A programme of discussions, workshops and events exploring the contribution of the Arts in healthcare and health promotion.

Organised by
the Centre for Health Education and Research
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Canterbury Christ Church University College
2001 - 2002

Edited by Sally Robinson & Stephen Clift

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Contents

Acknowledgements

Arts, Well-being & Health at Canterbury Christ Church University College
Sally Robinson & Stephen Clift

The National Network for the Arts in Health
Lara Dose

Arts and Healthcare

The effects of the visual and performing arts in healthcare:
Arts and health at Chelsea and Westminster Hospital
Rosalia Staricoff & Jane Duncan

Theodora Children’s Trust:
Clown-doctors for children in hospital
Joannie Speers & Colin Mahler

Visual arts in Kent and Canterbury Hospital
and the Pilgrim’s Hospice, Canterbury
June Pritchard & Jenny Tyler

The role of music in occupational therapy and
residential care for the elderly
Graham Duerdon & Trish Vella-Burrows

Arts and Health Promotion

Survivors’ Poetry and the value of literature for
mental health
Alison Coombes

Imagination Time: the role of literature for
children in hospital
Natasha Innocent

The Sound Start Project: the value of singing to
babies in the womb and after birth
Maggie O'Connor

Workshop on drumming, gender and health
Julian Raphael & Sarah Hoskyns

Workshop on music and its value for health
June Boyce-Tillman

Humourworks! The value of humour for well-being
and health
Sharon Eden

Arts, Well-being & Health Programme 2002-2003

Suggested reading

Useful websites
acknowledgements

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Sally Robinson and Stephen Clift describe the development of the programme.

The Arts, Well-being & Health programme of discussions, workshops and events set out to explore the contribution of the Arts in healthcare and health promotion. The idea was conceived on May Day 2001, during a train journey from Canterbury to London to visit Lara Dose at the National Network for the Arts in Health. Stephen Clift had recently started evaluating the Sound Start project on the Isle of Wight in which mothers were being encouraged to sing to their unborn babies and he and Grenville Hancox, Professor of Music at the College, were pursuing research on the perceived health benefits of choral singing with members of the University College Choral Society (Clift and Hancox, 2001). Sally Robinson was in the process of planning a mental health promotion course for nursing students in which raising their awareness about the potential of the arts to improve emotional health was a key feature. Sally had also recently paid two visits to the Chelsea and Westminster Hospital. During the first she attended an exquisite piano recital and heard about the groundbreaking research going on to evaluate the impact of performing and visual arts in the hospital. On the second, she attended a celebration of a project called ‘Imagination Time’ where children’s books had been put into London hospitals and had given enormous joy to hundreds of sick children.

By the time the train arrived in London we had a list of the people we wanted to come to Canterbury to help us establish the arts as an important component within our work in health promotion, and to inspire others across the college to explore the role of the arts and humanities in healthcare. We quickly added to the original list, as we kept hearing about people doing wonderful work: David Aldridge who has made such significant contributions to the field of music therapy, Alison Combes at Survivors’ Poetry who works to advocate literature as a tool for healing, the colourful clown doctors from the Theodora Children’s Trust who bring joy and laughter to children in hospital, and Sharon Eden who popped out of the Internet with a huge smile and a lot of laughter.

We were also keen to profile work in arts and health going on in and around Canterbury, and invited presentations from Jenny Tyler on the place of visual art at the Pilgrim’s Hospice, June Pritchard on art therapy with patients at the Kent and Canterbury Hospital, Graham Duerdon on the use of music in the context of his work as an occupational therapist in the local mental health services unit, and Trish Vella-Burrows on the role of music with elderly people in long-term residential care.

Most of the events took the form of engaging presentations and discussions and were held in the evening, although longer weekend workshops led by Julian Raphael and Sarah Hoskyns on drumming and percussion, and June Boyce-Tillman on music and health, gave participants the opportunity to more actively explore the links between musical participation and personal well-being. Grenville Hancox also proposed that we should include a choral singing event in the programme, and suggested a performance of Verdi’s Requiem in Canterbury Cathedral, open to anyone willing to come for at least two rehearsals before the event. Proceeds from the concert would go to support the work of the Theodora Children’s Trust.

Having drafted out what was rapidly becoming a rather ambitious programme, we approached South East Arts with a request for financial support, and as it turned out, our timing couldn’t have been better. Emma Stephens had recently been appointed as a part-time officer with a brief for Arts and Health, and with her help we developed a proposal for funding an Arts, Well-being and Health initiative, which would run over two years and would have three aims:

- to provide opportunities for focused, critical discussion on the diverse inter-connections between the arts and health that would be of interest to both arts and health professionals and practitioners across Kent
- to facilitate the establishment of a Kent-wide network of professionals and practitioners interested in the arts and health
- to explore possible avenues for further developments in practice, evaluation and research on the connections between the arts and health
opportunities for emotional and creative expression and as providing a vehicle for reducing stress and enhancing relaxation. In all these respects the arts serve to enhance personal and social well-being, and so make a positive contribution to health understood as a holistic balance involving mind and body. The following comments capture the ideas expressed over and over again in the feedback received:

At the same time, our participants were realistic about the pressures and difficulties that can prevent the best use of the arts in health promotion and health care, and the need for further encouragement, training, research and funding to support developments in this field:

This report is about spreading the word and helping to meet the three objectives we set for ourselves at the outset of this initiative. We hope it conveys some of the interest, stimulation, enthusiasm, poignancy, innovation and fun, which characterised these events. We hope too that it will encourage more people to attend the second programme of Arts, Well-being & Health events already planned for next year.


The application for financial support was successful and this allowed us to appoint Trish Vella-Burrows as a part-time Arts and Health Officer, whose role would be to assist in the organisation and evaluation of the programme. Further overtures to the local pharmaceutical company Pfizer secured funding for a report on the programme, and the Health Development Agency in the South East agreed to provide funds for printing publicity material.

And so we were set to begin the programme during the afternoon of October 30th with a major presentation on music therapy to be given by Prof. David Aldridge from the University of Witten/Herdecke in Germany. Unfortunately, this did not happen as David had to cancel his trip to Canterbury at very short notice due to serious illness. We had, however, also arranged for Lara Dose, Director of the National Network for Arts in Health to speak that evening following a launch reception. This attracted a great deal of interest and set just the right context for the rest of the events, which followed.

As organisers we were very satisfied with the numbers of people supporting the programme (over 300 attendances in total), and the consistently positive feedback they offered. In this report we have tried to give a flavour of each event and the work of our presenters. We also provide examples of comments given by participants and useful additional information coming from relevant research on different art forms and their potential benefits for well-being and health.

The people who came along to the events included: lecturers, nurses, occupational therapists, public health development officers, health promotion specialists, artists, students (in nursing, music, visual arts and education), musicians, retired people, health visitors, midwives, teachers, local authority housing officers, local authority arts development officers, hospital arts co-ordinators, people working with Alzheimer’s patients, workers in and managers of residential homes and carers of the elderly.

People coming to the events were generally positive about the contribution of the arts to health. The arts were seen as enriching the quality of people’s lives, giving opportunities for emotional and creative expression and as providing a vehicle for reducing stress and enhancing relaxation. In all these respects the arts serve to enhance personal and social well-being, and so make a positive contribution to health understood as a holistic balance involving mind and body. The following comments capture the ideas expressed over and over again in the feedback received:

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The National Network for the Arts in Health emerged out of research that was conducted by the King’s Fund. This identified a need for a UK-wide organisation to provide information, resources and networking opportunities for people interested in the field of arts and health. The research also identified some basic things that the national network should provide. Firstly, a membership directory, so people would know who was working in arts and health in their area. Secondly, a funding guide, since everyone seemed to be looking for money to support arts and health work. Thirdly, a bibliography of research and resources to assist decision-makers in the health service who might be considering whether to implement an arts programme.

The board of the National Network wanted it to be launched ‘as a success’ and so members of staff were appointed in April 2000 and the official launch was scheduled for October 2000. Before the launch we aimed to have a membership and all of the benefits of membership in place. So over six months we had a great deal of work to do! By the launch we had nearly 100 members and the facilities to support their needs. By the end of the first financial year, the membership stood at about 250 and it has grown to just over 500 in the past year. Currently the membership of the National Network represents 32 different arts forms.

We knew at an early stage that we would have a lot of information which we could disseminate to a national audience, so one of the first things we did was to set up the National Network website (www.nnah.org.uk). This became the hub of much of our activity. One of the advantages of having a website is that the web-log allows us to gauge how many people are accessing the site and the areas in which they are spending most time. Also there is a facility for visitors to enter the site and ask for information. This, together with phone enquiries, has been very helpful in relation to updating and modifying the site. For example there were some basic questions, which many people were asking repeatedly, and so we included fact sheets on the web site. Research and evaluation was a particularly common topic, as was people wanting to know how to get started with arts and health projects, whether in the community or in a healthcare setting.

The National Network has endeavoured to be responsive to the needs of its members. People basically wanted to hear from us more often, and also it was clear that not all members had ready access to the website and would appreciate more printed resource material. A monthly newsletter would have been too expensive, but a monthly mailing was possible. So we have produced a printed resource guide and introduced a monthly mailing - giving details of forthcoming events, conferences, workshops and so on.

Recently the National Network, in collaboration with the Centre for the Arts and Humanities in Health and Medicine (CAHMH) at Durham University, has run a series of four regional road shows (three in England and one in Scotland), with funding from the Arts Council for England and the Scottish Arts Council. The road shows aimed to build on some of the best elements of the two organisations: dissemination and networking on the part of the National Network, and research and evaluation from CAHMH. Each of the four events had an evaluation theme, but a different focus, and aimed to showcase work going on in each region. Round table discussions were also organised during the day to allow participants to get to know one another and talk about specific issues to do with arts, health and evaluation. The notes from these round table
discussions are being compiled at the moment and will form the basis of a forthcoming publication. These discussions provided an invaluable opportunity to get the views of practitioners about the contentious issues raised by evaluation.

Looking to the future, the National Network will increase its advocacy role for the arts and health with the general public. At governmental level there has been a growing appreciation of the value of arts for health and interest has also grown significantly in the arts and medical sectors. So now we need to get the general public behind this area of work, to ensure that they understand what arts and health is all about. The aim is to get articles into the mainstream media so that the general public can appreciate that they have choices about the quality of health care settings and the delivery of health care.

To me, the arts have a powerful role to play in contributing to well-being and health. Whether projects are based in a health care setting or in a community context, one thing that runs through them all in my experience is passion. In healthcare settings, the communication of this passion through the arts can significantly improve the quality of the environment for patients, staff members and visitors alike - as the research project at the Chelsea and Westminster Hospital has shown. Similarly in community contexts, the passion involved in how projects are delivered has a direct impact on anyone participating. I know of people who have changed careers because of participating in an arts and health project, or who have changed their eating patterns or begun to exercise, or have lost weight. It’s not because the information was any different from what they were getting through other sources, it’s because of the passion with which the information was delivered.

**responses**

to Lara’s presentation

“Excellent, inspiring, informative and helpful”

“Very positive initiative. The NNAH has the potential to be a very useful organisation.”

“Lara Dose’s talk was effective in stimulating an interesting discussion. She is very informative and enthusiastic.”

“Useful, and I will follow up!”

“Very interesting. It would be a good way to achieve health impact and improvement in Dover, in our areas of deprivation.”

“Vastly interesting and very well presented. It really put into perspective so many relevant issues which although have been brought up, have never been given the light.”

“Stimulating!”

**key events**

Key events in the recent growth of Arts and Health in the UK

1988 Arts for Health, Manchester Polytechnic established
1995 Healing Arts, St Mary’s Hospital, Isle of Wight established
1997/8 Nuffield Conferences on Art and Health, Windsor
1997 Chelsea and Westminster Hospital Arts Research Project launched
1999 Culture, Health and the Arts World Symposium, Manchester Metropolitan University
2000 Centre for Arts and Humanities in Health and Medicine, University of Durham, established
2000 National Network for the Arts and Health established
2001 Enhancing the Healing Environment Programme, King’s Fund, London
2001 The Arts as Medicine: Promoting Health and Well-being through the Arts Conference, Glasgow
The artworks are the first things you see as you enter the foyer: a wonderful collection of paintings, sculptures and murals representing the best of late 20th-century art. In the atrium, you may hear novelist A.S. Byatt or celebrated actresses, such as Patricia Hodge and Janet Suzman, reading their favourite prose or poetry. Your visit could coincide with a concert by the City of London Sinfonia or the Medici String Quartet; then again, that day’s diversion might be a performance of La Bohème or The Barber of Seville by a leading opera company. Yet you are not in an arts centre, nor any cultural or entertainment complex. The setting is the Chelsea and Westminster Hospital in London. (Susan Smails, The Lady, 25-31 May 1999)

Dr Rosalia Staricoff and Jane Duncan talk of the effects of visual and performing arts at Chelsea and Westminster Hospital.

Chelsea and Westminster Hospital Arts was conceived at the same time as the Chelsea and Westminster NHS Hospital was being built in 1993. Since then it has acquired over 1000 works of art, all of which have been funded by individuals, charities and businesses. Live performances occur two to three times per week. All are free and open to the public.

In 1999, Dr Rosalia Staricoff was asked to lead a research project, funded by the King’s Fund, to evaluate the effects of the visual and performing arts in the healing process at Chelsea and Westminster Hospital.

What I can tell you is that the Chelsea and Westminster Hospital is a leader in its field. The idea of integrating arts into the health care environment began with three medical consultants. They formed a committee and commissioned a number of works of art as the new hospital was being built. These included Allen Jones’ The Acrobat, which we have been told is the largest indoor sculpture in the world, and Stan Tucker’s rainbow-coloured mobile, Falling Leaves, which provides movement and distraction. These, and other special works of art fill the atrium, which is overlooked by the windows from the wards. This means that patients can view them from their beds and staff from their offices.

Hospital Arts is an independent charity, which works for the hospital, but is funded by private donations. It does not take any money from the NHS, but it provides visual arts and live performances for the benefit of the NHS. This was the idea of Susan Lopper. This was very challenging and she had firm ideas about aiming for the best in everything. It was claimed that at
every meeting she attended, someone would say, “If we only had evidence that the arts can play a role in health care.”

At that time I was finishing some work as a medical scientist, along with an artist, on a project called SciArt for the Wellcome Trust. This was an initiative to promote collaboration between science and art, and I was extremely interested in continuing to work with artists and all aspects to do with joining science with art. So I wrote a letter to Susan Lopper and she offered me the challenge of trying to evaluate the activities of Hospital Arts using scientific methods. I found that there appeared to be no precedent for this type of work, so I used all that my background had taught me and devised a strategy. This was accepted and the whole thing started in April 1999. The project began with almost no money at first, but when I wanted to start doing the research, such as measuring physiological responses, we sought funding from the King’s Fund who gave us a grant.

The research was pioneering because we were applying scientific methodology, meaning that everything had to be totally objective. The only variable we introduced was either for the patient to be treated in a room containing visual art or live music. So all other factors, including medical factors, remained the same. The studies were blind in that nobody knew what we were trying to find out. We obtained consent from patients with respect to asking them to complete a questionnaire and seeking permission to obtain information from their medical notes. After the intervention had taken place we retrieved the data from the notes in a completely objective way. So we did not observe, and we were not there when the intervention took place. We just provided the environment and then judged the physiological and biological responses of the patient towards the variables.

Now I think that people are more aware of the importance of the environment and particularly the incorporation of the arts and music into a therapeutic healthcare environment. I hope that this will be totally understood by the authorities. To be honest, the best thing that can happen in the future would be that the authorities understand that this can be cost effective because it can reduce recovery time and the length of stay in hospital.

Jane Duncan has worked alongside Dr Rosalia Staricoff as a research assistant since the beginning of the project. Jane is the artist in the arts-science partnership, and provides a fascinating insight into her personal journey into the world of Hospital Arts.

I graduated from Chelsea College in 1996. In fact I remember the whole concept of imagery and colour being something that I felt, psychologically, made a difference to me. On my course I remember one tutor who was interested in art and health, and he gave me great encouragement to pursue this interest. It wasn’t, of course, the hot commodity of the day! In the art world conceptual and issue based art was prominent. I was a contemporary of the Damien Hurst era and that was the style that people were looking towards. Although I have great respect for that trend, I was interested in colour and how that affected us as human beings. I really belonged to a different tribe and felt on a limb for a long while. I wondered if there was any scientific way of evaluating the effect of colour and images. Never did I think that I would actually find myself working with a neuroscientist in hospital, but that is what happened.

After I graduated my father got cancer and subsequently died, which I found quite life-transforming really. It makes one more compassionate in a way, thinking about the healing and grieving process. I didn’t do any artwork for a couple of years; I just couldn’t get it together so I worked as a dental nurse for a while. I worked with a dentist who had a painting on the ceiling. His patients got tremendous reassurance from having a distraction and he would ask them to focus on it when they were having an anaesthetic. I found myself using that as a focus for my own work. I wondered if I would ever get back to painting, and I did.

Eventually I saw a concert advertised at the Chelsea and Westminster Hospital, and I went along. That evening I met Susan Lopper and Rosalia Staricoff and told them how interested I was in their work. That was in the October, and by January 1999 I was asked to come and work on the project.

In the hospital I’m working as a research assistant, but firstly I am an artist. I was commissioned to paint a mural in the hydrotherapy room. I researched the function of the room, the patients’ needs and many practical issues. I liaised with Dr James Nobbs, a colour chemist at Leeds University who has an interest in people’s emotional responses to colour, and painted a mural which incorporates bright colours to encourage action. The anecdotal response to the work was so interesting that we went on to evaluate it in the same way as the rest of the project.
It has been one of those amazing stories. It’s been a fantastic project to work on, and I really mean that. We never began for financial gain, but for the pure belief in what we were trying to do. I am privileged to have been a part of such a pioneering project and to have worked with Rosalia. She is an amazing person both as a scientist and a human being. It’s really enriched my life as an artist and led me to great things in my work.

Chelsea and Westminster Arts will be producing a book about the project and its findings in 2003.

key findings

Some key findings from the research at the Chelsea and Westminster Hospital

- 93% of patients, 99% of staff and 96% of visitors reported that they had noticed the works of art within the hospital.
- 80% of patients found art and music helped to distract them from their medical problems and raised their spirits.
- Amongst patients with cancer who were undergoing chemotherapy, both paintings and music lowered depression by about a third.
- In an antenatal clinic, live music helped to reduce anxiety and depression.
- Live music increased the number of accelerations in the heart rate of unborn babies by a factor of four, without any effect on the mother’s pulse (brief accelerations are a good sign of the unborn baby’s health).
- Live performances were more effective than visual arts in helping to take people’s minds off their worries.


responses

to Rosalia and Jane’s presentation

“Very positive. There is great scope for research and development. This research can transfer to other settings such as schools.”

“Very interesting. We are interested in evaluating our theatre work with young people with profound multiple learning difficulties and the very young.”

“Interesting and informative. My work includes a project where we hope to use the arts to prevent heart disease and cancer in the community. I will need to evaluate the projects and use.”

“This is very relevant to my teaching. Students who are caring for the dying benefit from having an increased awareness about the means of improving well-being.”

“I am very interested in the effect of music on the physiological status of the body. I believe that health care could become a more enjoyable and stress-free environment. I agree that the arts are very important in the hospitals.”

“This is particularly relevant to work around ante and postnatal depression. Fascinating.”

“The use of music in maternity care is encouraged, but it could be more generally disseminated.”
In November, clown-doctor Dr. Kiku (Colin Maher) from the Theodora Children’s Trust came to tell us about his work and sprinkle some laughter therapy our way. After the event, Joannie Speers, the director of the Theodora Children’s Trust, talked to Stephen Clift about the Trust and the contribution that clown-doctors can make to the recovery of sick children in hospital.

Q Joannie, could you tell me how the Theodora Children’s Trust started?

Two brothers from Switzerland, Andre and Jan Poulie, wanted to set up something in memory of their mother, Theodora, who had died of cancer and they came across a programme in New York called the Clown Care Unit, where clowns were trained specifically to work with children in hospital. The brothers thought this was a brilliant idea and they decided that setting up a similar programme in Switzerland would be a wonderful legacy for their mother. So a programme was set up in the Oncology Unit in a hospital in Lausanne, and it was so successful that they decided the idea needed to be taken to children everywhere. So over the last nine years, the Theodora Foundation has set up programmes in eight countries in addition to expanding in Switzerland: South Africa, Hong Kong, Turkey, Italy, Belarus, Spain, France and the UK. All told there are probably about 110 Theodora clown-doctors working in about 80 hospitals in these countries (www.theodora.org).

In the UK, the Theodora Children’s Trust was set up in London in 1996. At that point there were two clown-doctors working in Great Ormond Street Hospital, and beginning to visit Guy’s and St. Thomas’s. Now we have ten clown-doctors visiting children every week in those two hospitals, and Addenbrooke’s in Cambridge, Pendlebury and Booth Hall in Manchester and we are about to start in the Southampton General Hospital and the Royal Alexandra Hospital for Sick Children in Brighton, (www.theodora.org/theoeng).
Q And so, what do the clown-doctors do when they visit children in hospital?

First of all, quickly to explain, clown-doctors are very carefully recruited and trained to do this work. Most of them have a background working with children as entertainers. The training programme, which we run in conjunction with King's College, London is a mixture of artistic and medical workshops. The medical workshops are presented by experts from Great Ormond Street, King’s and Guy’s at the moment, and the artistic workshops are run by our own experienced clown-doctors. And then there’s a long period of observation of clown-doctors working in the hospital, and it takes about a year to complete this whole process.

Q What kinds of issues are covered by the training from the medical side Joannie?

We cover things like hospital structure, rules and regulations, and hospital hygiene, which is critical given the problem of hospital infections. We have been told, actually, that our clown-doctors are much more observant of these rules than a lot of people who work within the hospital all the time! We also cover what we call ‘well child development’ and ‘sick child development’ - what the impact of short-term, long-term and terminal illness is on children and also on their families - their parents and brothers and sisters. Also the training includes a certain amount of information about pain management and then quite a lot of discussion about issues that can arise when a child dies, particularly concerning the emotional impact on the clowns themselves. So really, the training tries to examine all the issues that clown-doctors need to be aware of so that they are able to fit in with the hospital regime. The emphasis obviously is on working in partnership with the hospital and all the staff. We are the guests of the hospital and we do not impose anything on the hospital in anyway. In their work, clown-doctors look to nurses and play specialists for guidance in working with individual children. So a lot of work goes into ensuring that what the clown-doctors have to offer fits into the work of the hospital and the therapeutic programmes for individual children.

Q So when clown-doctors go in, typically how much time would they spend with children?

Well it really depends. Each clown-doctor only works a maximum of two days a week in the hospital. It’s very intensive work and is emotionally and artistically challenging for them. The aim is to cover all of the wards in the hospital during the time the clown-doctor is there (once a week or twice a week depending on how many children there are). So they would plan their visit usually in Outpatients and then going through all the wards. Obviously at Great Ormond Street, where there are 250 beds, it takes two days and we have five visits in those two days. As soon as the clown-doctor arrives they are ‘in character’ and they only work in the afternoons, which is after the medical procedures are finished. Clown-doctors work on the wards from 2.00 to 5.30 or 6.00pm and don’t get a break during this period. We estimate that on average one clown-doctor would see up to thirty children during an afternoon, and that will range from a brief interaction with a child, to giving a child more attention for ten minutes or so. One of the things that takes time to learn is how to work out what is appropriate for each child - taking the cues from the child themselves in the light of guidance from the staff.

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**a clown on his rounds**

Dr Strumalong, a clown-doctor, on his rounds

I was at Great Ormond Street Hospital walking through the Reception area, playing my guitar and telling jokes, when I was approached by a mother with a small boy of about 4 years old in a pushchair.

I said hello and asked his name. ‘Charlie,’ said Mum. I tried some jokes and magic tricks, but Charlie was very morose and although he watched he didn’t smile or interact with me. ‘He’s very depressed at the moment,’ said Mum. I carried on, finally kneeling down to play Charlie some of my funny rhymes and songs. After a few more minutes I said goodbye and left a little present of a picture. I felt rather deflated. I had tried hard to get a smile, but Charlie wasn’t in the mood. I spent the rest of the afternoon on my rounds having fun with the other children in the hospital, but my mind kept returning to the little boy in the pushchair.

On my way back to the dressing room, I bumped into Charlie’s Mum. ‘Thank you so much,’ she said. ‘That’s the first time he has paid attention to anything for weeks.’ It turned out that Charlie had been sick for quite a while. He was depressed and was finding it difficult to respond to anyone. Even though I thought Charlie hadn’t reacted, his Mum knew that a little bit of clown doctor magic had got through and helped Charlie. She was thrilled and I was very happy to have helped.
Q Has any kind of monitoring or evaluation been undertaken of your work?

We’ve had no formal evaluation from an outside agency, but we have internal monitoring by the Trust and by the hospitals. What we do on the Trust level, I meet with my contact in the hospital - head of children’s services or head of play - every three to six months depending on the hospital and people’s availability, and talk about general feedback. On the clown-doctor level, during the first year of their work, they are observed three times by the trainer and given feedback on their performance. Also the clown-doctors have a meeting once a month to talk about their work, and the clowns meet three times a year with a psychologist to discuss any emotional issues. Once a year I meet with each of the clown-doctors for an assessment review. We do get very interesting feedback from all of these sources and one issue is that hospitals would like to see more of us!

Q So finally Joannie, how do you see the future of the Theodora Children’s Trust?

What we would like to do is take this programme to children’s hospitals around the country. That means recruiting and training more clown-doctors. My feeling is that this kind of activity is something people in hospitals are looking for. We have had phenomenal interest from people we have been to talk to. Our biggest problem is getting funding, which is terribly difficult, just because there are so many other good causes out there competing for the same sources of funding. If we didn’t have to worry about funding, we would be able to expand still further, although we are very conscious of the need to maintain the sense we have at the moment of being a high quality team with a shared vision. So we have to look at how we can get bigger without losing that sense of belonging as a group.

### initiatives

**International clown-doctor initiatives**

**The Humour Foundation, Avalon Beach, New South Wales, Australia.**

The clown-doctors use their skills such as magic, balloon sculpting, storytelling and other clowning skills to treat children with doses of fun to help them deal with the range of emotions they may experience – fear, anxiety, loneliness, boredom. The emphasis is on interaction with the patients and their families, rather than entertainment. ‘Clown rounds’ benefit the whole hospital community.


**Big Apple Circus Clown Care Unit, New York, United States.**

The Big Apple Clown Care Unit is a community outreach program of The Big Apple Circus that brings the joy and excitement of classical circus clowning to the bedside of hospitalized children three days a week, 50 weeks a year. Using juggling, mime, magic, and music, specially trained “doctors of delight” make “clown rounds,” a parody of medical rounds where the healing power of humour is the chief medical treatment. In partnership with each hospital’s medical staff, these professional performers work one-on-one with acutely and chronically ill children, their parents, and hospital staff to help ease the stress of serious illness by reintroducing laughter and fun as natural parts of everyday life.

[www.childrenshospital.org/ccu](http://www.childrenshospital.org/ccu)
"I like to work towards taking the mystery out of art, but leaving in the magic"

June Pritchard is an artist, teacher and art therapist. She works with a wide variety of patients including those who are learning to live with long-term health problems or recovering from acute events such as a stroke or an accident. Within confined spaces, and with minimal resources, she supports patients whilst they are in the care of the Kent and Canterbury Hospital.

What is art therapy? I teach art as a treatment. It helps people to focus. I teach people how to paint, draw, to realize their inner expression. When you go into hospital, your whole world is completely turned inside out. No wonder people feel angry, no wonder people feel confused, no wonder people feel, “What am I going to do, my life is...I’m not me.”

Art therapy is a member of the team of therapies; we complement each other. I view my work in a holistic way, because if the mind feels well the body will feel better.

Firstly, I approach the patients. I go to their wards, and I make time to sit with them and put them at their ease. I ask them, “May I call you by your first name?” They might say, “I would like to (do art), but I can’t draw a straight line.” “It doesn’t matter; you can do whatever you want,” I say. There is never any pressure for anyone to do anything, or to attend sessions.

I teach in many different media. We use pastels a great deal, because they are easy to manipulate. People with Parkinson’s disease put pastel to paper and, directly, their shaking may stop, and they will do something really wonderful. We may use watercolour, charcoal, pencil, and calendars and photographs. My patients, I call them students, focus on something outside their ills. Some people may have art therapy for half an hour, particularly if they are not feeling well, and others may continue for up to two hours.

Art therapy is also a means to getting people out of the wards to be with another group of people. I find that patients themselves really boost and encourage one another, and that is wonderful, although I do work one to one sometimes. Sometimes the whole room is zinging because people are focused and so interested in what they are doing. Perhaps someone will start singing a little. It touches your heart; it really does.

My husband, a consultant, introduced art therapy into what were then called the geriatric wards in Canterbury. When an art therapist left, I came in. My greatest education has been being with the patients, talking with them and listening, listening, listening.

When people have a stroke, it is a tremendously traumatic experience. People are not themselves any longer. I believe that art therapy can reach parts that other therapies can’t reach. It is so creative and it is a form of communication for people who have lost their speech.

For this work, you need to be a qualified art therapist and to be able to demonstrate and teach. One could be the greatest artist in the world, but you need to be able to teach. One has to be proficient and professional, but also compassionate, with all the patience in the world.

results

“June’s results have been remarkable. The patients consistently responded with great enthusiasm and many have found unknown skills. Through this medium many have been stimulated, so promoting rehabilitation, and many have found a skill that has given them hope and encouragement as they struggle to come to terms with a disability.”

Dr Jonathon Potter, consultant physician in geriatric medicine.
value and purpose

The value and purpose of art therapy
(from June Pritchard’s presentation)

- To regain self esteem.
- To learn a new hobby and to carry this hobby into practice at home.
- An ideal activity for the isolated and disabled.
- To assist the expression of personality.
- To boost morale in appreciation of new skills and a permanent visible output.
- To aid concentration and to slow down the hyperactive who rushes rehabilitation.
- To aid speech therapists in the diagnosis of problems such as visual agnosia (the inability to recognise words or shapes) and in expression when verbal interchange is difficult.
- For interpretation, as in the projection of internal anxiety, or diagnosis in conditions such as depression.
- To assist the aggressive to become more amenable and passive.
- To colour the life of depressed people with new interest.
- To awaken interest in life around the apathetic.
- The psychiatrist may interpret in images what cannot be expressed in words.

Jenny Tyler works as a hospice artist at the Pilgrims Hospice in Canterbury. In her presentation, she talked about some of the paintings produced by patients with whom she had worked.

The first example is a painting done by a one-time nurse who had been to a workshop where her vicar had explained the value of the spiritual mountain. When she was first told she had cancer, she put all the feelings and the pain she went through into the mountain, which goes up and comes down again. It took her a long time to do, and I’m pleased to be able to tell you that, today, she learned that she’s in remission. (see photograph).

The second is an example of a painting from within. This patient has been working with me for some time now. He loves to just sit. I say, “Would you like any inspiration?” He refuses. He likes to have a go at what comes from the inside, and this will reflect his physical and mental state.

This third painting was done by a lady who had painted in Adult Education for a long time, but she wanted to break away from that because she found it too restricting. She wanted to express absolutely - “I am NOT going to let death get me down,” and she chose to use the sunflowers that were in her window. Behind these, because she lives in an ecclesiastical setting, are the tombstones and the church. She was literally facing death. She tried watercolours and it wasn’t working. It was too close to what she used to do. So I said, “Why don’t you try collage?” This picture, then, is an example of collage expressing defiance. “I’m going to live until I die, and I’m not going to let death spoil my life.”

This is what my work is all about. It is so important to be able to live because so much of the treatment, and so much of the fears, and so much of the dwindling away of who they have known themselves to be, is going, going, going, going, going. And they’ve had things stuck in them, they’ve been stuck in machines, their body has changed. Who are they? So I’m working with people who are perhaps traumatized. They can’t talk about anything. They are very, very frightened or angry, but they don’t show any of these feelings because they have to be nice, and they’re either in bed or in a wheelchair and totally dependent on what the hospice can give. But when you’re dependent, that’s not good because that takes away ‘who I am’. So that’s what I try to address by finding out what is right for them. It can take a short time, perhaps three sessions, because I have to work in the now, and I don’t know how long people are going to live. It’s so important to engage straight away, as much as you can, so that the person feels that they have found something of value in themselves.

I have a lovely book by E.A. Bennett called ‘What Jung Really Said.’ It says, “Jung was concerned more with the healthy than the unhealthy elements of the personality,” and that’s what I’m about. Lots of unhealthy things will come out, but I’m not saying, “Let’s be angry today, we’re going to get rid of the anger.” I’m not saying, “Let’s face this depression.” I’m saying, “What would you like to do today? What can I do for you? What do you love?” and we work from that premise.

results

“...in addition to giving great pleasure to patients, art (especially in the hands of someone as skilled as Jenny Tyler) also allows patients to reveal feelings that are otherwise difficult to express. Thus it provides an invaluable diagnostic and therapeutic tool.”

Dr. Peebles, former member of the medical team at Pilgrims Hospice
I felt totally inadequate as I looked at him. Communication seemed impossible, as he would not talk or respond in any way. The bared teeth gave the impression of a tormented wild-man, caught in a state of mind, which imprisoned him in a paralysing fear. The only fragments of information given to me were that he had been in a German prisoner-of-war camp and it was believed he had regressed in his mind to that time...

I sat by him, quietly not moving. Then, when I felt calmer, I looked into his eyes as they turned towards me, wide and staring. I smiled, trying to convey that I was not a threat but trying to help, but I realised he wanted to reject everyone...

I decided to paint St Govan’s cave, which I had visited in Wales, which joins two cliffs and faces out to sea. Every now and then, I would talk about the subject, that St Govan had been a hermit - he had chosen to isolate himself from the world and build himself a cell in this wild place. It was so beautiful, living so close to nature. I spoke of the sound of the wind in the grasses, the stones on the cliff path and the sound of the waves as they swirled around the rocks. Every now and then, I would look up and find him waiting, observing and then turning away. I did not ask questions but concentrated on the subject before me.

When the painting was finished, he seemed pleased. He pointed to his mouth expressing that he had not allowed anyone to touch him.

Graham Duerdon uses music as a therapeutic tool within his work as an occupational therapist.

*My work is influenced by occupational therapy theory, it is client centred and it is focused around activities meaningful to the clients. As music can be very meaningful to people, it can be used to meet the goals of therapy. I have used music within anxiety and stress management sessions, and have noted that these clients are referred for further treatment less frequently than others.*

Graham carried out four exercises to demonstrate how music can be used therapeutically. The audience were given percussive instruments such as drums, ocean drums, rattles, tambourines, and sticks.

**Exercise 1** Validation dialogue through music

The audience were invited to ‘converse’ using their instruments. A continual process of validation emerged as they each mirrored or varied the previous player’s motif.

For people with failing verbal and intellectual function, this type of exercise allows the client’s contribution to communication to be accepted and validated, whilst keeping them orientated within reality (Denham, 1991). Reigler (1980) compared two such groups following reality orientation programmes, one using music and one without. After eight weeks, ‘...the group using music improved cognitive function significantly and the music helped clients recall names, days of the week and place of residence.’ (p.157)

**Exercise 2** Self-actualisation through the act of conducting

Using simple Makaton signs for loud, soft, fast and slow, a volunteer from the audience was asked to conduct members of the audience in their percussive music making. The use of percussion instruments produces an impressive musical performance whilst avoiding the need for knowledge about notes, chords and keys. So everyone involved can feel empowered and creative through their improvisation, self-actualisation and psychosocial connections. A variation is using the instruments to imitate environmental sounds such as a storm, the sea or a stampede. If such a performance is recorded, the recording can be used for reflection and fine-tuning.

**Exercise 3** Sound-Beam: magical music making in the air

The sound-beam produces an electronic sound when the infrared beam is broken. Even the slightest movement of a finger can interrupt the beam and produce a high or low note depending where, on the beam, the break occurs. The speed of the music depends on how quickly the music-maker can move in or out of the beam. A volunteer from the audience created and performed music in the beam.

The sound-beam can be used by both ambulant or wheelchair users. It can be used, in the context of physiotherapy, to extend a client’s range of movement, and it has been shown to have both physical and psychological benefits for people with learning disabilities and sufferers of physical or mental ill health.


**Exercise 4** The sedative effect of music

Graham induced a state of relaxation amongst the audience through imaging and the sound of a Nepalese sounding bowl. The bowl ‘sings’ in natural harmonics and can calm distressed clients.
Trish Vella-Burrows has a background in nursing and recently completed a degree in music. She brings these talents together through using music as part of the care of elderly people. Trish began this work by entertaining people in care settings which included reminiscence work through ‘singalongs’ and listening to music.

I suppose it was curiosity about my own inhibitions that led to greater exploration. Why, I wondered, were the majority of health care workers reluctant to embrace wider possibilities? And that went for me too!

So my interest in the potential of music to impact positively on the lives of elderly people living in residential homes was sparked. It seemed to me that, in most cases, music in some form or another could make a difference even for people with severe physical and mental dysfunction. However, I had the sense that we were skirting round the edges of something much greater.

I had read about the work of Linda Rose and the Shimmer Project, which took professional musicians into residential homes to work specifically with people who were severely affected by Alzheimer’s disease. The workshops proposed ‘self actualisation’ through creativity, irrespective of physical or mental state.

I’d already been privileged to see responses to music in people who didn’t seem to respond to the world around them in any other way, and my fascination grew to the point where I felt the need to research into the neurological process of accessing musical sound. I also wanted to view perceptions of care staff in the context of employing music in a much broader sense, as part of a holistic approach to care.

The research project divided into various components:
1) review the scientific view of Alzheimer’s disease including its causes, prevalence and patterns of progression
2) examine musical activity in a small selection of nursing/residential homes in East Kent
3) view the impact of activity on staff and clients
4) present four case studies of people with Alzheimer’s disease who were undergoing various musical experiences

The findings were both exciting and disappointing. There was some wonderful and often deeply moving evidence of musical potency. John, whose agitation diminished significantly when listening to the operettas of Gilbert & Sullivan; the cathartic impact on David, a usually jolly man, who suddenly began to cry when listening to the Countess’s aria from Mozart’s Le Nozze di Figaro; Grace, who, in spite of having very little coherent speech, sang the words of the song ‘Daisy, Daisy’ without hesitation, including a complete little known verse; and Pat, who emerged from the depths of introspection to tap a small tambourine in perfect time to the rhythm of tango.

Generally, the staff in the residential establishments had a positive attitude to the value of music, but this was only insofar as it didn’t interfere with their normal work routines. When flexibility and accommodation were called for, staff attitudes became more negative. One reason they gave was a shortage of staff. So the physical routine of care tended to take priority over more creative activities.

It seems as if, at policy, community and individual levels, the Department of Health and Royal College of Nursing strive to embrace the ideals of holistic care in Alzheimer’s disease. However, in the main, nurse education appears to have yet to embrace the wider dimensions of the arts where it matters most - on the shop floor.

I would like to see music achieving wider recognition for its ability to induce self-expression and creativity for the growing number of people who are living with the agonising, relentless march of senility.
responses
to Graham and Trish’s presentations

How was this presentation relevant to your work?

“Every aspect of my teaching - from restraining patients to care of the dying.” (lecturer in nursing)

“Some of the ideas would work well with children - conducting, sound beams, relaxation techniques after P.E., music sessions etc.” (student teacher)

“Could be used in the day hospital with both organic and functional patients.” (co-ordinator day hospital)

“We deal with a lot of clients who suffer dementia, confusion and immobility.” (carer)

“I hope to use some of the ideas when on placement at the local hospital. I may not be able to do much, but may be with individual patients.” (student nurse)

“I work in stroke rehabilitation. Sound beam work would be very useful in upper limb work. Also it would provide cerebral stimulation of cognitive/perceptual function.” (occupational therapist)

“Any new ideas for activities for dementia sufferers leading to their well being are very important.” (manager, Alzheimer care centre)

“I work with elderly people and information about music to help with therapy for moving limbs could work for them.” (senior carer)

useful resources

Music and dementia care - some useful resources:


music in health care environments

Nurses perceive that music enhances sleep, decreases distraction, agitation, aggression and depression. (1)

Music played via headphones reduces anxiety in patients during normal hospital care, but has no impact on the anxiety of patient undergoing procedures such as bronchoscopy or surgery with a spinal anaesthetic. Music appears to improve the mood and tolerance of patients. (2)

Music therapy and rehabilitation therapy are starting to find a common niche. Their combined goals could include improving strength, range of motion, balance, communication and cognition. (3)

In an intensive care environment, listening to music decreases blood pressure and changes moods from anxiety, apprehension, sadness and pre-occupation with pain to those of relaxation, calm and diminished pain. (4)

For older people who are suffering from memory problems, music can act as an important socialising vehicle, literally re-connecting them with reality. (5)


Alison Combes is the director of Survivors’ Poetry. She talked about the origins and role of Survivors’ Poetry, and took us through exercises to explore the value of literature for well-being.

Survivors’ Poetry was set up ten years ago in order to promote the use of poetry for survivors of the mental health system. Now participants prefer to describe themselves as survivors of life, which is more inclusive. This is because we’ve found that people have been drawn to the readers’ and writers’ groups who don’t fit the classic definition. They may have relatives who are using mental health services; they may have been bereaved; they may be holocaust survivors. All sorts of people, for whatever reason, choose to embrace the label. We now have 2500 members and 35 groups, who write, read and perform their own poetry, and listen to other people’s poetry. Some of this is published in our quarterly newsletter Poetry Express (see A Mother’s Story).

I suppose it is about promoting the individual voice of the people we work with, and enabling them to discover and develop their voice and any other skills to the best of their ability, or as far as they want. As I see it, it’s an organization which enables people, if they want to, to proceed right the way from first skills, basic skills, through to publication, performance and careers as award-winning poets. The organization encompasses somebody who literally has just come off the streets, to one who has combated dyslexia to produce poems, to one who has just performed on Radio 4 quite recently.

Alison outlined three reasons why reading literature can be good for well-being and health:

**Literature can make people feel less alone**

Alison asked the audience to explore what they knew about the derivation and meaning of their own names.

Perhaps my name defines me, or I define it, but one way or another we’ve grown up together and I’m not getting rid of it. Survivors’ Poetry is often about making connections between people who are alone and very isolated. The writing and reading groups, which run all around the country, are often an opportunity for those who, otherwise, don’t get out of their houses very much and don’t feel comfortable in particular environments, to meet together in a very safe setting. We also work with housebound people, and we’re starting to do more work via email and the Internet.

Often the reason we read or write is to make us feel less alone and one of the things that I enjoy most is to have books recommended to me by friends. So I’m always keen to know what other people have read. There’s something about the communality of an imaginary experience, which we can share, that’s very safe. So literature is a very safe place in which we can invest our emotions and make connections. This is a lot safer than relationships with other people.

People who have been involved in literature and linguists know that there is much discussion about names and labelling e.g. Beckett’s ‘What is a pot?’ A pot, for me, is a blue and brown vase sitting on my mother’s windowsill with the morning sunlight coming through and a bunch of daffodils in it. For you, I’m sure it is something different.
Literature gives people permission to be playful

Alison asked the audience to think about the sound of words, and consider which word might be their favourite, and how they might characterize it.

Apparently, the nation’s favourite word is serendipity. Onomatopoeic aspects of language are often about playfulness, which is something, as adults, we frequently lose. However, we can find this through poetry. In Survivors’ Poetry, people have often had a rough time, and find it difficult to access their emotions. If they are given permission to be playful, and often through their experiences they have stepped out of the norm anyway, they find it easy to engage with poetry, perhaps more so that those of us who feel more constrained.

Literature is about taking time out

Alison guided the audience through a very relaxing visualization exercise in order to demonstrate the mental health benefits of being immersed into a tale.

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poetry & well-being

The potential benefits of reading poetry for personal well-being are well illustrated by the findings from research by Phillips (1999). 196 people were asked about poetry:

- 2/3 said that reading poetry reduced stress
- 2/3 said that writing poetry was an outlet for their emotions
- 10% said that reading poems improved their mood
- 13 said that poetry had helped them to stop taking anti-depressants or tranquillisers

One said, “Reading a poem with a relaxing rhythm can be almost hypnotic. The most tranquillising effect comes from poetry with rhythm, and when in need of calm, the natural ‘rocking’ sound of the words takes me back to being a child and I find the effect very soothing.”


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One Day Mum

Nine long years have been and gone - are we any further on?
The years they seem to come and go Recovery grudgingly, savagely slow
Others outside looking in Just can’t perceive the pain I’m in
They think she’s fine, They think she’ll cope
I sleep, I breathe, I live in hope I grieve for all the things you’ve missed
For all the girls you would have kissed The friends, the fun you’ve been denied
Countless times I’ve sat and cried The normal things that bring us pleasure
Far too numerous to measure
Traps abroad, parties, driving
Whilst you’re in rehab ever striving Striving to be well someday
One day Mum, you say, one day.

‘The Word’

Schizophrenia; there, it’s done, Doesn’t quite roll off the tongue.
Nine years it stayed within my mouth, I’ve finally managed to spit it out.
It certainly set me one hell of a test, But at last I’ve put the word to rest.
A sad achievement but there, it’s done, A label for my precious son.

We thought naively they’d be able Within weeks to make you stable
Sadly, you sleep your life away, 16 hours on an average day.
Now you’re timid, quiet, subdued, Not fiery, angry, hyper, rude.
My senses scream, my senses shout: For God’s sake, what’s this all about?

GP gave me Prozac and, after a while, I’m flying high, I wear a smile.
We both feel exhausted from the strain. We watch you struggle, feel your pain.
Split mind, split personality? Get the leaflets, then you’ll see, Just ask me, I’ve read them all,
It’s really not like that at all.

Poetry Express. A Quarterly Newsletter from Survivors’ Poetry, 11, 6-7.
Imagination Time is a project, which brings together arts and health. It was developed by LaunchPad, a children's reader development organization which acts as an advocate for children's library services. LaunchPad is working in partnership and with funding from Walker Books and The Arts Council of England. Imagination Time is a London based pilot project which involves 21 London hospitals and 15 London libraries. The hospitals include inner London teaching hospitals, suburban hospitals and specialist hospitals such as the Royal Marsden, one hospice and a mental health unit.

Walker Books donated a collection of books designed to meet the needs of toddlers through to teenagers. We didn’t want to just put a collection of books into the hospital, we wanted to find a way to help children, parents and staff to find their way around the collection. In addition to both librarians and Walker Book storytellers visiting the hospitals, we created a reading wheel. We divided the collection up into eight different sections. When the wheel is turned, the child can see a list of books relating to: Time for a Rhyme, Time for Action, Time for a Tale, Time for a Hug, Time for a Picture, Time for Magic, How do you Feel or Time for a Smile.

In the section called How do you feel, we included books which allowed children to explore how they were feeling about their whole experience of being in hospital. They may be separated from their families for the first time. Parents found this very useful because, I think, it is difficult beginning a conversation about how you’re feeling. It was a way of gently talking to children.

(See: The Okay Book)

We also scanned in characters from books so that children who couldn’t read could see a picture of a character, and find a book.

On the back of the wheel, we included tips for parents about how to share books with children, and how to contact the charity Action for Sick Children.
It's okay to be short
It's okay to be tall
It's okay to wear two different socks
It's okay to have freckles
It's okay to eat all the icing off your birthday cake
It's okay to wear glasses
It's okay to come from a different place
It's okay to be scared
It's okay to wear what you like
It's okay to share
It's okay to laugh out loud
It's okay to cry
It's okay to live in a small house
It's okay to try new things
It's okay to have no hair
It's okay to hang out in the rain
It's okay to be skinny
It's okay to be BIG
It's okay to be friends with a mouse
It's okay to be a different colour
It's okay to wear braces
It's okay to put fish in your hair
It's okay to sing out loud
It's okay to dream BIG

_The Okay Book_ by Todd Parr,
Walker Books

**responses**

How effective was Imagination Time? These were comments made in response to the project:

“Last week my daughter was rather poorly and the library visit encouraged her to get out of bed and take part in the activities.” (parent of 7-year-old receiving treatment for leukaemia)

“Perhaps an unexpected outcome was that children began to interact with each other and make friends within the ward.” (librarian)

“I got my Jimmy out of bed when he had refused all morning.” (parent)

“One very special event was Pat Ryan’s visit, they’re lovely kids at the hospice and he really made them feel special. You could tell they were listening to his every word because they were laying so still. They were so relaxed that one little boy actually fell asleep in his carer’s lap.” (librarian)

“I especially enjoyed the visits from the authors, illustrators and storytellers.” (child)

“The storytelling is fascinating to listen to and really makes the parents and children escape.” (play staff)

“The reading wheel was useful not only to help them choose the kind of book they wanted to read, but they also liked to cross off the books that they had read. The wheel was easy to use and gave the parents tips about reading with their child in a non-threatening way. Younger children, who could not read, were able to recognize the characters on the wheel, which helped them to choose books.” (primary coordinator, hospital school)

“I felt the children really benefited from the sessions, regardless of their disabilities, they really responded to the contact be it verbal or physical.” (librarian)

“Looking back on Imagination Time, what made it successful?”

I think the funding was the most important thing in the end. It enabled us to broker the relationship between the hospitals and library services. Once you’ve set it up, it can just run.

“What were some of the practical challenges?”

We had quite a lot of volunteers such as the storytellers. That was an issue in terms of health and security checking. However the biggest challenge was initially creating the link between the appropriate library staff and the hospitals.

“What have you learnt from Imagination Time?”

My work has specialized in children for some time, but it was a learning curve to find out how hospitals work. They’re all totally different. I don’t think that this is the type of thing that they would have thought of doing. I think we have to be very clear about what we’re offering.

“How would you evaluate the project?”

It promoted social inclusion which is a big area for library staff now. I suppose I think that we can get very stuck in our library buildings. It is important that we get out there, try to get the message across and actually help people.

“What is the future?”

LaunchPad, along with the Reading Partnership and Well Worth Reading, is part of what’s now become the Reading Agency. The Agency aims to develop good practice and innovation with reading partnerships and a whole range of partners. Imagination Time is part of a larger strategy about reaching parents and children in hospital who don’t have access to library services.
Members of an antenatal group sing to their babies

Healing Arts, based at St. Mary’s Hospital on the Isle of Wight has a national reputation for its innovative work in the field of Arts and Health. Maggie O’Connor, Musician in Healthcare at the hospital, talks here about her project to encourage parents to sing to their babies before and after birth.

The initial stimulus for this project came from my previous experience over ten years running a musical group for parents and children under five. Quite often women in the group were pregnant and so they would be coming to the group pregnant and three weeks later would be back with a new baby. And so it occurred to me that it would be a good idea to specifically undertake a project for parents and babies before they were born. Once I began my post at St. Mary’s this provided the ideal setting to take this idea forward. Then I became involved with the National Foundation for Youth Music and they became very excited about the idea of working before babies were born and so they asked me to put forward a proposal for a pilot project on working antenatally, and with the encouragement of the Director of Maternity Services, things developed from there. The plan initially was to run five groups in different parts of

the role of the storyteller

When our school opened at the Royal Brompton Hospital, it was the first time that we had worked with children who had cystic fibrosis. One day Paddy, a six-year-old boy, was hiding in his bed and I asked him why he wouldn’t come into school. He said in a very breathless voice, “I can’t talk and breathe at the same time and everybody keeps talking to me.” Roberto (the storyteller) came in and spent some time with Paddy telling him stories and the next day when I asked Paddy how he enjoyed it he replied, “Yes, I like storytelling, it keeps on working when everybody else is asleep.”


promoting the health of the young through reading


Web Sites

Action for Sick Children www.actionforsickchildren.org
Booktrust www.booktrusted.com
Healthy Books www.healthybooks.org.uk
REACH National Advice Centre for Children with Reading Difficulties is, sadly, about to close down, but its director Beverley Mathias can be contacted on: Beverley@manorpark.fsnet.co.uk

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imagination time

the sound

of singing to babies in the womb and after birth
the island in three stages: the first stage would take place for six weeks following the 26th week of pregnancy, when it is known that a baby’s capacity for hearing sounds outside the womb is well developed. The second and third stages would then take place after birth when the children were three months and then nine months old, and again groups would run for six weeks. In addition to myself, two other musicians, Angelina Grimshaw and Sandra O’Toole, were involved in facilitating sessions.

The content of the project as outlined to parents in Sound Start publicity material is shown in the box.

You are invited to take part in this exciting new SOUND START programme. There will be three six week courses, informal fun sessions with an opportunity to get to know other parents to be. The course before birth will cover the following:

1. Sharing, learning, singing lullabies
2. Singing songs in a group for your own enjoyment and for your baby in the womb to listen to
3. Breathing and toning (singing long notes) to relax you and your baby
4. Discussion of what and how music affects the baby

You don’t need to worry about the sound of your voice; your baby will think your voice is the best in the world! This is about expression and communication, not about performing.

And then two 6 week courses after your baby is born, one at around 3 months, one at about 9 months, covering the following:

1. More lullabies and simple rocking and action songs
2. Dancing and moving with your baby
3. Making and playing simple instruments
4. Playing musical games to develop musical knowledge and confidence so that you can make music with and for your child
Despite the organisational difficulties, feedback from mums to be was generally very positive, with most feeling they had gained a great deal from the sessions:

“It’s nice to be able to have a chance to sort of relax as well at the same time. The relaxation, breathing and all that. Because you don’t really get to learn about that really from midwives or anything. So that was quite good as well.”

“I think it’s given me an opportunity to have a closer bonding with the child, probably more of an understanding of what they can hear and obviously looking at it week to week and actually thinking about it more, I’m realising that maybe they can hear more that I anticipated they could.”

“I felt I went into it a bit naive really, I wasn’t really expecting anything, to react to it at all. But it was amazing how after we had done a couple of tunes, a couple of times, he seemed to pick up on it. I was quite amazed at that and they were quite nice lullabies anyway. So they’re probably the ones I’ll try out when I’ve had the baby. I was quite amazed.”

“I found them very good, actually, because I liked the relaxation techniques and it was nice to meet other people and just participate in singing and doing something different, really. Something that you wouldn’t normally have done. I certainly wouldn’t have done singing, not singing like that to the baby on my own or at home.”

The experience of the antenatal courses led us to revise the plans for the postnatal phase of the project and rather than run five groups for six weeks when the babies were three and nine months old, we set up three groups open to mums with young infants which ran continuously over a period of 12-18 weeks. This made it possible to attract a larger group of participants - almost exclusively mums, with many becoming involved who were not part of the antenatal groups.

Feedback from the participants has again been very positive:

“She definitely enjoys it. The rattles - she does definitely play with the rattles and then some of the songs we do, she actually is aware of some of the other babies when we do the clapping ones or hitting the sticks. I think all the babies - it grabs their attention. It’s quite amazing how they are all still and listen to it.”

“When he was born and he was particularly upset especially at night, I think it’s really good. It has really benefited us. It’s regular every week, it’s good structure, you know that it’s always there. If you’ve had a bad week, it’s like Wednesday morning is singing. It is very good and we enjoy it.”

It might be said that singing to babies is something that parents do quite naturally, and that no encouragement is needed. There is some truth in this, but the fact is that the role of singing in our culture has been gradually eroded over the years, with the decline in opportunities for people to come together and sing, and with the ready availability of recorded music, so that people no longer have to make their own musical entertainment! Young parents today may lack knowledge of lullabies and action songs suitable for infants and young children, and they can also lack the confidence and skills to sing to their children. Mothers have been surprised by how much their babies have enjoyed singing and how responsive and attentive they have been during sessions. They have discovered that singing gives them an extra resource in relating positively to their babies at times such as feeding, nappy changing and settling them down to sleep - times which can be a source of stress and difficulty. Coming together on a regular basis, to participate in a structured activity has also been beneficial for the mums themselves, and they have gained from the social support and development of friendship networks that the project has promoted.

responses to Maggie’s presentation

“I found the discussions very interesting. I also felt the interaction was very good. I would love for the same subject to be revisited when the research has been completed and the possibility of any conclusion could be visited. It would have been wonderful to monitor heart rates too.”

“It was very interesting. I discovered lots of new things. I realised that after all singing (especially to baby) is a natural thing to do but being lost and forgotten.”

“Interesting, informative, thought provoking.”

“Very interesting - well presented, relaxing and lots of fun.”

“Singing in nursing could be therapeutic. As a student in Ireland it was not unusual to sing on the ward - that doesn’t happen here!”

A full evaluation report on the project will be available at the end of 2002.
Julian Raphael and Sarah Hoskyns

In addition to organising presentations on the role of the arts in healthcare and health promotion, we wanted to run longer participative workshops that would give people the chance to experience the impact of the arts on well-being. So, on a Saturday in May, twenty-three people came together with Julian Raphael, a senior lecturer in music at Canterbury Christ Church University College, and Sarah Hoskyns, a music therapist, to explore the experience of drumming in mixed and single sex groups.

Trish Vella-Burrows, one of the organisers of the Arts, Well-Being and Health programme, gives her impressions of the drumming workshop as it unfolded through the day.

"Keep...in...time...with...your...NEIGH-BOUR!" was the watchword of this workshop, and certainly by the end of the day twenty-three separate and essentially different people - many coming to drumming for the first time - had cohered into a performing whole.

First drumming exercise

Twenty-three people, each with a drum, made a large circle. Julian demonstrated some simple drumming. Forty-six hands attempted to mirror Julian’s movements through observation and repetition. The continuum of the ‘drumming circle’ was established, although everyone’s focus remained on Julian. After a while, people began to avert their gaze, but only whilst the precision of their own beat remained intact. At the end of this 40-minute session, the group was beginning to act in unison, though there was still some residual anxiety and few individuals were able to drum without the regular references back to Julian.

Second drumming exercise

In the second exercise, the basic rhythmic patterns learnt earlier were re-established. However, the ‘drumming circle’ began to move towards proficiency. The sound became more confident and people responded to Julian’s improvisations confidently. ‘Carry on playing,’ said Julian cheerfully, ‘Don’t worry if I play something different’. ‘Oh no, don’t leave us so soon!’ was the overriding silent response as some people shuffled in their seats or sat upright. Any resulting physical tension, however, was temporary. One by one people relaxed as their capabilities grew.

Now a hypnotic element began to emerge. There was an impression of perpetual response as repetitive rhythms were perhaps impregnating memory banks. This was the point when to me as an observer the urge to share the experience of a potentially hypnotic embrace became irresistible. Perhaps one of the most profound elements in my own perception of rhythm in this exercise was the growing sense of unison, with the sound continually changing in density - moving from one intensity to another. The group were becoming more physically free with increasing fluidity of body movements in response to their instruments and the rhythm. “Keep...in...time...with...your...NEIGH-BOUR!” It was beginning to happen!

Third drumming exercise

The group was split into men and women. Each was left for about an hour to develop a performance for the other. I joined the women’s group where we spoke to one another about our experiences as women. Empathy and sympathies developed. The women’s performance used percussion, song and movement, to explore the themes of the social positioning of women as sisters, partners and mothers, giving expression to sources of frustration and
sources of support and power. The men chose to give an improvised sound picture of a small band of hunter-gatherer men waking in the morning and preparing to go off and hunt, returning home eventually with food for the communal pot! Stereotypical maybe, but the real message that came across was the capacity of a group of men to respond sensitively and co-operatively to one another in achieving a performance.

Final drumming exercise

The ‘drumming circle’ was brought back together for the final session of the day. The beat from the morning began - thick, rich, pulsing, confident and comforting in its familiarity. After a while, the ‘experimental’ left the safety of this base and began to offer new embellishments and ornamentation. Some temporarily abandoned the group entirely with counter and cross-rhythms. All the while ‘pulse keepers’ kept a solid steady unison beat, the welcoming home ground. Rhythmic action appeared to be accomplished on a half-conscious level now, allowing for individual representation and imagery - evident through free body language - and visual contact with other participants. And yet, supporting these possibilities of individual expression, was the foundation provided by the group, who followed the steady guidance from their leader...

“Keep...in...time...with...your...NEIGHBOUR!”

After the workshop Julian Raphael explained that when working with mixed groups, of musicians and non-musicians, he is led by certain guiding concepts and perspectives.

The running of drumming workshops derives from methods of African traditional oral teaching. Drum strokes and patterns are taught by movement; sound and vocalising are reinforced through repetition by the group and internalisation by individuals.

Each participant needs to have a drum which they can play in comfort and which can ‘speak’ with minimal effort or technical mastery. The drum is a very tactile instrument and the contact of skin again skin can produce sensations of closeness and of being one with the sound-producing object. Players can choose to be introvert or extrovert in their performance style and this may vary in individuals according to stamina and physical ability.

The drum allows each participant to communicate in a non-verbal dialogue with the group and this quickly enables participants to establish a connection and integration within the ensemble without speaking. Personalities need not be exposed until participants feel confident.

The circle of players helps the group to contain itself, allowing participants to observe, copy, listen and think about what they are communicating. This also allows players to be sensitive to those needing more help or encouragement.

The act of performing the music together can bring about a unifying process within the group. At the same time the music can relieve tensions and anxieties by building cohesiveness and a sense of belonging. Rarely will external pressures, hierarchies or concerns impinge upon the group dynamic once the performance takes hold. This aspect may well invest the drum circle with the power to alleviate stress, demotivation or lack of confidence resulting from work or other personal situations.

For non-musicians the result can be very satisfying and can give them the feeling of being engaged in real music-making. This is because the individual parts can be quite simple but will combine to a powerful effect within the ensemble. Indeed, the ‘instant gratification’ element is a necessary ingredient especially at the start.

When a common beat or groove is established within the ensemble individual performers can be given the freedom to express other ideas through improvisation. Players should always feel supported by the group, both musically and empathically. The groove acts as a strong foundation from which ventures into unknown territories can be approached with either a sense of tenacity or complete abandon.

The repetition of metrical grooves can bring about a unifying dynamic from within the group. Players can experience being part of a whole while at the same time recognise the significance of their own contribution. The overall effect, both musical and social, is always greater than the sum of the individual parts.

An extra dimension can be attained through the addition of vocal chants or call and response sequences. In African cultures little distinction is made between drumming and singing (and dancing); they are just different components of the same experience. Players can experience profound feelings of liberation and whole body integration through this type of holistic performance. This involves coordination of breathing, vocal sounds and movement of the limbs in a manner that can allow the player to feel in complete control and involved in a complete system of ‘energy management’. Participation at this level can tap directly into a player’s emotions as they are literally moved by the experience. Participants may have the sensation of being tied or locked in with the other players and singers around them and this can invoke one’s internal energy or spirit. The whole group may end up breathing as one body with the timing of the music. It is at this point that players may sense themselves being completely inside the music.
Over a series of workshop sessions participants can become empowered through their familiarity with rhythms and metrical divisions. They will be able to practise co-ordination techniques and drum strokes in private and bring these developed skills to the group thereby supporting a sense of progression and increasing competence. This in itself is very satisfying and life-enhancing and may well lead the individual into areas of musical communication and interaction that were previously not thought possible.

drumming is good for health

A controlled study to investigate the possible health benefits of participating in group drumming activities has been reported recently by Barry Bittman and his colleagues. On the basis of his experience as a physician with an interest in music therapy, Bittman knew that patients enjoyed group drumming sessions and gained a great deal from them on a personal level, but the research group was interested in determining whether drumming could reduce stress hormone levels and enhance immune system functioning. A series of preliminary studies compared the effects of listening to drumming, with different forms of involvement in drumming activity. These showed that when volunteers performed ‘basic’ drumming in a drumming circle facilitated by an experienced person, positive changes did not occur, and so they added specific techniques aimed at relaxing participants, enhancing camaraderie and group support. A controlled trial using this modified approach to drumming showed that potential health benefits were associated with a single group drumming session. These included statistically significant increases in the activity of cellular immune components responsible for seeking out and destroying cancer cells and viruses, amongst the participants who drummed.

Bittman’s research should encourage health professionals to consider the potential of group drumming activity as a health-promoting activity, which not only provides opportunities for self-expression, group support, exercise, and stress reduction, but also possible benefits for immune function.


responses

What participants said about the health benefits of drumming

“The heartbeat can be viewed as a natural subliminal drum rhythm. Drumming in a group in particular, using native and ancient rhythms can develop and balance body energy and restore health.”

“Having seen the Japanese drummers perform, I’m sure drumming can improve fitness! Also I’m sure there is also a therapeutic value, which can help to reduce stress and improve general quality of life.”

“I feel sure that rhythm can produce calmness and reduce stress, hence improve health.”

“Rhythms affect people, make them tap their feet, want to dance, move, make them relax and feel happy.”

“Have witnessed the use of drumming to develop communication with children with developmental delays. Drumming to relieve tension. Links between rhythm and mood.”

“I find drumming very therapeutic. It’s like meditation with exercise. It’s great for co-ordination too and I’m sure it’s excellent for my brain. It makes me happy which is good too!”

What participants gained from the session

“Complete enjoyment and satisfaction. Feeling of group communication in very relaxed environment and with very few feelings of inhibition.”

“Conquered my ‘I can’t play a drum and remember rhythms’ anxiety. HAD FUN and remembered how much I had loved drumming as a child.”

“I’ve had a lot of fun and enjoyed finding my rhythm again. Felt invigorated and uplifted.”

“A greater sense of rhythm ability along with breaking down of barriers so that the inhibitions go and I felt free to enjoy myself. I was not self conscious.”

“Fun day of playing, experience of different drums, more experience of state of unity in music.”

“Breaking down inhibitions, a stronger sense of humanity, regained ability to play without explicitly tapping the pulse or counting.”
In the second of our longer experiential workshops, we invited June Boyce-Tillman, Professor of Applied Music at King Alfred’s College in Winchester, to run a weekend workshop on ‘Music and Health’ in April.

June is author of ‘Constructing Musical Healing: the wounds that sing’ (2000, Jessica Kingsley) and the workshop was based on a dynamic model of the self, presented in her book. The model consists of seven continuums each of which mirrors the processes of living. June asked participants to engage in a variety of exercises in order to demonstrate how these continuums can be related to the nature of music.

One of the participants, Alison Rook, describes in ‘A view from the floor’, what it was like to take part.

After the workshop, June Boyce-Tillman discussed her work with Trish Vella-Burrows:

Q. Can you describe your work on music and health?

My book ‘Constructing Musical Healing’ compares the healing dimension of western classical traditions with Shamanism, the New Age and music therapy. The book was a commission from Jessica Kingsley who wanted a text covering those particular areas.
I drew on my experiences in education and a lot of workshops in the area of music and healing and music and spirituality, which I sometimes call ‘Music and Wellbeing’, which I’ve taken all over the country with adults ranging from therapists to patients or clients of some kind.

I’ve also undertaken empirical work on the therapeutic value of music lessons for children with chronic anxiety. This was a long-term project running over three or four years in association with the Health Faculty at Winchester College and a local child guidance unit.

Q Has any particular theoretical perspective informed your work - previous practical work or research perhaps?

Well, I’ve created my own model of the musical self because it became clear that no existing model would be adequate to produce a book to cover a wide range of cultures.

Most of the models of musical healing were based on a particular culture so I set up a new model. In my own work I have been heavily influenced by people like Leslie Bunt’s writings but also the model is based on a huge variety of conceptual frames ranging from anthropological conceptual frames and the nature of various societies according to Myers-Briggs personality typing. Other elements are taken from sociological writing on the way in which people use their leisure time and educationalists like John Dewey. Also from Carl Rogers’ Briggs personality typing. Other elements are taken from sociological writing on the way in which people use their leisure time and educationalists like John Dewey. Also from Carl Rogers’ literature on creativity and from psychotherapeutic literature with people like Jung and Freud and later writers like Fordham and Redfern. I used my own research from the 70s and 80s in which I tracked children’s musical development.

Q Has your work been monitored and evaluated?

Well the book has had good reviews, and practitioners and child guidance teams evaluated the work on music lessons with young people. Some improvement was seen with all those who participated.

The Music and Wellbeing workshops are regularly evaluated both orally and in terms of written evaluation. In general, people find them both healing and stimulating to their own thought process about how they use music in their everyday life. I’ve just come back from a workshop in which it was quite clear that two people experienced actual healing through one of the exercises. Other people found it very exciting to explore ideas and that gave them new insights into how they might use music both for themselves and with their patients.

Q It is so fascinating to hear about where you have been and what you’ve done, how do you see your work developing in the future?

I think it’s a very interesting question and one that I’ve wrestled with a lot. I’ve synthesised so much literature it fits everywhere but nowhere in a sense, and which of the possible areas I will go into next; I’m not sure. Since my work brings together musical healing and spirituality it’s difficult to know whether one should keep it all together as a package or whether it should be separated out. I could go down the route of exploring in more detail, New Age traditions and their developing models of spirituality, and how they fit in the context of the materialistic Western culture. Or I may develop work within the more mainstream music therapy field in which spirituality is less central, although there is an increasing interest in spirituality in the therapy literature.

Currently, I’m working on a big project with 500 primary children attending schools in the poorer areas of Battersea. The piece is entitled ‘The Healing of the Earth’, and was commissioned for the Queen’s Jubilee. It’s a performance piece that is about being at one with the earth and how that is healing for both the earth and oneself. One aim is to improve the general well-being of the schools by being involved in this project. I have done some semi-structured interviews with the children in the areas of spirituality and healing. I shall conduct further interviews after the performance to see whether involvement in the work has changed their views, and whether there have been any effects on the general well-being of the school and neighbourhood.

This project is based on many ideas from my book, and brings together songs from Hildegard from 12th century Europe, Native American material, Urdu and Gujarati and Hebrew material together, and texts that look at the healing in the context of Shamanism and the New Age. All of the material is concerned with ourselves in relation to the wider universe.

I think I want to keep with the notion of music and well-being, rather than music with the seriously ill. I don’t want to become a music therapist. I am a composer and performer with healing as part of the profile.

responses

to June’s workshop

“I hadn’t realised all the links with healing that June mentioned - a very holistic experience.”

“Extremely stimulating and enjoyable.”

“Thank you for an empowering and enlightening weekend. I feel inspired to look again at my own study of music empowerment.”

“Music is very therapeutic and relaxing. It can also help children to learn and improve other skills such as concentration, listening and creative development.”

“I’m so glad to hear June’s insights. They give me inspiration to go on.”

“I really enjoyed June’s ideas - found them stimulating - didn’t always agree but that was good fun in itself. Enjoyed the reflections on gender and age in our society and others.”
Sharon Eden, a UKCP psychotherapist established ‘Humourworks’, to provide training in the role of humour in therapy, management and education. Here she explains to Stephen Clift the background to her interest in humour, and explores its significance for health and well-being.

Q How did you get involved in working with humour Sharon?

I got involved in the work some while after qualifying as a very straight kind of psychotherapist. You know you have this kind of template of how therapists are supposed to be and that didn’t include humour. Then one day I was working with a client who was going over a fantasy which we’d worked on many, many times, and all kinds of things were going on in me, and I was monitoring myself, but we got to a point where I felt, ‘I can’t be doing with this’ and I actually responded to her by saying ‘Oh bullshit!’ She laughed and I laughed - a nervous kind of a laugh - and I’ve never behaved that way before! It was near the end of the session, and I didn’t know what to do with it, and so I spent a week agonizing and went to supervision, and felt ‘Oh my God, what have I done?’ But when she came back the next week, she said: ‘That was absolutely it, I’ve got it, it is a load of bullshit!’ And then, I thought, all this time I’ve been sitting on this goldmine of my own humour. So that’s really how it started.

I didn’t do anything with it really except include humour more and more in my work, until it came to my Masters in Psychotherapy. I was going to investigate a protocol on depression. During one of the course sessions the tutor went round the room and four people before me wanted to investigate depression, and he came to me and said: ‘Oh no, not another one on depression!’ Who researches joy, who researches happiness? And when he said that, a light came on in my head and I thought ‘Humour!’ To begin with, I could find nothing on humour in psychotherapy, but eventually I found a book, and then found a huge amount of material more generally on humour and its benefits. And that’s really how I came to be involved in this area of work. And I learned an enormous amount about the place of humour as an essential quality of being human, and being able to cope with the ludicrous thing we call life! Humour to me is aligned to the sacred.

I was recently involved in some time-limited therapy work with a health visitor on her personal difficulties, but also on issues related to her return to work after illness. During the afternoon after one session she was due to run a clinic and she was talking about her difficulties in coping with stress and so we started exploring different aspects of her personality, and particularly how the extravert side of her personality could help her deal with her stress. And through discussion she discovered ways of lightening up and bringing music into her clinic. Humour is not used in isolation, it can be linked with the other arts. And then we talked about using some visual material too. She felt the other health visitors and the doctor would be receptive to these ideas, and suddenly this woman, who initially was stressed about the idea of going into the working situation was enthusiastic about it!

Q Could you tell me about the workshops on humour you have run for people working in business or education or health?

The basic issue is education - that’s what I feel I am there for in the workshops I run. I’m introducing humour to help people relate better, to manage better, to lighten up and cope better with stress and so on. When I was in my training as a counsellor, one of the elements of our training was to focus on our ‘purpose’ as a human being - and the purpose that came to me was: for the birthing of humanity’ and that has stayed constant with me, whatever work I am doing. Birthing humanity in myself first so that I can facilitate that process in other people. And the bottom line of all the work I do, and actually particularly with humour, is helping people to free themselves up and find out who they really are under all the social conditioning and all the terminal seriousness of life. So
when I am working with managers, or with teachers or with nurses, it’s about allowing them to be more themselves in whatever they are doing, and to be more humane - with themselves as well as with other people.

In our programme we have focused on the role of the arts in healthcare and health promotion, and we felt that humour and entertaining are art forms, which certainly add something to our quality of life and sense of well-being. But I wondered what research has shown on the health benefits of laughter.

Well, there are a lot of health benefits of laughter and I’ll tell you them first and then come to the ‘but’! There was a famous autobiographical account given by Norman Cousins of the role of humour in giving relief from pain. Cousins had a serious collagen disease - ankylosing spondylitis, which affects the connective tissue of the spine and joints, creating intense pain and reduced immune system functioning. He was given a 1 in 500 chance of survival. He was getting standard medical treatment but he wasn’t satisfied with it, so booked himself out of hospital and devised a whole humour programme for himself: he watched comic films, read humour magazines, had friends over, organised parties - and what he discovered was that ten minutes of belly laughter gave him two hours of analgesic-free relief from pain. So that was an important starting point for people giving attention to what humour might contribute to health. Since then, researchers have argued that humour has a wide range of positive benefits - such as reducing stress, relieving pain and boosting immunity.

The only problem with these claims, however, is that the scientific quality of much of the research in this area is questionable and there continue to be problems even with defining what humour is. So, we have also to take account of our everyday human experience in making a judgement about the value of humour and laughter. I don’t know really, for instance, whether laughter boosts the immune system, but I and everybody else knows that to have a good laugh makes you feel good! So let’s go with our experience and make use of humour as a valuable resource for promoting well-being!

Humour and health - some research evidence

Humour boosts the immune system, e.g. by increasing levels of immunoglobulin A which protects against upper respiratory problems. (1, 4, 5)

Humour is involved in reduction of mild to moderate pain (7, 9, 10). For patients with rheumatism, neuralgia or other conditions characterised by a spasm-pain-spasm cycle, reduced muscle tension resulting from laughter disrupts the cycle and reduces pain experienced. (6)

Humour is involved in stress reduction (2,8) and laughter appears to reduce some neuro-endocrine hormones associated with the stress response. (1)

Humour is involved in psychological wellbeing, e.g. in a literature review support was found for the claim that humour as a response to events and humour as a psychological process, including sense of humour, can positively affect mental health. (3)

However, findings are not scientifically conclusive due to different researchers using different definitions for humour and, at times, methodological problems in the research.

Michaelmas Term

Saturday 2 November
Music and well-being day in association with the Metropole Gallery, Folkestone.
Day workshop with Linda Rose, Director of ‘Music for Life’, on the role of music in the care of the elderly.

Wednesday 20 November
Visit to the Blackthorn Trust, Maidstone, with guided tour and talk by Dr. David McGavin, and art and music workshops.

Tuesday 3 December
The role of the arts at Medway Maritime Hospital, Tony Crosse.

Lent Term

Tuesday 28 January
‘Time Being’ an arts project as part of the Isle of Wight Healthy Living Centre initiative, Jacqui Ager.

Wednesday 19 February
The uses of theatre in promoting health, Claudia Leaf, Channel Theatre, Margate.

Saturday 1 March
Francis Biley will lead interactive workshops on language, poetry and health.

Tuesday 18 March
Children’s drawing and identity, Bryan Hawkins, Canterbury Christ Church University College.

Trinity Term

Tuesday 29 April
Dance and Health workshop, (facilitation tba), Clare Gammon, South Kent College.

Tuesday 13 May
Suzie Minns will talk about the work of ‘Art Operation’ at Maidstone Hospital.

Tuesday 3 June
Art in the Hospital Ward: exhibition and discussion, Canterbury Christ Church University College.

End of June (date tba)
‘Sing for your Life’ - singing events in Folkestone and Faversham, to promote personal and community well-being and health.

All the events will take place at Canterbury Christ Church University College, with the exception of those marked with *.

For further details, or to be added to the mailing list, please contact:
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Health Education (2002) Special issue on the arts and health, 102, 4, Guest Editor, Stephen Clift.
Hendrey, D. (undated) Words from the Wards: Poems and Stories by the patients and relatives at Dumfries and Galloway Royal Infirmary: Dumfries: Dumfries and Galloway NHS Trust.

useful websites

Artsworks in Mental Health 
http://www.artworksimentalhealth.co.uk/index.asp
A large NHS sponsored web site about the arts in the context of both mental illness and mental health promotion.

CAHHM
University of Durham: The Centre for Arts and Humanities in Health and Medicine http://www.dur.ac.uk/cahhm/index.htm
A research unit which is studying the effectiveness of the arts in health care.

Creative Remedies
http://www.creative-remedies.org.uk/
Examples of good practice in arts and health work in Staffordshire County Council and West Midlands Arts

Health Development Agency
http://www.hda-online.org.uk/index.html
On behalf of the Government, the HDA evaluates which strategies best improve people’s health. Within the Resources and Links section, see Arts and Community Participation for Health.

JABADO Centre for Movement Studies, Leeds
http://www.jabado.org/
A research and development agency concerned with the contribution that movement specialists can make towards well-being

LAPIDUS (Literary Arts in Personal Development)
http://www.lapidus.org.uk/
A membership organisation promoting the use of the literary arts in personal development.

Medical Humanities
http://endeavor.med.nyu.edu/it-med/medium.html
Medical Humanities at the New York School of Medicine. See the literature, arts and medicine data base.

Medical Humanities Resource Data Base
http://www.mhnd.uc.ac.uk/
Educational resource to support and promote the incorporation of the arts and humanities within medical/health professional education.

Mentality
http://www.mentality.org.uk/
A charity devoted to the promotion of mental health. See the section on mental health promotion.

National Network for the Arts in Health
http://www.nnah.org.uk/
Comprehensive information, resources and useful contacts across the UK.

Survivors’ Poetry
http://groups.msn.com/survivorspoetry
A charity which promotes the poetry of survivors of mental distress.

The Arts Council of England
http://www.arts-council.org.uk
Responsible for developing, sustaining and promoting the arts in England.

The Association for Applied and Therapeutic Humor
http://www.aath.org/
An American organisation which promotes research into the therapeutic effects of humour, and aims to educate and disseminate useful findings.

The British Holistic Medical Association
http://www.bhma-sec.dircon.co.uk/
For the promotion of a holistic approach to health care.

The Kings Fund
http://www.kingsfund.org.uk/
An independent charitable foundation which aims to improve health. See Simon Jenkins’ lecture 5th July 2002 ‘Why are hospitals so ugly’.

The Nuffield Trust
http://www.nuffieldtrust.org.uk/confer/confer.htm
Carries out research into the National Health Service. See Conferences: Arts and Humanities in Health - 1999 Windsor Communique.

Theodora Children’s Trust
http://www.theodora.org/theoeng.html
Special clowns for hospitalised children.