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Please cite this publication as follows:

Deboys, Rachel, Holttum, S. and Wright, K. (2016) Processes of change in school-based art therapy with children: a systematic qualitative study. *International Journal of Art Therapy*, 21 (3). pp. 1-14. ISSN 1745-4832.

Link to official URL (if available):

<https://doi.org/10.1080/17454832.2016.1262882>

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Processes of change in School-based Art Therapy with Children: A systematic qualitative study

Abstract

Although theoretical processes of art therapy with children have been suggested, they lacked a systematic research basis. This systematic qualitative study explored children's school-based one-to-one art therapy in order to create a theory of change. Across two primary schools 14 children were interviewed individually, as were their parents, teachers, and art therapists (total N = 40). All children had received art therapy within the previous 12 months. Children completed an art activity to aid the interview process. Interview data were analysed using grounded theory methodology.

The analysis generated a preliminary model with three components. 'Component 1 – school context' highlights the systemic nature of art therapy as well as its mystique to those not directly involved. 'Component 2 – core model' describes art therapy as individualised and child-centred. Art-doing and making were considered central to children's expression and developing understandings. 'Component 3 – change and no change' describes the connection between identifying therapy aims and perceiving change .

Recommendations are that art therapy be considered for children struggling to verbalise their difficulties; that therapists focus on therapeutic experiences being fun and enjoyable for the child, as well as embedded within the child's system; and lastly that clear target problems are identified at the start of therapy.

Key words: Art therapy, primary school, children, grounded theory, qualitative

Introduction

Mental Health in Schools

Teachers in England are increasingly reporting the effects of child emotional difficulties in the classroom (Burns, 2015). Early intervention agendas (Allen, 2011; Field, 2010) and policies such as Targeted Mental Health in Schools (TAMHS) (Department for Children, Schools, & Families, 2008; Department for Education, 2011), Children and Young People's Increasing Access to Psychological Therapies (CYP-IAPT) (Young Minds, 2011), as well as Pupil Premium funding (Department for Education, & the Education Funding Agency, 2014) have all attempted to tackle children's mental health problems in UK schools.

For some children, school can provide a chance for reparative relating and act as a secure base to enable learning (Bombèr, 2007; Geddes, 2006). School staff can take into account children's zones of proximal development (Vygotsky, 1978) in ways that can be absent in early home life. This refers to the developmental zone in which a child has the beginnings of capability but has not yet mastered something. Because of their readiness to learn, it needs relatively little guidance for them to progress. Seen by some as an optimum environment for the delivery of therapeutic work (Department for Education, 2011; Fazel, Hoagwood, Stephan & Ford, 2014), many schools now offer a range of interventions including counselling, play therapy, and arts therapies. Moore's (2011) Bristol Child and Adolescent Mental Health Services (CAMHS) Commissioners' evaluation of the local TAMHS Project described the collaborative working of art therapists and concluded that the interventions led to enhanced emotional wellbeing of the children involved, with noticeable improvements in social and academic areas.

Children's Art Therapy

Taylor Buck and Hendry (2016), in their description reached by consensus of UK art therapists experienced in work with children and families, cite one of the key processes of art therapy with children as assisting children in understanding their emotions through the art-making and reflecting on the artwork. In the US context Malchiodi (2013) similarly describes art therapy as an encounter in which the therapist supports children's exploration of art materials and concurrent emotional processing, enabling them to experience themselves and their environments differently (Kramer, 1971; Malchiodi, 1999; Rubin, 2005). The therapeutic emphasis is on non-verbal artistic expression, the insufficiency of words, and the narrative need for imagery (Karkou, 2011; Levick, 1986; Malchiodi, 2013; Pifalo, 2007). Mirroring (Kuhns, 1983) and affective attunement (Winnicott, 1973) are considered vital.

Research suggests that school-based art therapy can help children with processing of trauma (Chilcote, 2007; Roje, 1995), communication development (Evans, 1998), ego resilience (Jang and Choi, 2012), and behavioural difficulties (Rosal, 1993). Several case studies give insight into processes but they tend to be unsystematic and from therapist viewpoints (Deaver, 2002; Gilroy, 2006; Kapitan, 2010; Malchiodi, 1998, 2013). Despite such shortcomings, the limited research has highlighted the possibilities for new emotional expression and self-understanding arising from art-making (Chilcote, 2007; Gersch & Goncalves, 2006; Jang & Choi, 2012; Sutherland, Waldman, & Collins, 2010). Existing research varies in the extent to which systemic factors are considered, although some studies have used systemic working to enhance the art therapy interventions (Chilcote, 2007; Pleasant-Metcalf & Rosal, 1997; Sutherland et al., 2010).

Art therapy has historically been viewed by many clinicians as mysterious (Rubin, 2010), yet Malchiodi (2013) and Wilson (1996) suggest partnership with other professionals

to develop the research base. Health and Care Professions Council (2013) guidelines for arts therapists affirm the need for greater research, inter-professional collaboration, and involvement of experts by experience.

Rationale and aims for the Study

Research on children's own experiences of art therapy remains limited, and systematic studies exploring processes of change are scarce. Change is predominantly therapist-reported, and data triangulation absent. We aimed to create a model of children's art therapy process, using a rigorous qualitative methodology, incorporating multiple perspectives: child, parent, teacher, and art therapist.

Method

Research Design and epistemological position

The grounded theory method of Strauss and Corbin (1998) was followed because it enables hypotheses to be created, grounded in qualitative data, about psycho-social processes. Individual interviews were conducted in a non-experimental design, the aim being to capture rich data for in-depth analysis, in order to generate rather than experimentally test hypotheses, and to create a preliminary theoretical understanding of the therapeutic processes of art therapy within a primary school context. Data triangulation was sought by interviewing children, their parents, teachers, and art therapists. The epistemological position of the study is critical realist, sometimes referred to as constructivist (Charmaz, 2006; Gorski, 2013). That is, the authors assume that the theoretical model produced will partially reflect an underlying reality about the psychosocial processes that can occur in art therapy with children, and will have some analytic generalisability, but the model's closeness to this reality is limited by the

social lenses through which all parties experience and understand the world, and the authors' own personal biases. We attempted to limit the effects of our biases by the use of quality assurance procedures (see later section). In the use of one-to-one retrospective interviews, the current grounded theory study followed a similar approach to Yurdakul, Holttum and Bowden's (2009) exploration of autogenic training for anxiety.

Data collection was undertaken at two UK primary schools, both larger than average, in areas of high social deprivation, and rated by the regulator Ofsted as "good" (Ofsted, 2015). Pupils at the first school predominantly came from White British backgrounds. The second school was in an area of high ethnic diversity, many children having English as an additional language. At the time of data collection, art therapy had been provided within both schools by HCPC-registered art therapists for several years, the first employing an art therapist one day a week. The second employed their main art therapist four days a week and regularly provided trainee art therapist placements.

Art therapy as practised with children in the study

Art therapy was one-to-one. Although in one of the schools it was also offered in a small, closed group, all the children spoke only about one-to-one art therapy. The art therapist met with parents and teacher first to obtain their understandings of the child's difficulties, and enquire about developmental history, sources of resilience in the child and family, and any traumatic events. Engagement in art or other activities together that had a creative element, such as play, gardening or choosing clothes may be enquired about. The art therapist then met with the child to talk about what difficulties therapist and child might work on together, explain how making art may help the child to talk about and understand difficult feelings, and explain about confidentiality. Four to six sessions were used for assessment, during which the

child usually made art from the first session. Work was usually 20 sessions, or up to a year for more complex cases. There was on-going liaison with parents, teachers and where applicable a home support worker or social worker, to consider the child's progress in terms of behaviour and mood. The art therapist also discussed with the child their perception of achievements such as better concentration in class or conquering fears at home, and the child may make an artwork to represent this and take it away at the end of therapy.

Participants

A one-to-one interview was held with each of 40 participants, including 14 children (6 boys and 8 girls) aged 7 to 11 years who had received art therapy within the previous 12 months. All children had one parent participate and one child had two. Eight teachers were interviewed, two speaking about the same child. One teacher talked about a child (Child 15) who subsequently did not participate. Three art therapists described their work, covering five children between them. Children's ethnicity included White British (9), Black/Black British (4), British/European (1) and British/Middle-Eastern (1). Children who reported positive change, no change or unhelpful experiences were approached to include negative cases (Strauss & Corbin, 1998). Children had a range of identified problems (Table 1). All sources including the child were synthesised in order to summarise their main difficulties. In five cases social services were working with the family at the time of referral to art therapy, and two children were undergoing neurodevelopmental CAMHS assessments. Art therapy was on-going for 9 children and completed for 6. Duration was less than two terms in 3 cases, two terms in 6, and more than two terms in 6.

Table 1: Presenting problems identified by or for the children

Identified problem as communicated to the authors	N
Challenging behaviour, anger or emotion regulation difficulties	7
Social and communication difficulties	3
Effects of bereavement	2
Self-esteem difficulties relating to visible physical disability	2
Effects of domestic violence or abuse	2
Undergoing assessment for neurodevelopmental condition	2
Social anxiety and phobia	1
Diagnosis of developmental trauma	1
Difficulties related to parents' mental health	1

Note: More than one issue was identified for some children

Interview Schedule

Interview schedules were created following a literature review, discussions between co-authors, CAMHS and education professionals, and piloted in role-play with two colleagues. The questions were designed following Strauss and Corbin's methodology (1998) to elicit data relating to children's experience of school-based art therapy using open-ended questions. No concepts from the existing literature constrained the interview, but it was important that the authors were aware of existing concepts in order to avoid imposing them on the interview or the data (Strauss & Corbin, 1998). The interview schedule for children is shown in an appendix to this article. Grounded theory interviews tend to be modified during the study as hypotheses emerge to enable testing or extending with subsequent participants, so the interview shown is only the initial version. Similar questions were asked of art therapists, teachers and parents, though from their perspective, so for example what the parent remembered the child saying about the art therapy rather than personal experience of it.

Procedures

Following receipt of ethical approval from the applicable ethics panel at her university, the first author (a trainee clinical psychologist at the time) contacted the British Association of Art Therapists (BAAT), and met with several art therapists, The art therapists, Special Educational Needs Co-ordinator, and School Support Worker within the two participating schools approached parents initially. Consent was given by all parents for their own and their child's participation. Assent was provided by all children. All participants were interviewed at their child's school.

Parent interviews ranged from 9 to 40 minutes. Child interviews lasted between 20 and 46 minutes. All were audio-recorded and transcribed. Children were invited to create an image using art materials describing their experience of art therapy, during their interview. The rationale was to facilitate the expression of their experiences and recall of art therapy rather than to create visual data, so images were not studied, but their creation aided the interview process.

Quality Assurance

Quality guidelines were followed throughout (Chiovitti & Piran, 2003; Mays & Pope, 2000). Reflective supervision, peer supervision, reflexive writing (Koch, 1998), and an arts based journal by Author 1 deepened her awareness of potential biases including interests in art, mental health in schools, and social justice. Author 2 is a research psychologist and Author 3 provides art therapy to a primary school (Author 1's supervisors during the study).

Data Analysis

Line by line coding was undertaken for 33 interviews and focussed coding for the remainder. Line-by-line coding stays relatively close to the data, whereas focussed coding occurs after these initial basic codes are clustered to form higher level, more abstract categories (Strauss & Corbin, 1998). In focused coding these higher level categories are sought in subsequent data. However, vigilance was maintained for any new lower-level codes when focussed coding only was performed. Constant comparisons were also used, in which the authors compared the raw data and codes and categories from one participant with those from others and sought to verify codes and categories and to notice data that did not fit. Codes and categories were re-defined, expanded or removed as necessary to better fit the emerging theory to the data and maximise the likelihood of accurately reflecting participants' experience (Strauss & Corbin, 1998).

Attention was paid to 'negative cases', that is, where a participant's experience seemed in contrast to the majority. This helped in forming key parts of the model, such as discriminating between instances where participants could describe positive changes and where they could not. Instances where they could not were in the minority, and they were linked with not recalling an initial aim for art therapy, thus suggesting a potential key aspect of art therapy for children at primary school. However, this is at the level of a hypothesis to be tested in future research rather than an established fact, as is the nature of producing a grounded theory (further consideration in Discussion section). Author 1's coding and theory development were regularly reviewed with Authors 2 and 3, aided by scrutiny of coded transcript, and tables of basic codes and higher-order categories. Respondent validation, where participants check the study findings presented as a user-friendly summary, was undertaken with four participants (a child, parent, teacher, and an art therapist).

Results



Figure 1: Model component 1 - The context for therapy

Model and Detailed Analysis

A theoretical model with three components was generated. ‘Component 1- school context’ describes the systemic context of the art therapy, ‘Component 2 – core model’ the reported key aspects of art therapy and its outcomes, and ‘Component 3 – change and no change’ the perceived link between prior identified therapy aims and subsequent change for child participants.

Although depicting connectivity with supportive school systems, ‘Component 1 – school context’ shows art therapy occupying a distinct space. Its separation embodies its perceived non-intrusive approach and perpetuates its mysterious and unknown persona.

The school environment – safe, supportive and natural

Many parents and teachers spoke of school being a natural and supportive setting for art therapy, contrasting with mental health clinics as intimidating and stigmatising.

P13 (Parent of Child13): ... they [children] got noise, chaos, normal going on around them [in school] ... They don't feel like they've been pulled away and they're a bit different... Cos it's like – it's [the clinic] intrusive – it's like being spied on and you're never gonna act yourself

Only one child expressed a negative view of school, with most talking about loving school as a safe and good place.

C7 (Child7): I actually feel lucky because I come here [to this school], it's that good

P8: oh, she [child] loves school

Accessibility, liaison, staff availability, and embeddedness of art therapy

Parents talked about easily approaching staff and art therapists to discuss concerns and progress. This seemed to assist both parents' and teachers' understanding of the therapy.

P5: ... all these things [at home] that used to come up I would come straight to [art therapist] and say "This has happened" and she'd say "Okay we'll work on that"

T5-1 (Teacher 1 of Child5 talking about the art therapist): *we'd meet every few weeks and sort of say, like it'd just be in the staff room in passing and how she was getting on*

Art therapy as mysterious and unknown, non-intrusive and gentle.

Although able to meet with the art therapist, many adults said they knew little about what actually happened in art therapy, though they viewed it as gentle and non-intimidating.

T1: ... art therapy seems like this kind of wholly separate thing that they do

P6: She [art therapist] did say some kids like to share things with their parents – some kids don't ... It wasn't about my feelings ... it was very about [child] being able to feel comfortable and express what he needed to express within those four walls [...] and I quite liked that ...

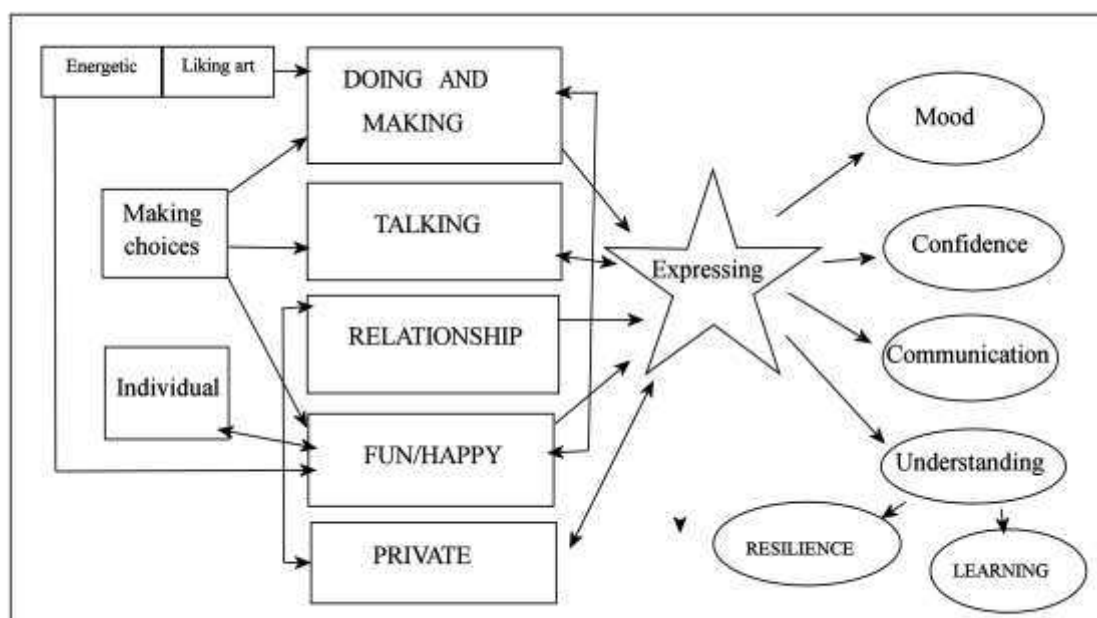


Figure 2: Component 2 - core model

The core model portrays the core categories relating to the children and their therapy sessions and the perceived changes arising from those processes. The core model incorporates both actions and their context and proximal inputs to these such as perceived character of the children, as well as perceived outcomes. A strong element of the core model was the child-centred nature of art therapy, reflected in participants' emphasis on children

making choices and the individualised nature of the therapy. Also central was doing as facilitating expression.

Energetic

Many adults described the children as doers or very active, with preferences for physical tactile activities.

P14: She [child] loves football and she's very hyper.

Liking art

All but two of the children were considered to enjoy creativity. Several said that art was one of the things they liked best. Two parents described their children having less positive relationships with art.

P11: she [child] could sit and do art all day

P9: he [child] doesn't really like art

Making choices

Children's choice about what they could do, make, and talk about seemed important. Several children spoke about being able to do whatever they wanted to, even making a mess. It seemed to help the children feel less pressured and have increased agency.

C2: I can do anything actually. I can like, make a mess

P6: ...so I think for [child] it must be that there's less structure which he would possibly like – free flow ... For him wanting to do whatever he wanted to do

Parents and teachers felt that this level of choice was a very different experience compared to typical classroom interactions and appraised this as important.

T10: ... they [art therapist] take it from what the child's doing and what the child's saying and take it from there

A few children described different levels of choice. In one 'negative case' a child talked about actively disliking a session because the art therapist (not a participant) had not allowed him to make choices.

C3: she [art therapist] just didn't let me do anything

Whilst it is not possible to draw broader conclusions about the practice of a specific therapist without further context, this illustrates how a negative case (i.e. one inconsistent with others in that making choices was not experienced) supports the overall core model. Not being able to make choices was experienced negatively. The child in question also reported on more positive experiences of art therapy, which formed the main data for this child.

Individual

Participants talked about the importance of sessions being one to one; providing focussed attention from a listening, supportive, caring adult. This was an especially strong idea for the parents. Given some children's home contexts, several teachers also felt this individual time was crucial. Children gave an impression of tailored sessions, where the art therapist altered her interactions to the child's needs, including introducing specific materials. Being away from their peers and the demands of the classroom also seemed important.

P3: I think it was nice for him [child] to have his own time. I don't think it would have worked as well in a group because there can be distractions in that, and he probably liked the one to one ...

T15: he [child] is probably absolutely loves the fact that he's got it all to himself

Doing and making

The children spoke about using a range of art materials including paint, clay, glue, and fabric, with some saying they did their own art-making whereas others did art with the therapist.

C10: ... erm, painting, drawing, making a photo

C14: ... papers, crayons and felt-tips

C8: We, we done, we done colouring

C6: I liked to do the clay and the Lego.

Parents and teachers felt that the doing was one of the most important elements, providing a distraction for the children and facilitating their talking.

T15: You know I think [child] would have struggled to sit and talk for 45 minutes. I *think the art is the distraction at the beginning and then the focus ...*

P13: Yeah because like most kids [...] give them something to do. They want to do. *And he'll just chat along while they're doing it... I think it's the only way to start getting them to relax*

Talking

For some children the opportunity to talk expansively seemed central. For others, the freedom to say nothing appeared just as important. Talking within art therapy was different to talking outside of therapy as anything could be spoken about without worry of criticism or inability to manage the emotional content. The individualised sessions afforded privacy, enabling children to talk more openly about often very difficult subjects.

P1: ...[art therapist] is there for you [child] to talk to if there's anything that you want to talk about ...

C11: Um we talk about things about *Daddy ... and what I've done ... and lots of other things*

AT12 (*Art therapist of Child12*): ... *she [child] was able to talk about her, erm, her father. She was quite scared. She had nightmares and talked about how she felt about those nightmares and what was happening there and being scared*

Expressing

Facilitating expression was a central aim of art therapy as viewed by the adults. Many children also said that doing art enabled them to explain things more easily, or remember things more clearly. The verbal expression appeared to follow art creation. The autonomy given to children within their interactions with the art materials seemed to support expression.

C1: I felt happy because [art therapist] taught me about how it feels like, draw how I feel

C4: Like if I was sad at the moment then I would do a sad picture. It makes me express my feelings

C11: ... *because when I make stuff it helps me ... explain*

P10: ... and [child] *can't explain herself* – probably she done that better in the art

Several participants described a letting out of something from the child's internal world through the creative activities.

AT4: ...*to be able to feel those emotions that are not so tolerated, you know, in our households, in our schools, you know....*

Relationship

The centrality of the relationship between the child and art therapist in mediating the doing, talking, and expressing, as well as in creating change, varied amongst participants. The art therapist was seen as a helper, gentle, fair, and good at listening, someone who could be trusted and provided a nurturing environment.

C7: Well she [art therapist] was definitely kind and she listened

C4: She [art therapist] was kind. She was nice and she never said "don't do that, don't do that"

C5: Yeah, and she [art therapist] like helps, *so when I say I don't like this, she helps...*

Consistent with these children's reporting, the art therapists spoke of attending closely to the child. For some children, the art therapist felt that their containment, mirroring, and creation of a safe space through their non-critical accepting stance was a vital new experience, enabling fuller exploration of the materials and deeper self-expression.

AT6: ... I was clearly there and responding, [...] trying to track, track him [child], rather than um, engaging in a very vigorous way

AT11: ...we're both getting down, looking at the [artwork] together, so we're both really close to that, and so that enables her [child] to start to feel that somebody is alongside and maybe seeing the world how she sees the world

Teachers and parents rarely talked about the relationship explicitly but when they did it was positive:

P4: He [child] absolutely adores her [art therapist]

T10: [Explaining how art therapy worked] Relationship plus drawing

Teachers and parents often emphasised not knowing what happened in sessions, as described earlier. For one parent the relationship was seen as secondary to the materials:

P4: Maybe having somebody is important but it's not the magic thing ...

However, this is the same parent as quoted above about the child's adoration for the art therapist. We consider this apparent contradiction in the Discussion.

Private

Art therapy was viewed as a boundaried, safe, calm space; a private experience between child and therapist. The word 'private' is used here to reflect the word most often used by participants, and may reflect how therapeutic confidentiality was conveyed to the children and their parents. The extent of this privacy differed among participants, with some children sharing nothing of their sessions and others more.

C4: but if we [child and therapist] talk I just keep it between me and [therapist]

P6: ... it was very secretive the art

T2: Line 122: no, she'd [child] never say anything about the session or tell me anything about it

P3: ... he [child] used to come home and say "Oh I done a wicked drawing of this" or "I done that"

Fun/ happy

With the exception of Child 3's experience with his most recent art therapist (which contrasts with the above quote), all children described art therapy as enjoyable. They wanted more, and said it made them feel happy, safe, and confident. The parents used similar words to describe how they felt their child had experienced the sessions.

C10: I was amazed, happy, glad, fabulous, and that's all I can remember

P1: She [child] actually loved it yeah

C7: I didn't enjoy it, I loved it [art therapy]

Children portrayed a playful quality and connected to the feelings of freedom expressed within the doing process. This included Child 9, whose parent said he did not like art. However, one art therapist emphasised the serious purpose.

C4: Because with art therapy that's when I have my fun time and so then after that I'm all like calmed down.

C9: It was just having fun.

AT12: ... you're right in there with them, you are going to get splattered and that's kind of okay, that's part of being art therapy and stuff like that. So it's quite fun!

AT11: It [art therapy] is not just having fun, it is sometimes really quite difficult for the child and sometimes people need to appreciate that

Reported change

Changes described by participants related to four main areas: improved mood, confidence, communication and understanding. Of the 14 children interviewed, 8 reported change, corroborated by both a parent and teacher in 5 cases, and the rest by one secondary informant. The precise type of positive changes reported by different sources tended to agree – for example the child behaving more calmly – but did not always, as is indicated in Figure 3. Of all 6 children who said there had been no change, teachers reported positive change. Positive change was reported by at least one informant for all 15 children (recall that one child subsequently did not take part). No deterioration was reported.

Improved mood

The children, their parents, and teachers talked about the children being happier, more settled, calmer, and having fewer outbursts. Sleep improvements were also described.

C11: she [art therapist] helped me learn how to calm down

C1: Everything did change because I was much happier than what happened [the parental difficulties], and stuff

P9: He [child] was calming down a lot more, erm, he wasn't losing his temper

Increased confidence

Several children reported feeling more confident at school and home. Their parents and teachers also noticed these changes.

C12: It's [art therapy] helping me like be like more confident and all that and trusting myself

T10: ... I think it has helped in the sense that it's given [child] the confidence to talk about how she feels

P5: Yeah but in school it's made her really confident all the time

Improved communication

Parents and teachers particularly highlighted the changes in the children's ability to share worries or concerns and articulate their feelings more, post-art therapy.

P9: he [child] is talking now. *Before he just bottled everything up, but he doesn't stop talking now which is good*

P11: Um I mean to start off with if something happened at her Dad's she just wouldn't talk about it at all ... But we have had an incident recently and she could

come straight home now and was very actually "This is what's happened, this is how I felt, this is and..."

Increased understanding

The development in the child's understanding of their situations and life experiences tended to be reported by the adults rather than by the children themselves.

P2: ... because before she couldn't really, she doesn't understand why things happen [...] But I think what it is it's just the art is just making her understand a little bit...

Several parents spoke about art therapy having increased their own understanding of their child, giving them new and valuable insights which would not otherwise have arisen.

P10: You can get so much information from children with them drawing you know whether it's sad, bad, or good, you know what I mean, but at least it helps you to umm help your child really

AT12: Yeah, changing that [other people's understandings], that she [child] wasn't just this naughty girl

Resilience

More broadly, participants expressed that art therapy had enabled the children to become more resilient and better able to cope with difficulties.

T10: she's [child] got strategies to cope with it [emotional difficulties]

P3: The art therapy helped him cope with lots of things

C4: I'm happier at school and home, and I'm more concentrated now.

Learning

A wider impact of the reported social and emotional changes was reflected in the children's increased engagement in learning. Teachers and children described improved concentration, academic progress, and reduced behavioural difficulties.

T15: Yeah – he [child] started to settle again. A lot of it is about head space to learn.

You know, he ... just engaging in the lesson

AT12: Her [child] confidence in reading went up as she could go up in stages of what she was reading as well. *So she was more able to focus on that ...*

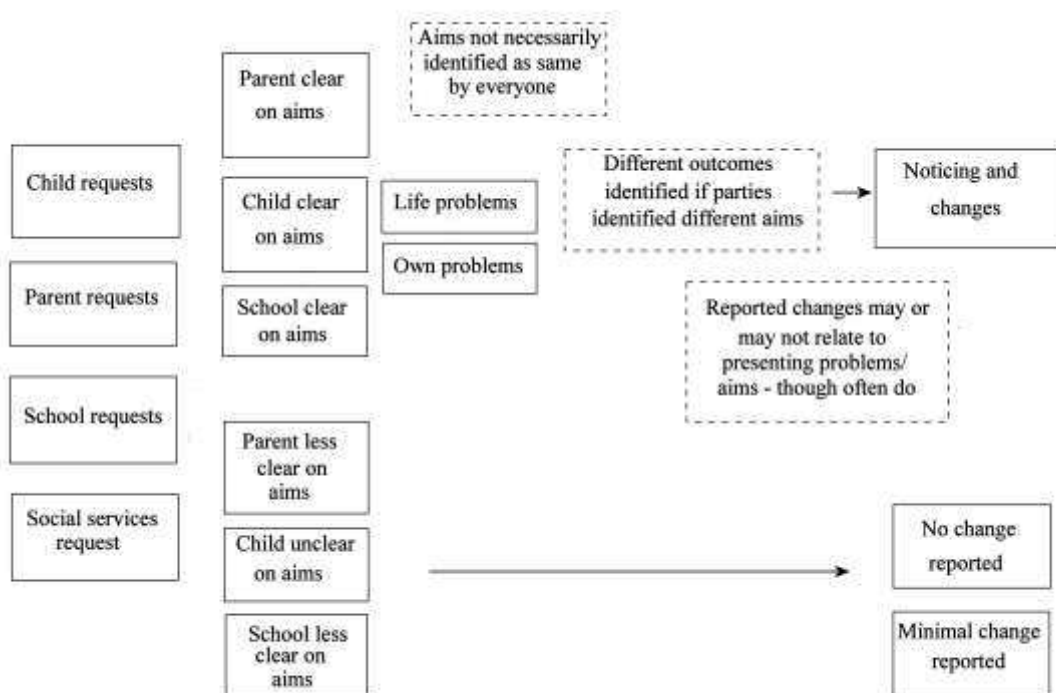


Figure 3: Model component 3 - change and no change

Component 3 of the model shows a key reported antecedent of change for participants: the relationship of the identification of initial target problems or therapeutic aims to the reporting of change post-therapy. For some children everyone in their interview network reported change, while for others it was observed by selected individuals only. Some

participants described the observed changes as arising directly from the art therapy whereas others thought that additional factors had contributed.

T5-2: You know, not just art therapy that's helped. It's been everybody's approach and all of us thinking together.

Request

Only one child said that they had asked for help themselves. Several parents had sought support from the school and many said the school had suggested the intervention. One parent said that social services had required art therapy.

P7: ...it was the school that flagged it up, and they'd noticed things in [child's] behaviour, and he has anger issues because he can't communicate

Therapy aims

There was diversity in participants' accounts of the difficulties that had brought the child to art therapy. Therapeutic aims were not clearly articulated for all. Some children expressed explicitly what had led them to therapy, but several could not.

C2: I used to hide under the table because I was sad

C12: Umm it was going on not good ... Like um Mummy keeps crying ... and all that... And my sister kept being moody.

Change reported

There appeared to be a connection between recalling clear initial target problems and identifying change post-therapy. With well-articulated pre-therapy difficulties, changes were reported either by the same individual or another informant.

P4: ...and then after his session on the following Friday he went into his own room [overcoming separation anxiety] and he's been there ever since. That's just like the biggest achievement and I so believe it's come of out this [art therapy]

P12: she [child] had so much anger and as I say she doesn't seem angry any more... really doesn't seem angry anymore and I do believe that's through talking.

T12: [child is now] cheerful and happy. Art therapy has had a positive impact on her mental health

Change not reported or minimal change reported.

Several children said that nothing had changed for them after art therapy (though another informant thought it had) and two parents reported minimal changes.

C13: Mmm - no! Nothing's changed! Only being a bit better at school

P1: Um things stayed the same... the art therapy didn't really bring out that there was any problems. It just settled everyone's mind that they [child and sister] were actually fine.

The children who reported no change were also the children who could not articulate why they had come to art therapy. Child 5, who had a visible physical condition, had begun to be reluctant to go out when at home and go out to the playground at school. Although she did not herself seem aware of the reason for art therapy or report change, her teacher did:

C5 on reason for art therapy: *I don't know why I went to art therapy*

C5 on change: Yeah it stayed the same

T5 on C5's reason for art therapy: The whole thing was the self-confidence in the playground, in going swimming, in going to the park and things like that

T5 on C5's change: There's less of an issue [anxiety] when she goes out to the playground

Discussion

'Model component 1 - school context'

The mysterious aspect of art therapy seemed unhelpful for some teachers and parents. In part the centrality of privacy ('Model component 2 – core model') perpetuated this. Although there was some ongoing liaison, this seems in line with Bush's assertions (1997), suggesting a need for additional communication between teachers, parents, and art therapists to elucidate therapy processes more clearly and openly. Such difficulties and tensions have been reflected within broader contexts, for example with CAMHS clinicians describing difficulties understanding art therapy practices (Cornish, 2013). Hopefully studies like this will begin to bridge some of these gaps.

In accord with Fazel et al. (2014) and Wengrower (2001) the school context was considered important by most parent participants. Delivering therapeutic interventions within an environment which has already been established as responsive and understanding may be key in providing the grounding for therapeutic engagement and seemed to offer containment for the teachers in their management of children's emotional needs.

'Model component 2 – core model'

Perceived helpful elements of the art therapy were choice, individual time, and being able to make things and talk. The elements of doing, relating, and expressing depicted within the core model correspond closely with Case and Dalley's (2006) and Luzzatto's (2014) proposed understandings of the centrality of image-making within art therapy, and

communication following image-making. The core model depicts expression as central. In accordance with existing theories of children's art therapy (Case & Dalley, 2006; Malchiodi, 1997), the ability to express difficult things and come to new understandings and perspectives was also reliant on the doing / art-making processes. Expressing the non-verbal seemed to facilitate verbal expression, first within art therapy and then in other contexts.

In contrast to much research advocating the centrality of the therapeutic relationship in enabling change (Rogers, 1951), this study did not position that relationship as the most important element. Aspects of attachment-relating seemed present (Winnicott, 1973), but several participants did not mention the relationship. However, children may lack the developmental ability to adequately describe the impact of the relationship (Allen, Fonagy, & Bateman, 2008). Parents and teachers emphasized not knowing what happened in therapy sessions. One parent expressed both a perception that her child adored the art therapist and also that it was art-making rather than the therapist that was key to the successful outcome. These statements may not be contradictory, since they are consistent with Case and Dalley's (2006) suggestion that it may be necessary but not sufficient to have the presence of an attuned, containing, caring adult. The relationship is part of the core model presented here, and was present in the data, and the suggestion is that it enables important therapeutic processes to happen. Its centrality may, however, be more visible to art therapists than child recipients, or to others who cannot observe therapy directly. Future research could involve direct observation and analysis of therapy sessions to further elucidate the role of the relationship and other therapy components.

'Model component 3 – change and no change

A variety of changes were reported as occurring by the child, their parent, and the child's wider system. Several children could not say why they had art therapy, possibly

because of still-developing reflective abilities, understandings of causation, and vocabularies for change (Fonagy & Target, 1997). Where the child or an adult appeared unclear about aims, another informant usually was clear. Current practice within CYP-IAPT (Young Minds, 2011) and the National Institute of Clinical and Health Care Excellence (2015) recommends transparency and collaboration within referral processes and intervention provision. Taylor Buck and Hendry (2016) also emphasize the importance of enabling the child to understand the reason for art therapy. Ideally a prospective study would establish whether stated aims at the start were linked with reported benefits at completion.

Study Limitations

No male art therapists were included and the parent sample was predominantly female. However, this reflects the art therapy profession, in which at the time of writing 2,601 (85%) of registered English art therapists are female (Health and Care Professional Council, 2016), and the greater links mothers tend to have with primary schools (Fletcher & Silberberg, 2006; Lerman & Sorensen, 2000), strengthening the transferability of the findings. As art therapists and school staff initially approached participants, it is possible that selection-bias may have reduced the inclusion of negative cases (Strauss & Corbin, 1998). However, two schools in very different locations were included, and the children had a range of difficulties.

Quality assurance was undertaken, and a ‘bracketing’ interview (Creswell & Miller, 2000; Drew, 2004) enabled the first author to increase her awareness of her own positioning by talking about and reflecting on her thoughts and feelings about the study; her enthusiasm for art and belief that creative expression can facilitate processing of thoughts and experiences. It is possible that the child participants may have wanted to give a positive view

of art therapy. However, some children were easily able to state that they had experienced no change. Respondent validation confirmed the accuracy of the model's representation of art therapy in the eyes of four participants. Some children took part in creating a leaflet for the school to inform other children and parents about art therapy.

Although it is possible that factors other than art therapy accounted for some of the changes documented here, the triangulation of sources from both children and other informants is a strength of this study, and the findings make theoretical links between specific art therapy components and change. The systemic nature of the context has been acknowledged here, and the findings may be transferable to other primary schools with similar embeddedness of art therapy.

Ideally some of the images made by the children during their interviews might have been included in this article. However, during the consent procedure, consent to reproduce the images was not obtained. This is regrettable as, although they did not constitute data, their inclusion may have enabled greater understanding of the children's worlds by readers.

Practice Implications

This study highlights the importance of art-making in facilitating children's expression and processing of emotional and social difficulties and supports art therapy referrals when children are struggling with verbal expression of these difficulties. When considering Pupil Premium (Department for Education, & the Education Funding Agency, 2014) funding, it will be helpful for schools to note the value participants attached to the embedding of art therapy within the school and the improvements in learning engagement and academic progress attributed to art therapy. Similarly, the study informs CAMHS commissioners of the possible benefits of therapeutic interventions within schools.

Importantly, before children can articulate what had changed for them, they may need to have understood why the intervention was provided.

The model produced in this study is largely consistent with the stated elements of practice and their purpose arising from Taylor Buck and Hendry's (2016) Delphi survey of art therapists working with children, but there was particular emphasis in our study on the importance of fun, playful, enjoyable sessions. It is likely that this may be just as important in change processes as the therapeutic relationship, and indeed that the relationship is of the kind that enables fun in addition to, or to help contain the more difficult elements of therapy.

Future Research

Future research could consider testing the model within other primary and also secondary schools. The value participants accorded to the private space suggests that additional research could examine children's experiences of group art therapy, where different processes may occur. Future quantitative research could use standardised measures to track children's communicating, confidence, mood and educational attainments, pre and post-art therapy and at follow-up, in a randomised trial. Potentially our model could be a starting point for specifying key components and testing treatment fidelity, alongside guidelines such as those of Taylor Buck and Hendry (2016). Therapy aims specified at the start could be mapped onto standardised measures to assess how well they have been addressed, in addition to gathering specific qualitative data from children, parents and teachers relating to them.

Further exploration of the psychological processes of change is needed. Winnicott's (1973) theorising about the importance of enabling the child to relax enough to be able to play, and the consequent emergence of the self from that potential space of play, may

underlie the ‘fun / happy’ category within the core model. Additional research could thus isolate and examine the impact of the playful, fun elements of art therapy on reported outcomes, possibly using Barnett’s (1991) Children’s Playfulness Scale. Observational studies of therapy sessions may also help to clarify the complex interplay between therapist and child, and any changes in children’s articulation of feelings over time.

Core model categories ‘making choices’ and ‘individual’ may reflect the art therapist working within the child’s zone of proximal development (Vygotsky, 1978). In-depth observations of art therapy sessions would be required to test such a hypothesis. The attachment relationship (Ainsworth, 1964; Bowlby, 1979) that the art therapist provides may be crucial. Such theorising may underpin several categories within the core model; ‘making choices’, ‘individual’, ‘relationship’, ‘talking’, and ‘private’. Measuring the therapeutic alliance, perhaps with the Therapeutic Alliance Scale for Children-Revised (TASC-R; Shirk & Saiz, 1992), may be one way of capturing this possible mechanism of change. Mentalizing (Allen, Fonagy, & Bateman, 2008; Fonagy et al., 2015) may also be involved within the ‘relationship’, ‘doing/making’, and ‘talking’ categories of Model 2. Assessing the child’s mentalizing abilities over the course of therapy, for example using the Test of Emotional Comprehension (Pons & Harris, 2000, 2005), may thus be beneficial.

Conclusion

This grounded theory study examined children’s experiences of art therapy from multiple perspectives. A model with three components illustrates the processes identified for art therapy in primary schools. The importance of the systemic context was highlighted as was the need for clearly articulated aims in facilitating participants’ subsequent reporting of change. Core therapy elements were identified as child-centred choosing, doing and making,

talking, expressing through doing and talking, the relationship with the therapist, the privacy of the intervention, and the therapy being a fun and happy experience. These elements were identified as enabling expression, and thereby contributing to improvements in the children's mood, confidence, communication, and understanding, leading to improved resilience and learning. The results indicate the importance of enjoyable, child-centred, creative, and accessible art therapy interventions in supporting children's emotional and social health.

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