Published in: Line Kossolapow: Arts – Therapies – Communication. Vol II,
Lit-Verlag Münster, Hamburg, London
S. 450 - 455

Rosemarie Tüpker

Education in Arts Therapies

To begin with, I think I should say a few words about my training as a music therapist since a knowledge of my personal background will help you understand my perspective.

When I went to university in 1970, there was no training in music therapy available here in Germany. I dare say that most of the "seniors" here did much the same thing as I did: I studied each of the subjects that seemed important to me, some successively, some together. In my case, the main subjects were: music, then musicology, psychology and philosophy. Then, the first postgraduate training to be offered in Germany took place from 1978 until 1980: the "mentor course in music therapy in Herdecke", which I took part in. This course can be regarded as the beginning and origin of official training in music therapy in West Germany. Not surprisingly, as far as curriculum, teaching methods and much of the contents were concerned, the course showed signs of inexperience, but this was compensated – amply in my opinion – by the spirit and the creative impulse of the pioneering situation, but also by a sound financial basis. There were only about twice as many students as instructors, and thanks to generous scholarships no one had to work for a living on the side so that we could really concentrate on studying for two years – from morning to evening, often on the weekends, too.

I emphasise this point because public policy in Germany is currently guided by the idea (or has fallen prey to the delusion) that it is possible to improve the quality of training by economising on positions and by reducing finances; and because every day I see the numerous restrictions and pressures under which my students are working simply because they have to work in addition to studying.

I then worked as a music therapist for about ten years in a psychotherapeutic sanatorium with a psychoanalytical orientation, first with young people and later with adults. It was in day-to-day work there that I became acquainted with the other artistic therapies and came to appreciate them. In addition to the intensive psychotherapeutic training which I received within the sanatorium and outside it, the fact that I had the opportunity to conduct music therapy at a high level of independence and as a principal therapy was of fundamental importance for me and my teaching career, which began at this university in 1990. That is, my contact with the patients began with their admission to the sanatorium and taking their history, it included the full range of psychotherapeutic treatment and its organisation, and it ended with the final psychotherapeutic report.

Thanks to this professional situation and the fact that physicians, psychologists and art therapists worked together on a relatively equal footing, there was relatively little friction due to rivalry and defensive attention to professional boundaries – at least for a time. This made it possible for music therapy to develop and to become established as a treatment of **equal** value; there was no unproductive stress due to a need to prove that it is the **better** treatment. (For various reasons, this unfortunately did not apply to the same extent to art and motion therapy, but it did apply to psychodrama.)

The basis for my standards and ideals of music therapeutic training is an experience of treatment in which music therapy is an independent form of psychotherapy.

For the sake of simplicity and because it is my profession, I shall restrict myself in my remarks to music therapy. But I am convinced that comparable claims can be made with respect to the other forms of arts therapy. If you think differently about this, whether from the perspective of dance therapy or art therapy or otherwise, then this could perhaps be an issue for the discussion.

Music therapy is an independent form of psychotherapy: this means that it is not just a supplement to verbalising therapies or to "proper" psychotherapy. It does **not** mean that that it cannot be combined with other forms of therapy. On the contrary: music therapists must be capable of working in a team. They must be able to present their experience in a team so that it can be understood.

But it also means: as a matter of principle, music therapists must be capable of coping helpfully with **all** mental and emotional processes which they trigger or which happen to the patient in music therapy.

The relationship – the therapeutic relationship – cannot be delegated. We cannot say to the patient, "You are quite welcome to act out your affects here, but you will have to take the conflict that you have just bumped into to my colleague X. You know, I don't work on conflicts, I am only here to give you support."

We cannot tell the patient who recounts a dream to us: I'm sorry, but I didn't learn dream interpretation – psychoanalysis is responsible for that. Of course we can say that, perhaps we can even say it a little more tactfully, but we cannot say it without committing a serious mistake in treatment.

If we regard the therapeutic process as a whole against the background of transference and countertransference, we will clearly recognise – and it may be a shock to us – that there is no way for us to draw boundaries which will not have a significance for the matrix of transference in a way which **we** do not determine because it is already determined by the patient's particular history.

To illustrate the point: if we take the initiative of delegating a part of the relationship, and in the patient's transference this is experienced such that "she doesn't want to listen to this, suffer it, bear with it", then **this** is the reality and effect of our action. Arguing that this is nothing more than a sensible or necessary constraint on the specialty in question may sound reasonable on the level of rationalisation. But this does nothing to change the fact that this sort of practice will retraumatise the patient who has already been traumatised and found no-one who would listen to the distress. Here there is no location of reasonableness or objectivity **outside** of the patient's subjectivity. The subjective aspect – the patient's lived experience – is **itself** the objective reality of the relationship and thus the only possible standard for our action.

Transference (or, to put it more generally, the therapeutic relationship) cannot be controlled or organised, and in particular neither the therapist nor the health system nor the health insurance organisation can determine that the patient should perform all his essential transferences with recognised psychotherapists – or if behavioural therapy is prescribed, that he should do no transferring at all.

My hypothesis, from which substantial requirements for training are derived, is as follows:

All psychotherapies – all therapies which work psycho-logically – including the artistic therapies must on the one hand be complete in themselves, and on the other hand open for cooperation with other forms of therapy.

The sort of combined treatment programmes which are usually offered in almost all therapy centres permit the patient to determine what form of therapy will have what psychological status for him or her. All therapists involved have to be equipped for this.

Now of course the patient does not determine this status (this psychological location) consciously. Rather, it happens to him or her – just as it happens to us, the team of therapists. And if the treatment concept does not accept this – perhaps for reasons of professional rivalry or because of financing regulations – it will happen all the same. There is no getting out of it. But the possibility that the whole thing remains an unconscious process will be greater, and the chances for understanding and healing will be accordingly reduced.

What does this mean for training? What requirements and demands result from this?

You can well imagine that the result has to be something completely at odds with current developments in training – it is something that really cannot be achieved in a training of less than ten years.

What does a music therapist have to be capable of?

1. Therapists have to have a command of the **basic instrumentation of music therapy** to such an extent that they do not bother the patient too much with their own insecurity, nor restrain the patient because of their musical limits. (I cannot go into detail about this because there is no time for it. In the case of music it generally means that the music therapist must first be a good musician. But that too is a broad topic: what is a good musician?)

2. Basically, the music therapist has to have a command of everything that can be expected from a typical psychotherapist of average skill. If the orientation is psychoanalytical, this means: **appropriate and reflected handling of transference and countertransference**, dealing with resistance, understanding, interpretation, and so on; in other cases, it will mean an equivalent **methodologically reflective grasp of the therapeutic relationship** according to another psychotherapy concept.

3. As already pointed out, the therapist must be able to cope therapeutically will all processes which occur in his or her treatment.

4. This also means: the therapist needs the same **thorough knowledge of mental illness** as a typical psychotherapist of average skill. And by the way: I am not of the opinion that the art therapies need their own theory of psychopathology, much less that each one of them needs a theory.

5. As a matter of course, it means that music therapists must go through a **training therapy** the same way that all psychotherapists do; the same holds for **supervision**.

6. Finally, I would like to mention the **ability to work in a team**. At this point it is even harder to say “like a typical psychotherapist of average skill” than it was with the other

points. So let's take a chance: arts therapists have to more capable of working in a team than is now normal.

You would be right to ask at this point: how can this be made into a curriculum? How are we supposed to teach all this in the period prescribed and allotted to us? And, at least within the compass of German law, we could ask: why should we aim at such a high level of qualification when the scope of professional activity open to arts therapists does not by any means correspond to this level – neither as regards status nor financially?

You have noticed: I have got completely carried away – even if I have to admit that I have a clear aim. I have no way of making a curriculum out of this, nor do I know how to overcome the various contradictions which I see in the training situation and in the current situation of society as a whole. Here in Germany, at least, these contradictions are on the increase due various social and political developments.

Instead of making a pretence to solutions that I myself do not find convincing, I would like to give you the opportunity to participate in the quandary which I am in because of my role as the director of a programme of training and which is becoming more pressing – although this programme has a relatively high status in the academic world in comparison with others in Germany and abroad.

I would like to set forth very pointedly and briefly four of these contradictions, which in my opinion are irresolvable. All of them need further discussion and substantiation, but I think you will be able to appreciate what I mean because after all we live in the same reality, even if there are different nuances in the various countries.

1. The contradiction between the colleagues' qualifications, which can be very high, and the scope of work permitted by the health system.

2. The contradiction between what an average patient can in my opinion legitimately expect when he goes to an average psychiatric hospital, for example, and what he really encounters there.

3. The contradiction between the many speeches on quality assurance and the system's lack of interest in the quality of the work done. This applies to the hospitals, to the health system and to training. At this point, we should discuss the question as to what who means by quality. (Of course, this is also necessary prior to any measures to **assure** quality.)

4. The contradiction between the call for innovation in science on the one hand and on the other hand the maintenance of models of science whose relevance for the human sciences has often enough been questioned and whose heyday in the natural sciences is long past. And still these old models are used as the measure for decisions on health policy. Even worse: it is increasingly the case that **science** is misused to support power interests in deciding questions that can only be decided by seeking a social consensus.

In conclusion, I would like to set forth some propositions and ideas as to how we can respond to this situation, where we can direct our efforts:

Instead of adapting ourselves to what present systems want from us (that is, a brief, direct, linear course of training restricted to what is necessary), we can insist on what we personally find really important and necessary, both for our work and for the patient – I am certain that there will be differences among us on this point.

Instead of training "human capital" – a demand that was proudly made at this university some time ago – we could consistently insist on a humanisation of training.

Instead of imparting unified, canonical knowledge (which is never adequate anyway), we could make an effort to implant in our students an adequate sense of their and our lack of knowledge. Instead of finished concepts, an ability to reflect. At the end of the training, there should not be more answers, there should be more questions and manners of asking questions.

Instead of concentrating on a unified output of knowledge and skills, we could direct our efforts to discovering, appreciating and promoting the peculiar talents of each individual. We should put our trust in the idea that this society will in all probability function better when the specific individual values of trainees are promoted than if we make a selection of the things which **society** purportedly needs – when in reality these are **market** needs. Instead of only asking: what must an average arts therapist be capable of, we could also ask: what is special about this student? How can this special talent be promoted in such a way that it will be a help to other people?

As people involved in teaching, we have a dual task: we have to have a direction, but at the same time we have to trust in the openness of the development which we initiate. It is not our first and foremost duty to impart our knowledge, but to initiate a process which will open the way to more knowledge and skill than we could achieve ourselves.

The arts always have a potential for social criticism. But they are also always in danger of an affirmation of the existing situation. I think that both of these points also apply to artistic therapies, and that it depends on us as instructors which side will lead. A nice conclusion on the tasks of the new millennium could be derived from this.

I wonder, however, whether this new millennium is not perhaps more a market strategy than anything else; and somehow I am not willing to let it become too much of an emotional reality for me. Is it not a very eurocentric reality? After all, the Jewish congregation is celebrating the year 5760 last weekend, and our tasks will not be transformed by a huge New Year's Eve cracker; rather, I think that the important point is the numerous day-to-day decisions in our dealings with students, patients and colleagues.

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Overview

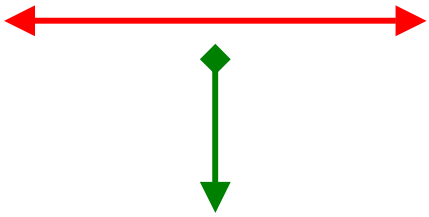
Personal background

Ideals of music therapy / arts therapies

Requirements and demands for training:

What does arts therapists have to be capable of ?

Some Contradiction



How can we respond?

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Music therapy (art therapy, dance therapy …)
is an autonomous form of psychotherapy

- not just a supplement
- can be combined with other therapies

- The therapeutic relationship can not be delagated
- Transference can not be controlled, organised …
- Everything we do, has (possibly)
  a significance for matrix of transference.

All psycho-logical therapies have to be
- complete in themselves
- and open for cooperation

What does a music therapist have to be capable of?

art
drama
… …

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1. Basic instrumentation of music therapy
   including: “good musician” ! ?

2. appropriate and reflected handling of transference and countertransference
   or: therapeutic relationship according to another concept
   - as a typical psychotherapist of average skill -

3. Able to cope **therapeutically** with all processes which occur in the treatment
   - as a typical psychotherapist of average skill -

4. Thorough knowledge of mental illness
   - as a typical … … -

5. Training therapy; supervision
   - as a … … -

6. Capable of working in a team

Contradictions

1.
Qualification ⟷ scope of work permitted

2.
What a patient can legitimitely expect ⟷ what he really encounters in a psychiatric hospital (for example)

3.
quality assurance ⟷ lack of interest in the work done

Who decides what quality is?

4.
call for **innovation** in science (and healing) ⟷ power and misuse of **mainstream** science (and mainstream methods in psychotherapy)

How to respond?

Critical or affirmative function of arts (therapies)

- Adapting or insisting?
- "Human capital" or humanisation of training?
- Unified knowledge or an adequate sense of our all lack of knowledge?
- Finished concepts or the ability to reflect?

  More answers or more questions?
- Unified output of knowledge and skills or promoting the peculiar talents of each individual?

  (Society needs or market needs?)
- "What must an average … … … be capable of" or: "
  What is special about this student?