Art Therapy, children 0-6 years and their families: A research project surveying the Sydney region of New South Wales, Australia

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KEYWORDS

Art therapy, children, families, survey, Australia

ABSTRACT

This article presents findings of a research project in partnership between The Infants' Home, Child & Family Services (TIHC&FS) and the Research Centre for Social Justice & Social Change, University of Western Sydney (SJSC, UWS) on art therapy practice with children 0-6 years and their families in Sydney, NSW, Australia. A literature search was conducted and information gathered from ten Art Therapists by questionnaire, focus group and art making. It provides the first survey of art therapy of its kind in this region and is intended to contribute to the development of a clinical and evaluative framework for art therapy with children 0-6 years and their families.

INTRODUCTION

Art therapy as a profession and clinically recognised intervention is still emerging in Australia. As such it is not available in all child and family services. It is different to standard psychotherapeutic or family interventions as it employs art making and play as the central focus of the therapeutic relationship. Anecdotally agencies that employ art therapists (ATs) report valuable outcomes in working at emotional depth with children and families presenting with traumatic and challenging issues. This project begins to chart the local practices in the field and contributes to the development of knowledge and understanding of this intervention. The long term aim is to contribute towards the development of a clinical and evaluative framework for art therapy with children 0-6 years and their families. This will form the foundation of art therapy practice becoming more evidence based, which is of strategic importance for its development and availability to improve the health and well being of this client group (Gilroy, 2006).

The key research question of this project is: 'How is art therapy being practiced with children 0-6 years and their families in the greater Sydney region?' To answer this question information was gathered on: organisational contexts, theoretical frameworks, referral, assessment, evaluation procedures and documentation.

PROCESS

An advisory committee[1] was established to define the question and process. A method was designed to gather information from three sources: a search and review of literature on art therapy with children 0-6 years; a questionnaire to survey practicing (ATs) in the Sydney region working with children 0-6 years; a focus group involving discussion and art making on the topic. This was followed by analysis of the material to identify emerging themes.

As the project required gathering information from people an ethics process was put in place. Formal consent has been obtained for all the images and material presented. The questionnaire was designed through a peer review process and sent to relevant ATs. Participants were selected by either a search on the Australia & New Zealand Art Therapy Association register or through professional networks. A focus group was held with ATs working with children and families. Four ATs attended plus three of the researchers. The structure of the group included discussion on work contexts, art therapy practices and art responses to the topic. Information was also gathered by questionnaire and six others contributed in this way.

Information was gathered from March to May 2008 and the literature review was also completed in 2008, therefore this article is reflective of the information available then.

LITERATURE REVIEW

The review was conducted and written by Catherine Keyzer, and surveys the literature of art therapy with preschool-aged children including individual and group work, dyad work (mother or primary caregiver and child) and family work where there is a child or children under the age of 6 (Keyzer, 2008).

Thinking and writing about art therapy with children first emerged in the 1940s from the USA with the work of pioneers Naumburg (1947, 1958, 1965, 1966/1987, 1973) and Kramer (1958, 1971/1993, 1979). ATs that followed on and made substantial contributions on this topic include: Rubin (1978/1984); Klorer (2000); Malchiodi (1990/1997, 1999) from the USA; Case (2005); Case & Dalley (1990, 2008) from the UK and Proulx (2003) from Canada. Relevant articles from Australia include Swan (1998) and Kozlowska and Hanney (1999, 2001).

The authors reviewed are predominantly ATs however some of the literature reveals other professionals such as psychiatrists and clinical psychologists in collaboration with ATs who recommend art therapy as a helpful and valuable intervention (Kozlowska & Hanney, 1999, 2001; Willemsen & Anscombe, 2001; Sluckin, 1998).

The review shows there are very few publications that refer directly to art therapy with pre-school children and their families although there does appear to be a gradual increase in art therapy literature in the context of current research in neuroscience and its trajectories (Malchiodi, 1990/1997, 1999; Klorer, 2000, 2005; Kozlowska & Hanney, 2001; Proulx, 2002, 2003; O'Brien, 2004, 2008; Case, 2005; Case & Dalley, 2008; Hosea, 2006; Hall, 2008). One of the key areas that emerged in the literature is the development of clinical practice in art therapy related to research in child development, trauma, neurobiology and early intervention (Van der Kolk, 1987; Van der Kolk, McFarlane, Weisaeth, 1996; Terr, 1988; Schore, 1994; Perry, Pollard, Blakely, Baker, Vigilante 1995; Perry, 1997a 1997b, 2000). Particularly research on the links between art making, trauma, emotion and memory and

how art therapy can enable brain development. O'Brien talks about how early trauma affects the infant's developing brain and considers whether the sensuous qualities of art materials may access somatic memory of emotional experience (O'Brien, 2004, 2008). There is increasing evidence for early intervention in enabling child development and preventing ongoing cycles of abuse. ATs are writing about the significance of early relationship and the potency of engaging mother and child in creative activity together (Sluckin, 1998; Swan, 1998; Proulx, 2002, 2003; Hosea, 2006; Hall, 2008). Research in the fields of infant observation/development and attachment and trauma theory have also influenced art therapy practice to take into account developmental limitations of the child due to trauma, loss, abuse and disturbances in attachment (Alvarez, 1992; Case, 2005; O'Brien, 2004, 2008). The literature also shows ATs drawing from theorists such as Dissanayake (2000) whose studies in anthropology support evidence of art making as an essential human activity (Hall, 2008).

Overall the literature review revealed that young children are more likely to make sense of damaging experiences by engaging in painting, drawing and play. The art therapy setting can offer children a safe place to express themselves on a non-verbal level without being overwhelmed, and can access material or reach places that other interventions cannot. Art materials, the art making process and the containment of the setting and the relationship with the therapist provide a place that can give the child a 'voice'. This brief summary of literature provides a backdrop to present the findings of the survey.

OVERVIEW OF FINDINGS

The questionnaire and focus group generated information from ten participants on the previously mentioned topics which are presented below.

Employment

Of the ten participants, two were employed in public health services, one in a hospital context and one in a pre-school context under the auspices of a health authority. The majority (six) were employed in community services funded by charitable organisations such as; the Benevolent Society and Wesley Mission and two were in private practice. Length of employment ranged from 10.5 years to 1 month, with the majority being employed for four years or more. Three participants had generic job titles such as Parent/Infant Therapist or Programme Coordinator and seven use the title of Art Therapist.

Training qualifications

All participants had Masters qualifications in art therapy. Other background experiences included teaching (three), fine arts (four), sociology (one), social work (one), nursing (one), counseling (one), and science (one) – some hold multiple degrees.

Relevant experience/interests

Participants identified a range of special interests including: sand tray, play therapy, aesthetics, early intervention, mother-infant relationship, attachment, supervision, music performance, art community projects, children whose parents have a mental illness, ante-natal and peri-natal experience, and the experience of having a baby oneself.

Organisation contexts

Contexts included medical, educational and social/community settings. ATs are working in hospitals with children who are considered

complex cases diagnosed with severe reactive attachment disorders, often wards of state or in foster placements (one). Other ATs are working in specialised early intervention programmes providing parent/infant services with mothers in an antenatal stage through to children 3 years old (two). Others in early intervention preschool settings (two) in community based family services (two), specialised arts therapy programmes (one) or private practice (two). The nature of the private practice can vary from seeing individual children independently to undertaking government and charitable organisation funded referrals in the community supported from within schools or other agencies.

Theoretical / clinical frameworks

In some cases the theoretical model of the service differed from the individual ATs' theoretical approach. The most commonly found approach in services were: family systems (five); strengths based (four) attachment theory (four); Other approaches included: child protection (three); psychodynamic (two); feminist (one); neuroscience (one); and narrative (one). Numbers in brackets indicate the number of references made by each participant. The most common approaches used by ATs were: psychodynamic/object relations (five); and attachment theory (four). Other approaches were: family systems (one); neuroscience (one); narrative (one); and gestalt (one). Services appear to favour a family systems, attachment theory, strengths-based model, while the ATs favour a psychodynamic and attachment perspective. The most shared perspective between the services and ATs being attachment theory.

The references that are cited as most valuable in guiding these practices include:

- Art therapy literature (Kramer 1958, 1971/1993, 1979; Kwiatkowska 1962; Rubin 1974, 1978/1984 1981; Wadeson 1980, 1987, 2000; Schaverien 1987, 1989, 1992, 1993; Oaklander 1988; Case & Dalley 1990, 1992/2006, 2008; Rosal 1996; Silver 1996, 1998; Killick 1997; Malchiodi 1990/1997, 1999; Shore 2000; Proulx 2002, 2003; Case 2003, 2005, 2006; Meyerowitz-Katz 2003; Hall 2008)
- Child psychotherapy and related literature (Winnicott 1958, 1965, 1971a, 1971b; Bick 1968; Bowlby 1969, 1973, 1980; Alvarez 1992; Fonagy, Steele, Moran, Steele, Higgett 1992, 1998; Fonagy 1998; Rodd 1996; Geldard & Geldard 1997, 2001; Pearson & Wilson 2001)
- Psychoanalytic literature (Bion 1962; Jung 1964; Fordham 1978; Freud 1979; Stern 1985; Meares 1992)

The following comments from the focus group capture the way ATs think about their work:

> *What I think I'm doing is holding a space that the child can express their concerns and hopefully there is an opportunity to integrate some material that's not easy to deal with… a safe space to process some of their life experience… conscious and unconscious.*
>
> *We are supporting the child's emotional development and that helps the child become more able to get on with normal developmental tasks.*
>
> *We are thinking about things in a particular way – transitional space – imaginary space.*

Organisational structure / support

Most ATs are working as part of teams with a range of professional disciplines. Multi-disciplinary hospital based teams encompassing medical, social work and psychology, occupational therapy, speech therapy and physiotherapy. Early intervention teams with

early childhood teachers, child care workers, social work, psychology, parent/infant therapists and community programmes with various other arts therapists such as music and drama therapists. ATs in private practice make links to relevant case workers or school-based professionals, but are largely independent.

With regard to organisational support and supervision, ATs reported regular internal supervision with relevant managers: weekly (one); with teams on a weekly or fortnightly basis (four); and with a child psychiatrist in teams monthly (one). Some ATs supplement this with self-funded supervision: with an AT (two); and with a child psychotherapist (two). There are some instances of organisations funding external AT supervision (three). Finding AT supervisors with early childhood expertise seems to be difficult.

Referral criteria, process, length/type of intervention

The nature of the child and family referrals to ATs are varied. They reflect a wide range of circumstances that have compromised the developmental experience of the child. ATs are most often working with children in liaison with the team or referring agency. Those receiving art therapy include:

- Children 4-12 years who have complex issues, commonly diagnosed with severe reactive attachment disorder, displaying sexualised behaviour, have experienced long term abuse and/or neglect, wards of state, or in foster placement.
- Children with pronounced emotional, behavioural, social or attachment difficulties, developmental delay, failure to thrive, illness, bereavement, abuse, neglect, separation, self-esteem issues particularly related to anxiety and bullying.
- Families at risk who need support with the care and parenting of children during early years, with complex family issues, social, emotional and developmental needs.
- Vulnerable pregnant mothers who require support to establish a healthy attachment with their babies, from the antenatal period up to the child reaching 3 years old.
- Aboriginal children and families transitioning between play group and school in the community.
- Referrals from Centa Care, Department of Community Services and Samaritans of children 5 years to adolescence with a wide range of emotional and behavioural issues.

The children are usually seen individually, occasionally in small groups, dyads between child/parent or in family meetings. Other interventions include mothers/parents groups and community arts programmes.

The duration of art therapy varies from brief (eight sessions) which are most likely to occur in the community programme contexts and up to three years or more in the health, early intervention and preschool contexts, where the needs of clients are usually more complex and long term.

Relevant comments from the focus group on the topic of referral:

> *Generally the younger children come to me and then it's usually to do with the child having difficulty talking about what happened.*
>
> *I'd say art therapy probably tends to get more complicated children simply because their behaviour warrants a different sort of involvement.*

ASSESSMENT AND DOCUMENTATION

In most contexts the AT has a period of observation or sees the referred child and/or family for an introductory meeting. Two

assessment sessions are usually undertaken to establish what can be offered, then a therapeutic plan and contract is usually agreed with regular review. Most ATs indicated they ensure the client is appropriately supported while in art therapy through team networks or support to other family members.

Assessment involves consideration of the suitability of art therapy for the child, taking family dynamics and other factors into account. Art therapy is usually offered as a way to support the integration of traumatic experiences consciously and unconsciously, to establish basic trust and rework attachment experiences.

Most referral processes are recorded in various written formats and in some cases drawing assessment tools are used such as the one developed by Malchiodi (1990/1997). Client feedback is also sought by some ATs through standardised outcome rating scale forms. Generally ATs keep detailed process notes of sessions over the course of therapy which they use to facilitate supervision, chart the process of the work and make reports. The art work is also carefully handled, recorded (as necessary) and stored. In most cases the AT reports information on progress to all those involved on the team and with the parents on an ongoing basis.

EVALUATION

To evaluate the intervention, most ATs integrate all aspects of the work and supervision to make meaning of the experience. This is usually written into a report and discussed with relevant team and family members. A review of progress against the original goals of the intervention and listening to, and including the client feedback, are part of the evaluation process.

ATs generally integrate observation of the transference and any shifts in the therapeutic relationship, particularly the emotional aspects of the experience with review of the artwork which documents the internal landscape of the child.

Evaluation was described as based on analysis of themes in the sessions including artwork and observation of changes in the child's ability to enter the play space, develop spontaneity and confidence with materials and the development of symbolic capacity and a capacity to play.

One AT had formulated her own evaluation tool to fit the organisations' strengths-based model. Another described a parent evaluation conducted at the end of ten weeks for feedback on changes in behaviour/coping strategies of the child. This was followed up at three months and 12 months.

Relevant comments from the focus group on evaluation:

Shifts in relation to context – the transference – how you are being invented differently by the child… it's emotional work… and it's just so important to be held and contained… emotional holding are two words that are meaningful for what I do.

I see it as relational work – it is actually reworking the attachment within the session very directly in relationship with me. So as the relationship with me changes – that's when I get a sense that the work has been done.

I think it's very long term work and in terms of evaluation one of the things that really does matter is whether that girl or boy then turns out to be a (healthy) young woman/man and how they are as a mother or father.

One goal would simply be that the foster placement doesn't break down.

IMAGE MAKING AND THEMES FROM THE FOCUS GROUP

Images were produced at the focus group to capture and explore ideas (Figures 1-6). The accompanying words were extracted from the group transcript and provide a poetic condensation of the emerging themes.

Figure 1. A rush, softness, movement, tears, moisture.

Figure 2. Glow, currents, waves, a little boat, movement, diving down deep, being here, not alone.

Figure 3. Coming together – child, family, therapist, our adult selves, our child selves.

Figure 4. Softness, wordlessness, the unspoken.

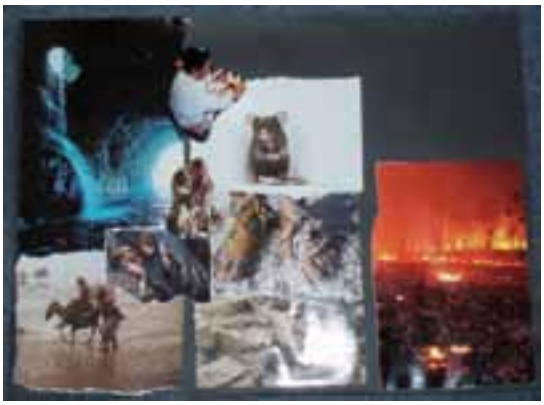

Figure 5. Working with instincts, fire, trauma, devastation, integrated with cherishing, taking care.

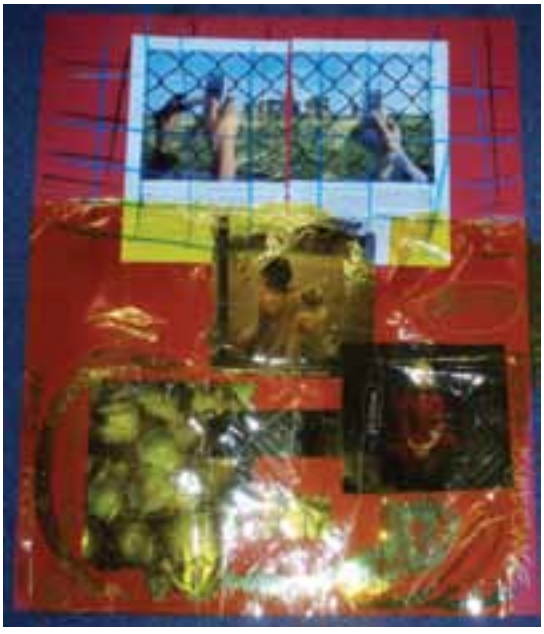

Figure 6. Stonehenge behind mesh. Words, proof, evidence.

The themes revealed in the discussion that complement the images were as follows:

Evidence based research

Further research was considered a priority to develop a stronger evidence base to expand the field and fund more art therapy positions. A gap in the literature on this area of practice was also identified.

Professional issues

Finding employment as an AT was considered challenging and pressure to slip into a more generalist role which can dilute the practice was identified. It was noted that several long standing art therapy positions had developed from training placements. Professional areas considered important included: supervision; involvement in one's own art making; and additional training in child protection and infant observation. The ATs' experience of motherhood was also considered relevant.

Theoretical developments

The influence of attachment theory, neuroscience and neurobiology in child and family services was considered to have grown significantly. This was seen as generating a positive impetus to understand emotional trauma which is relevant to the work of art therapy. Support for carers/parents/teachers was also seen as vital to enable understanding of the child's experience for successful outcomes.

Limitations and future research directions

The number of participants in this study was limited to ten. The design of the questionnaire did not elicit detailed information on assessment and evaluation. Future research could investigate measures for referral, assessment and evaluation over a wider region or from a specific context. A clinical and evaluative framework could be formulated for art therapy with children and families.

CONCLUSION

This survey has brought together information on the practices of ten ATs working with young children in the Sydney region for the first time. Coupled with the review of literature it provides relevant background material to support the potential formulation of a clinical and evaluative framework for art therapy with children and families. This would increase the evidence base for art therapy and support the development of services for young children and families. Potentially creating greater access to art therapy for vulnerable children and families so they may be better served and that those often without a voice may be given one.

ENDNOTE

1. Jennifer Evans, CEO: TIHC&FS; Dr Wendy Foote, Manager: TIHC&FS: Helen Cormier, Art Psychotherapist TIHC&FS; Catherine Keyzer Art Psychotherapist, Spilstead Centre; Dr Peri O'Shea, SJSC: UWS; Jill Westwood, SJSC: UWS.

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