ministry of Education 561/2004 Coll. Educational institutions are divided into two categories: schools and other school institutions, such as counselling centres, institutions for preventive care, leisure time centres, etc. For the purpose of this study some types of special/inclusive schools and school counselling centres were selected.

Theoretical orientations of arts therapies in schools. The work environment influences theoretical background and preferred therapeutic principles, according to some authors. For example, Karkou (2010) writes that AT in schools have a closer relationship to learning theories, needs of pupils and demands of educational institutions. Karkou & Sanderson (2006) found (although with a low statistical significance) that the humanistic, developmental, active/directive and artistic/creative therapeutic principles are preferred by arts therapists in schools. In another paper on music therapy in educational environment McFerran (2010) had analysed theoretical orientations and found that they were mostly psychodynamic (52 %), humanistic (44 %) and behavioural (12 %).

The author realised an overview study with the aim to identify various theoretical orientations of AT in educational institutions (Kantor, in press). For the purpose of the analysis papers in the ERIC database, books and chapters thereof in English, Czech and Slovak language and an online search were used. The identified categories of theoretical orientations were described as active/directive, eclectic/integrative, community-based, artistic/creative, instructional, developmental, neuro-rehabilitative, psychotherapeutic, and others. Most of these categories were divided into several subcategories. Also, numerous papers connected to therapeutic arts and other related disciplines were identified. These results indicate that the spectrum of theoretical orientations of AT in schools is broad.

Typical goals of arts therapies in schools. Siegel (2016, p. 436) states that the aim of art therapy in educational environment is to *"help students cope with social, emotional, cognitive and behavioural barriers that hamper successful access to learning opportunities."* Also according to other authors (Chase, 2004; Hayes, 2016; Karkou, 2010), typical goals of AT in schools are connected to functionality (communication, mobility, self-service, cognitive

abilities, etc.), emotional and social area, learning process, therapy of various traumas and reducing the risk factors in the school environment (e.g. physical violence, bullying). A specific area of AT in the context of education is healing of mental traumas that are responsible for learning difficulties (Ottarsdottir, 2010) and the help to cope with stressors that occur in the school environment (Isis et al., 2010). Králová (2015) stresses several aspects that are responsible for pupil´s quality of life in context of music therapy.

Due to the interconnectedness of AT and special educational institutions, arts therapists in Czech Republic are particularly encouraged to focus on the development of functional abilities and support the learning process of pupils with special educational needs. The participation of arts therapists in prevention programs is not as common in the Czech Republic as it is elsewhere.

Organisation of arts therapies in schools. The form of intervention can be provided on the basis of different models, but generally it includes individual/group design and consultation/cooperation of therapists with pedagogical staff (Siegel, 2016). Johnson (1996) makes a similar distinction between so-called direct and consultative services, where direct services involve the implementation of therapy in special classes, inclusive classes or in a different pull out area. The current trend of inclusive education strengthens the importance of consulting services provided by arts therapists.

Therapists have varying privacy requirements during the therapeutic process according to their therapeutic approach, the therapeutic form and the fact whether the therapy involves work with confidential personal information (Moriya, 2011). The literature describes models of therapy with the whole class (Feldman, Jones & Ward, 2009) or even integration of AT into the educational process (Henley, 1997). According to Karkou (2010), it is necessary to distinguish whether therapy is focused on a pupil, the whole class, the teacher or the entire school community. Work with the whole class and school community corresponds to the social model of disability/disease and coincides to current inclusive tendencies (McFerran & Rickson, 2014).

It may be useful to include a particular member of a pedagogical team into the therapeutic process, if this does not contradict the requirements for privacy. This member becomes a link between work of the pupil in the therapy and in the classroom (Davis & Rosscornes, 2012). Continuing education of teachers and other pedagogical staff is needed so that they can understand the differences between the education and the therapeutic process (O'Neill, 2012; Pethybridge & Robertson, 2010).

Assessment of arts therapies in schools. Special types of arts-based assessments were designed for educational institutions. For (special) educational institutions the Art Skills Assessment for Special Education Students (Troeger, 1992), Kinetic School Drawing (Knoff & Prout, 1985), Music Therapy Special Education Assessment Tool (Langan, 2009), Special Education Music Therapy Assessment Process (Brunk & Coleman, 2000) are available. Therapists can further bring valuable contribution to the assessment of development (Levick, 2011), interaction and artistic involvement (Nordoff & Robbins, 2007), diagnosis of special needs (Silver, 2009; Oldfield, 2006 or Kalish, 1976), etc. There is no information on assessment of Czech arts therapists in educational institutions.

Methodology of the research

The qualitative part of the research was designed after finishing the quantitative analysis, the methodology and results of which are described separately (Kantor et al., 2016). According

to Hendl (2008) it is a sequential model of a mixed research design. The intention to understand some of the specific aspects of AT in the educational environment was formulated into the following research question: *"How does the work environment of educational institutions affect the realisation of arts therapies?"*

Methodology used semi-structured interviews with 18 arts therapists and qualitative content analysis. The research group consisted of two sub-samples: 8 arts therapists working in educational institutions, and 8 arts therapists from healthcare institutions. Participants from healthcare institutions were included for the purpose of comparison and easier identification of the specifics of AT in schools, as healthcare institutions represent a highly different work environment.

The design of semi-structured interviews included these topics:

- Therapeutic, artistic or other qualification of the participants, their motivation to work in educational/healthcare institutions, description of therapeutic practice, etc.
- Characteristics of the therapeutic approach, its development, main theoretical background, examples of intervention procedures, specific ways of linking the creative process with basic therapeutic principles, relation to the intermodal concept of expressive therapies, etc.
- The analysis of the way the educational/healthcare context affects the realisation of AT in terms of goals, documentation, organisation, ethical demands, interdisciplinary cooperation, etc.
- Characteristics of procedures and materials for the assessment/evaluation.

In order to assemble additional information, various documents and materials related to the realisation of AT were collected and analysed (photos, artistic products, records of therapeutic meetings, therapeutic documentation, etc.).

For the analysis, the inductive thematic analysis (including comparative analysis and an interpretative approach) was used. Inductive thematic analysis is defined as a *"rigorous, yet inductive, set of procedures designed to identify and examine themes from textual data in a way that is transparent and credible"* (Guest, MacQueen, & Namey, 2012, p. 15). The analysis process was carried out in several steps, including reading and segmenting text, identifying themes, and content coding.

For this procedure following definitions were used:

- Theme is a unit of meaning that is observed in the data by a reader of the text (Guest, MacQueen, & Namey, 2012).
- Codes are highlighted units of text that can identify a particular idea. They may relate to one or more words and include surrounding data (Braun & Clarke, 2006). The identification of themes precedes the identification of codes, because *"codes represent a greater level of abstraction than themes, and a single theme can engender multiple codes"* (Guest, MacQueen, & Namey, 2012, p. 52).
- Categories and subcategories are groups of codes assigned to each other on the basis of similarity or relationship (Hsieh & Shannon, 2005).
- Meta-themes are conceptually comprised of two or more data-driven themes that correspond to content codes. They are at a higher level of abstraction and are not directly observed in the data (Guest, MacQueen, & Namey, 2012).

During the process of coding three general sets of aims as outlined by W. J. Gibson and A. Brown (2009) were addressed: examining commonalities, differences, and relationships. The process of inductive thematic analysis was associated with an interpretative approach (Ženka & Kofroň, 2012). For each participant, it was necessary to determine whether the data could be interpreted on the basis of existing theories (most of them described in the first

chapter). The next step of the research process was comparing the material of the thematic areas of each participant within the sub-samples of educational and healthcare institutions, then comparing the results of these sub-samples to each other and synthesising partial conclusions into the final results.

Research sample

The research sample (18 participants) were divided into two sub-samples – 8 participants from educational institutions, 8 participants from healthcare institutions and 2 participants with sufficient experience for inclusion into both samples (each of them was included in a different sub-sample). The criterion for participation in the research was:

- Qualification in some area of AT (although not with the demand to fulfil the standards defined by professional associations, participants with high level of qualification, experience and expertise were preferred).
- AT practice in some type of educational or healthcare institution.
- The possibility to realise the interview and share documents and materials, if needed to understand the therapeutic practice of the participant.

Potential participants were reached first through AT associations and further through recommendations from professional members of these associations (personal contacts of the author were also used). The description of the sample can be found in the Table 1. The participants were coded by the combination of a number and a letter signifying the educational institutions (E) or health care institutions (H). Two participants belonged to both samples (they were coded as EH1 and EH2).

Table 1. Overview of basic data on participants[1]

Type of institution:		**Educational**	**Health care**
Areas of arts therapies	Music therapists	8	4
	Art therapists	1	2
	Drama therapists	1	1
	Dance-movement therapists	0	3
Gender	Male	4	0
	Female	5	9
Type of educational institutions	Kindergarten	7	0
	Elementary schools	8	1
	Inclusive schools	7	1
	Special schools	7	0
	Schools for teaching arts	1	0
Type of health care institutions	Hospitals	1	7
	Outpatient practice	0	2
	Other (spa, sanatorium, etc.)	0	1
Primary qualification	Special education	6	3
	Other pedagogical qualification	2	0
	Psychology	2	2
	Clinical psychology	0	3
	Medicine (psychiatry)	0	2
	Physiotherapy	0	1
Relationship to the employer	External employee	9	2
	Internal employee	2	7

[1] Some participants were included repeatedly in different categories if they fulfilled their criteria.

Results and their interpretation

During the analysis, codes were divided into several meta-themes: 1. theoretical background and therapeutic principles, 2. work environment and team, 3. the therapeutic process. The main research findings are summarised in Table 2.

Theoretical background and therapeutic principles. Both types of institutions represent a wide range of therapeutic principles. Table 2 shows the therapeutic principles for both working environments. Some patterns were more typical in some types of institutions or client groups (eg. preference psychoanalytic/psychodynamic principles for clients with psychiatric disorders or active/directive trends in persons with neurological disorders), but in general, there were no characteristic therapeutic principles or theories related to the working environment (educational vs. healthcare institutions).

Table 2. Categories of therapeutic principles in educational and health care institutions (ordered from the highest to the lowest data saturation)

Type of working environment	Therapeutic bases (therapeutic principles)
Educational	Humanistic, eclectic/integrative, active/directive, artistic/creative, marginally also instructional, analytical and psychodynamic with spiritual, biomedical and body-oriented influences
Healthcare	Psychoanalytical/psychodynamic, humanistic, eclectic/integrative, active/directive, artistic/creative, family and biomedical

Work environment and team. This meta-theme included the categories of team collaboration, qualification, understanding of the specifics of work/the role of arts therapists and the influence of arts on the whole institution.

Team collaboration is more pronounced in healthcare institutions due to the vast diversity of professions that are part of an interdisciplinary team. This concerns hospitals or institutional treatment, since in outpatient practice interdisciplinary cooperation is often low. Similar is the difference between inclusive schools and special schools. In the latter case the availability of the different professionals is better than in inclusive environment. The table 3 compares team collaboration of one participant from inclusive educational institutions (E3), special school (E8) and one participant from health care institutions (H3) that represent the typical team for their settings. The consequences of this difference influence the therapy, eg. by the possibility of proper interdisciplinary assessment which is often missing in educational institutions.

Table 3. Comparison of team collaboration in educational/health care institutions

Participant (type of institution)	Professions available	Professions available from external facilities
E3 (inclusive school)	Teachers, teacher´s assistants, school special educator, school psychologist.	The counselling centre (special educator and school psychologist).
E8 (special school)	Special educators, teacher´s assistants, social worker, physiotherapists, employers in the social care (the school is a part of a non-profit organisation offering education and social care services).	The counselling centre (special educator and school psychologist).
H3 (hospital – rehabilitation clinic)	Doctors of different attestations (rehabilitative medicine, cardiology, neurology, etc.), physiotherapists, occupational therapists, clinical psychologist, social worker, special educator, dance movement therapist, speech therapist.	Broad spectrum of different health care services from other departments in the hospital.

In educational setting the primary **qualification** is in special education or psychology while in healthcare setting the qualification in some healthcare profession is required. This situation is caused by the absence of the law for regulating the profession of AT. In spite of this, some arts therapists with primary qualification in special education have therapeutic practice in healthcare institutions (this example was represented by EH1 and EH2 in the research sample). Their experiences offered several examples of good practice that could be used for creating a legislative regulation for non-health professions in healthcare institutions (e.g. clear specification of their roles and therapeutic competencies towards clients in cooperation with healthcare professionals). This topic is also current.

Generally the health care system requires higher qualification and therapeutic competencies than educational institutions (it is evident from the requirements for attestation in health care disciplines, eg. clinical psychology). This situation creates a hierarchical system in the community of arts therapies which was reflected also in the data. Some participants from health care institutions mind that arts therapies are practiced also by special educators (eg. H8).

Insufficient **understanding of the therapeutic roles** of arts therapists/the specifics of their work requires staff training in educational institutions. Insufficient understanding is caused by the idea of the complementary character of arts therapies (E4), by the fact that the therapeutic process has not as transparent outputs as education (E6), and that the therapeutic processes is rather hidden to direct observation (E5). For teachers it may be difficult to accept the therapist who is often considered as a more advanced expert. The presence of pedagogical professionals in the therapeutic process may be advisable as well as counter-productive, depending on the particular case (both types of experiences were referred by participants). E1 and E6 suggest that it is useful to make a contract with the teacher in the beginning of therapy concerning their role in the therapeutic process.

Arts therapists can **influence** both types of institutions through artistic medium. However, in healthcare setting, the change of the whole institution is more noticeable (E5), because in educational institutions arts are already present (although not in the form of therapeutic applications).

Therapeutic process. This meta-theme consists of categories relating to the formulation of therapeutic contract, therapeutic goals, organisation, therapeutic room and privacy and assessment/evaluation. **Formulation of therapeutic contract** with all relevant parties requires greater effort in educational institutions, because the formulation of the contract is often not clear (E6), the management of the institution does not have clear referrals for therapy (E4), teachers´ ideas about therapy are sometimes even opposed to the therapeutic process (EH2), and the therapist has to make much more effort to achieve a clear contract than in healthcare institutions (EH1). The relationship network and the contract are wider than the dyadic relationship between the client and the therapist in educational institutions and therefore a three-party contract (including pupil, parents and institution) and a number of informal contracts with pedagogical staff (E5, EH1) must be formulated.

The therapeutic goals in educational institutions are primary of social (integrative), preventive, educational and functional character. Table 4 offers a more detailed description of different categories of therapeutic goals that were identified in the process of coding. Compared to healthcare institutions the focus on personality development and health promotion is typical for educational institutions.

Participants repeatedly mention that educational institutions are performance-oriented and they need to create enough space for the pupil´s emotional experiences in the creative process (E5). Ve školách žáci potřebují dostatek času na prožitek s uměním a hodně pozornosti se věnuje práci na vztahu důvěry (E8), terapie je mnohem více orientovaná na žáka, na jeho emocionální prožitek (E6, EH1) a kreativitu (EH2). Healthcare institutions are more behavioral and symptomatically oriented, and the specificity of child psychiatry is also to convey a positive experience (EH1). In addition, a well data-saturated category of psychodynamic and causal-oriented psychotherapeutic treatment (H5, H6, H7) emerges in the subsample of arts therapists in healthcare institutions.

Table 4. Categorisation of therapeutic goals in educational institutions

Categories	Subcategories	Examples of goals
Preventive	-	Prevention of educational and social failure and exclusion, orientation on healthy living style, relaxation, enhancing the social relationships in the classroom, etc.
Therapeutic	Physical level and movement	Supporting breathing, development of movement functions, synchronisation of brain hemispheres, enhancing muscle tonus and activation of body functions, focusing the attention on pleasant stimulus during perceiving pain, etc.
	Psychic level	Development of cognitive functions, support of imagination and intuition, self-confidence, awareness of self, the body and the voice, enhancing identity, supporting creativity, therapy of traumatic experience, understanding one´s emotions, etc.

Continued Table 4

	Communication and social goals	Development of speech, ability to express, self-assertion in communication, mediating the contact with the group, training of alternative communication through arts, awareness of others in group activities, etc.
	Behaviour	Treating the maladaptive behaviour, abreaction and an outlet for aggression and other emotions.
Educational and formative	-	Motivation to educational activities, self-knowledge, development of creativity and intuition, supporting relationships to nature and environment, mediating the experience with sound and vibrations, meaningful free-time activities, etc.

Organisation: In both types of institutions there are difficulties in creating an appropriate, undisturbed space and equipment for therapeutic process (most of participants talked about this problem). In addition, it is more difficult for educational institutions to protect pupils' privacy and confidential information (E5, EH1 or EH2). The therapeutic process is also negatively affected by some other factors, such as organisation of the school year (E2), disrupting the therapy due to holidays and school events (E6, E7), finding a suitable time in the day with regards to pupils´ fluctuating levels of energy (E8), etc. Due to formal obstacles AT are sometimes offered as leisure time activities in schools (E1, E8). Some participants have doubts whether parallel roles of the teacher and the therapist are counterproductive (E2).

Part of the organization is also the preference of a form of therapy. Arts therapists in educational institutions more often refer to the community-based form of therapy, working with whole classes (E1, E4, E5, E7, EH1). Working with the whole class can be supplementary to individual therapy with a lesser frequency (E5). In healthcare institutions, community work is usually the equivalent of family therapy (H2).

The assessment/evaluation of therapeutic process seems to be indifferent to the type of institution (the differences are not related directly to AT but rather to the institutional practices generally). In both type of institutions there are cases when assessment/evaluation is not required from arts therapists (E2, H3), but the healthcare context creates more pressure on therapists to communicate the conclusions of therapy in their interdisciplinary team (H5, H6 or H7).

Categories connected to assessment/evaluation focus on depth and nature of the assessment, methods of assessment, assessment of content, organisation of the assessment process and other themes. In the practice of Czech arts therapists, there is a strong tendency towards qualitative evaluations, which combine mainly observation and reflection of the artistic process with verbal procedures (clinical interview). We also encountered theoretically sophisticated assessment procedures, typically Laban movement analysis (H5, H6, H7), one standardised art therapy assessment (H8) and some original assessments of music therapists (E5).

Table 5. Summary of differences between arts therapies in educational and healthcare institutions – environment and team

Educational institutions	ENVIRONMENT AND TEAM	Healthcare institutions
Lower (especially low availability of healthcare professions)	**Presence of different professions in the team**	More diverse (not applicable to outpatient practice)
Special education (inferior therapeutic competencies – not qualified for the healthcare environment)	**Primary qualification and therapeutic competence**	Relevant healthcare qualification (higher therapeutic competencies)
Lower (AT are less congruent with pedagogical framework)	**Understanding the roles and work of arts therapist**	Higher (AT are more congruent with the therapeutic framework of healthcare institutions)
Less important (arts already present, albeit in a different context)	**Impact of arts on the institution**	More substantial (arts often absent)
The changes are rather superficial, symptomatic and associated with the learning environment.	**The depth of therapeutic change**	The possibility of profound changes in the psychodynamic organisation of personality.

Table 6. Differences between arts therapies in educational and healthcare institutions – therapeutic process

Educational institutions	THERAPEUTIC PROCESS	Healthcare institutions
Greater effort needed to specify the contract and to sign the three-party contract of the institution-pupil-therapist (according to the nature of the planned intervention). Issues of parallel roles.	**Formulation of therapeutic contract**	Easier formulation of the contract with much narrower focus and specification.
Primary focus on health promotion, personality development and experience. Objectives have a social (integrative), preventive, educational, and functional character.	**Therapeutic goals**	Primary focus on pathology and its mitigation/elimination.
In addition to providing undisturbed and appropriate room, the issue of privacy protection and the organisation of the school year is present. Formally, schools sometimes offer AT and its practices within lessons or leisure time activities.	**Organisation of therapy, therapeutic room and privacy**	Difficulties can be the creation of room and the provision of material equipment.
The content of the assessment/ evaluation related to objectives specific to the educational institution.	**Assessment/evaluation**	The content and methods of assessment/evaluation related to objectives specific to healthcare institutions and procedures used outside the context of the creative process.

Discussion

Both educational and healthcare institutions are very heterogeneous work environments, enabling considerable variability of the therapeutic practice. Based on research findings, several meta-themes were identified that describe the main characteristics of AT in educational institutions (see Table 4 and Table 5). These relationships could not be found when comparing the theoretical background and type of institution. Also quantitative part of the research (Kantor et al., 2016) proved that approaches of AT, their theoretical background and characteristics are only minimally dependent on the work environment and can be applied in different types of educational and health institutions[2]. Many arts therapists practice their approach in different types of work environment. In Czech Republic specifics of AT in educational institutions can be found namely in categories related to environment, team and therapeutic process (see previous chapter).

The above mentioned specifics correspond to the findings of theoretical analysis summarised in the first chapter, therefore the importance of the study can be found in deeper understanding the differences between AT in educational and healthcare institutions. Analysing the therapeutic practice in educational institutions reveals and describes new identities of AT (primarily considered as healthcare professions). This fact stresses interdisciplinary relationships to pedagogical and social disciplines, importance of social aspects of disability, concept of health rather than illness, etc. (McFerran & Rickson, 2014).

The outcomes of the study were discussed in regards to the disciplines of AT as well to special education. Because the educational institutions create a specific work environment with characteristic demands, guidelines for practice of arts therapists specific for this setting would be useful. Such guidelines could be based on the research findings, including the findings of theoretical analysis, relevant literature (Moriya, 2011) and educational setting standards of other professional associations.

In the Czech Republic, arts therapies are often practiced by special educators. The development and growth of undergraduate and postgraduate programs in AT can create sufficient number of arts therapists in educational institutions and promote the interdisciplinary transfer of relevant practices to the area of arts-based (special) education (Anderson, 1996; Mardirosian & Lewis, 2016). Examples of these practices are in developmentally and functionally appropriate artistic experiences, instructional artistic practices for rehabilitation, community activities for enhancing social participation, etc.

Another area for interdisciplinary cooperation of AT and special education is in the process of assessment/evaluation, because there is still a lack of assessment methods, especially for pupils with severe and multiple disabilities (Hrebeňárová, 2013). The range of arts-based assessments covers a large area of degrees and types of special needs, and they can be used for differential diagnostic needs (Kalish, 1976), for creating a therapeutic plan (Baxter et al., 2007), for indication of AT (Brunk & Coleman, 1996), for evaluation of therapy (Carpente, 2013), etc. The research findings concerning assessment/evaluation are particularly useful given the fact that there is only little information about arts-based assessment in Czech Republic and no information about assessment in educational institutions.

[2] R. Syrovátková explains the specifics of Czech AT through the theory of a *broken field* (a term borrowed from gestalt therapy). The prognosis of the future development of AT is difficult to predict here, the development has been disintegrated at various stages, influenced by a variety of impulses, etc. (from a discussion at annual meeting of Dance movement therapy association of the Czech Republic, 15th May 2017).

There are various ideas for continuing the research. There is a need to deepen understanding of how work environment influences the practice of arts therapists, which on one hand, means that also other types of work environments should be added into the analysis. On the other hand, such types of educational institutions need to be selected that are different enough to enable results drawn from a comparison with the intention to identify the unique and characteristic patterns of therapeutic practice.

The conceptualisation of the research problem that had then been explored qualitatively and described in this paper, emerged from quantitative research. Methodological demands on the qualitative part of this research were adapted to its (rather) complementary nature. Although the author has extensively addressed some of the criteria that determine the validity of qualitative research (e.g. by applying reflexive dialogue), it was not the purpose of this part of the research to create a theory saturated by data or to apply triangulation techniques at different levels of data analysis. As a part of discussion about credibility and validity of the study, the procedure called EPICURE (Stige, Malterud & Midtgarden, 2009) was used:

Engagement: The author had good access to the studied phenomenon, through his own experience and personal knowledge of the environment (which was, however, much lower when analysing data of healthcare institutions). Unfortunately, it was not possible to set up a research sample with a uniform representation of all the professions of AT.

Processing and interpretation: The advantage was in the possibility of comparing the qualitative data with the conclusions and with the framework of the quantitative part of the research.

Critique: The weakness of the research is that case studies are missing and research has not taken into account the pupils´s point of view.

Usefulness: The study is useful for the professional growth of AT and related pedagogical disciplines (special pedagogy), for the development of their theories and also for the growth of the therapeutic practice. Generalising research findings outside the context of Czech therapeutic environment may be misleading in some aspects.

Relevance: Conclusions of research bring innovative stimuli even in the context of the international scene of AT. The relevance of the study is, of course, limited by a lower number of participants and its scope since it used a mixed design.

Conclusion

Knowing the specifics of AT in educational institutions strengthens interdisciplinary cooperation between AT, special education and other pedagogical disciplines. Determining how the work environment affects the practice of arts therapists helps to uncover new identities of these disciplines. Educational institutions belong to an environment the specifics of which are only gradually being understood and the importance of which is increasingly recognised by arts therapists. This is especially true for the Czech Republic and supporting the research in this way may contribute to the growth of AT internationally.

Funds. Kvalita života osob se speciálními potřebami v aktuálním výzkumném kontextu (IGA_PdF_2017_013).

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SPECIFICS OF ARTS THERAPIES IN EDUCATIONAL INSTITUTIONS COMPARING THE INSTITUTIONS OF HEALTHCARE SETTING

Summary

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Educational institutions are the second most important work environment of arts therapists in the Czech Republic as found in a recently realised research (Kantor et al., 2016). Notwithstanding this fact it is surprising how little is known about specifics of this work environment and on the therapeutic practice.

This qualitative study was suggested as a part of mixed research design (the sequential model type). In this study, 18 arts therapists from educational and healthcare institutions in the Czech Republic helped to understand specifics of therapeutic practice in educational institutions through semi-structured interviews, and analysis of different documents such as artistic products, documentation of therapeutic process, photos, recordings, etc. Arts therapists from healthcare institutions were included in this study for the purpose of identifying characteristic patterns of practice in educational institutions based on a comparison of the two environments – educational and healthcare. The research sample was divided into a sub-sample of participants from educational institutions (8 participants), and a sub-sample from healthcare institutions (8 participants), while 2 other participants could have been included into any, so each had been added into one of the sub-samples. Inductive thematic analysis with a procedure of coding was used to identify codes, subcategories, categories and meta-themes and then to compare findings from both samples.

The meta-themes were labelled as theoretical influences and therapeutic principles (1), the team and the environment (2) and the therapeutic process (3). These themes included the following categories: presence of different professions in the team, primary qualification and therapeutic competence, understanding the roles and work of arts therapist, impact of arts on the institution, the depth of therapeutic change, formulation of therapeutic contract, therapeutic goals, organisation of therapy, therapeutic room and privacy and assessments/evaluation. Only in the second and in the third meta-theme it was possible to find differences between educational and healthcare institutions.

The findings were discussed in the context of professions of arts therapies, special education and other pedagogical disciplines. The results of the research can be used for creating guidelines for practice of arts therapies in educational institutions—a specific work environment with characteristic demands and challenges. Moreover, understanding and promoting interdisciplinary relationships between arts therapies and special education may be very helpful for the growth of both disciplines. Due to the absence of relevant legislation in the Czech Republic arts therapies in educational institutions are mostly provided by professionals with primary qualification in special education or psychology. Some findings (e.g. assessment/evaluation procedures used by arts therapists) were novel in the national context, as there is only little information available on these topics here.

Educational institutions belong to an environment the specifics of which are only gradually being understood and the importance of which is increasingly recognised by arts therapists. This is especially true for the Czech Republic and supporting the research in this way may contribute to the growth of arts therapies internationally.

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