Arts Therapies with Children and Adolescents

Edited by

Dafna Regev

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Arts Therapies with Children and Adolescents

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Editor

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About the Editor

Dafna Regev

Dafna Regev, Ph.D., is an art therapist and researcher. She is an associate professor, head of the art therapy program and member of the Emili Sagol Creative Arts Therapies Research Center at the University of Haifa, Israel.

Editorial

Special Issue: Arts Therapies with Children and Adolescents—Editorial

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Arts therapy dates back to the mid-20th century. It emerged from the conviction that artistic work has a unique meaning for people in general and children and adolescents in particular. Although many professionals use the arts in their work with children and adolescents, arts therapists have specific expertise in observing and encouraging processes in a variety of arts and have the knowledge base necessary to promote connections between artistic creation and stimulate mental processes and personal well-being.

Clinical work in arts therapy is expanding to education, hospitals, informal education, private clinics and other settings. Similarly, the research field has developed rapidly, especially in the last twenty years, and today includes a growing number of in-depth studies that not only examine the effectiveness and meaning of this profession, but also explore therapeutic processes and mechanisms of change and contribute to the formulation of protocols adapted to therapy work in a variety of populations. While many studies have focused on adults in arts therapy, research on arts therapy for children and adolescents still lags behind. This points to the need to find specific ways to treat these clients and for studies on how these approaches can be implemented.

For all these reasons, I am delighted to serve as the guest editor representing the field of arts therapy for this Special Issue in *Children*. This Special Issue presents a wide range of articles. First and foremost, several deal with arts therapy in the education system. Heynen and her associates [1] present a specific music therapy intervention developed in the Netherlands for refugee children and adolescents in school settings. Snir [2] explores the meaning of artmaking as one of the key components of art therapy within the educational system in Israel. Kelemen and Shamri-Zeevi [3] describe a unique open-studio intervention designed to facilitate identity development in teens recovering from mental health conditions. Korman-Hacohen and her collaborators [4] specifically refer to the challenges brought about by the COVID-19 pandemic and the creative way in which arts therapists in the education system continued to work with students by harnessing new and different approaches.

The second topic discussed in this Special Issue is arts therapies for children and adolescents with special needs. Bat-Or and Zusman-Bloch [5] describe art therapy in an open-studio model with at-risk children living in foster care. Schweizer and her colleagues [6] report on a 15-session art therapy program that aims to reduce difficulties in 'sense of self', 'emotion regulation', 'flexibility' and 'social behavior' in children diagnosed with autism spectrum disorders (ASDs). Bitan and Regev [7] investigate ways to work with clients with ASDs through parent–child art psychotherapy. Cousin and collaborators [8] describe music therapy interventions in pediatric intensive care units for anxiety and pain management. Ofer and Keisari [9] present a case study and the core concepts implemented during drama therapy with a young girl who lost most of her functional abilities due to brain damage. During the child's physiotherapy sessions at the rehabilitation hospital, a medical clown was brought in to work together with the physiotherapist in providing treatment.

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Beyond the therapeutic use of the various arts, greater attention is being paid to the diagnostic potential of arts therapies. These diagnostic methods are grounded in the realization that speech is not always the most appropriate channel for diagnosis, especially in children and adolescents. Bat-Or and her partners [10] describe diagnosis based on the Person Picking an Apple from a Tree (PPAT) drawing assessment scale. They evaluated the subjective experience of 156 preschoolers (aged 4–6.9 years) living in an area exposed to considerable political violence in Israel (on the border with the Gaza Strip) during a period of massive bombing. Gavron and her partners [11] describe a painting intervention called the Joint Painting Procedure (JPG) where parent and child paint together on the same sheet of paper. This is used to examine key facets of the relationships between adolescents with intellectual disabilities and their mothers. Jaroenkajornkij and her associates [12] provide a new look at the classic self-figure drawing, which they use to successfully identify three forms of child abuse: child sexual abuse, child physical abuse and child emotional abuse.

The last section deals with more general issues in the field of arts therapy for children and adolescents. Shuper-Engelhard and Vulcan [13] examine the distinctive qualities of group dance and movement therapy in the context of a remote emotional intervention with young children. Metzl [14] reviews current theoretical frameworks of working with children and adolescents with regard to their socio-political and developmental implications for art therapy practice within different settings and systems. The systematic review by Berghs and her associates [15] looks at the ways in which drama therapy contributes to a decrease in psychosocial problems. Moula and collaborators [16] conducted a pilot randomized controlled study that examines the effects of arts therapies on children's mental health and well-being. Keidar and her associates [17] explore the perceptions of 17 ultra-Orthodox parents whose children were receiving arts therapies.

I hope that this Special Issue will serve as a repository of knowledge for arts therapists and fertile terrain for further research in the field. It also aims to help more professionals working with children and adolescents to recognize the meaning and uniqueness of therapeutic work in arts therapies and the dedicated ways in which arts therapists use assessment tools and arts-based interventions to better understand the world of children and adolescents.

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Article

A Music Therapy Intervention for Refugee Children and Adolescents in Schools: A Process Evaluation Using a Mixed Method Design

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Abstract: Refugee children and adolescents have often experienced negative or traumatic events, which are associated with stress and mental health problems. A specific music therapy intervention is developed for this group in school settings. The aim of the present study was to set the first steps in the implementation of this intervention. A process evaluation was performed using a mixed method design among refugee children and adolescents (6–17 years) at three different schools in the Netherlands. Interviews were conducted with teachers and music therapists before, at the midpoint, and after the intervention. At these moments, children completed a classroom climate questionnaire and a visual analogue scale on affect. The results indicate that the intervention strengthens the process of social connectedness, resulting in a "sense of belonging". The intervention may stimulate inclusiveness and cultural sensitivity, and may contribute to a safe environment and the ability of teachers to adapt to the specific needs of refugee children. Refugee children and adolescents showed a decrease of negative affect during the intervention. When implementing the intervention in schools, it is important to take into account the initial situation, the prerequisites for the intervention, the professional competence, the experience of music therapists, and the collaboration and communication between the professionals involved.

Keywords: music therapy; refugee children/adolescents; process evaluation; sense of belonging; affect; resilience

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1. Introduction

In the past decade, the rising number of people entering Europe and the USA in search of safety has captured the world's attention. Up to 50% of them are children and adolescents, with a total of 25,000 unaccompanied minors applying for asylum annually across 80 countries [1]. Most of them have negative and traumatic experiences in their home country, while travelling to Europe, and during the search for a safe new home. They lost their social network, have to deal with uncertainties surrounding their future, and may experience cumulative stress of forced migration. This has shown to be strongly related with stress and mental health disorders [2,3], such as post-traumatic stress disorder, depression, anxiety, and substance use disorders [3–8]. Untreated, these disorders may become chronic and undermine functioning [9–11].

In schools, stress and instability is also recognized in refugee children, as for example seen in fewer social relationships and less positive integration and participation [12], resulting in a higher school drop-out compared with non-refugee children. Refugee children show a higher rate of concentration problems, more aggressive incidents, anxiety, and worry

more about their own safety and safety of others [4,12]. This behavior has been shown to influence classroom climate and the relationship between children and teachers [13]. Proper programs to prevent or address these problems are urgently needed.

Due to their daily contact with the children, schools obtained a growing role in helping refugee children and adolescents in preventing or adapting their (mental health) needs [14]. Positive education can prevent children from psychosocial problems and can improve learning and integration, strengthen psychological well-being, and prevent children from the development of mental health problems [14]. In order to address mental health of refugee children in schools, it is necessary to use specific programs that are sensitive for culture, take language difficulties into account, and have a solid evidence base. There is actually only a small amount of research focusing on interventions in refugee children that promote mental health or moderate stress in terms of resilience [15,16]. In fact, given the large number of children and adolescents displaced by war, there are regrettably few treatment studies available, and many of them were of low methodological quality [17].

Non-verbal interventions such as music therapy have shown to improve a positive psychosocial development of the child, reduce stress, and strengthen their resilience [18]. The use of music can serve to bridge the gap between languages and cultures, since it is universal to all cultures [19]. Neuroscientific studies have shown that music decreases physiological arousal and modulates activity in brain structures that are involved in emotional and motivational processes [20,21]. It is assumed that methodologically using music in therapy can strengthen the impact of music. Music therapy gives opportunities for self-expression and strengthening their (ethnic) identity [22,23]. In a group, music therapy provides opportunities for sharing and communicating on beliefs and hope for the future. In this line, it promotes peer-support and social engagement [24]. The intervention "Safe & Sound" is a music therapy intervention for children and adolescents who experienced negative and traumatic events during war and flight [18,25]. The intervention aims to focus on aspects such as helping each other, working together, feelings of safety, and collaborative learning. In practice, the intervention is already used in Dutch primary schools as a prevention strategy. Studies on the effectiveness of interventions in this population are sparse. This study aimed to set the first steps in the implementation of the intervention and in investigating the perceived effects of a music therapy intervention in refugee children. A process evaluation was conducted in order to obtain insight in the process and process results of the intervention "Safe & Sound" in general and on affect and the learning climate experienced by the refugee children and adolescents. A second aim was to identify influencing factors for the implementation of the intervention in schools. In addition, we wanted to evaluate whether the intervention was conducted as intended (treatment integrity).

2. Methods

2.1. Design

The current research was conducted as a mixed-methods (embedded design) longitudinal study, in which both quantitative as well as qualitative methods were applied [26]. A process analysis was conducted in three different schools in the Netherlands. At three measurement moments, interviews were conducted with teachers and music therapists and questionnaires were filled in by the children and adolescents: before the start of the intervention after the summer holidays (T_0), at the midway-point of the intervention in autumn (after one month, T_1), and after completion of the intervention before the Christmas holidays (after three month T_2). In addition, after each session, music therapists answered questions on treatment integrity.

The schools consisted of two elementary schools and one secondary school. These schools have specific classes with educational programs for non-native children and adolescents (most of them are refugees and asylum seekers). The educational programs have the aim to help them integrate and learn the new language and regular knowledge and skills. Schools were recruited by the professional network of the music therapist who developed the intervention. During recruitment, schools were informed about the topic

and the method of the research. All schools gave consent to participate in the music therapy sessions and the present study. An information meeting was held after consent with all participating teachers at each school.

2.2. Participants

The participants consisted of refugee children and adolescents even as their music therapists and teachers. The children and adolescents were non-native, between the age of 6 to 17 years following education at elementary or secondary schools (for more information see results Section 3.1). All teachers involved in the class for non-natives were asked to participate. One of the music therapists was the developer of the intervention "Safe & Sound (SG)". Two other music therapists were recruited by a formal application procedure. Inclusion criteria for music therapists were a bachelor's degree in music therapy and at least three years of experience with children or adolescents and/or trauma-related problems. In addition, these therapists received an additional two-day training on trauma and resilience from the music therapist who developed the intervention. Before participation, informed consent was obtained from children, their parents, teachers, and music therapists.

2.3. Music Therapy Intervention "Safe & Sound"

The music therapy intervention "Safe & Sound" was developed in order to strengthen resilience and self-control of children/adolescents who grow up under difficult circumstances such as refugees. In addition, the purpose of the intervention was to prevent or decrease psychosocial complaints and problems which result from a stressful or traumatic event in the past.

The intervention "Safe & Sound" includes two key elements, a classroom-based intervention and an individual intervention. The classroom sessions are embedded in the educational program of the participating schools. During the present study, classroom sessions consisted of ten sessions with a maximum duration of one hour per session. During these sessions, the music therapist worked on a positive climate in the group and aimed to optimize the prerequisites for the learning process, i.e., feeling safe and relaxed and open for new (learning) experiences. During the sessions, the therapist and children work together on interpersonal goals, such as listening to each other, helping each other, and trusting each other. Each classroom session has a specific theme (e.g., making new friends, sharing stories, dealing with difficult situations and emotions, and their talents), which were also based on topics that children want to share with each other or on characteristics of the atmosphere in the group. Finally, children/adolescents of the class present the song they worked out through the sessions to their teachers and parents/care givers, who are stimulated to discuss the song with their child.

During group sessions, music therapists are vigilant for children/adolescents who display behavioral issues or are at risk for further development of (trauma related) psychosocial problems. Music therapists are trained to signal these issues and will discuss this with the teacher of the group, the parents/care givers, school psychologist, or school doctor. If there are indications for further support of the psychosocial development of the child, individual sessions of "Safe & Sound" can be indicated. These individual sessions focus on the individual needs and possibilities of the child/adolescent and can thus provide attention and support to the psychosocial development of the child/adolescents. Those individual sessions mainly focus on stabilization and further try to set important first steps in the treatment of trauma-related problems, always in collaboration with the personal environment of the child/adolescent. If there are signals for need of further treatment, this will be discussed with the child/adolescent family, (remedial)teachers, and school doctor/psychologist.

During the time of the intervention, there was supervision and intervision for the music therapists held by the developer of "Safe & sound (SG)" during two group and two individual sessions.

2.4. Procedure

Directly after the start of the class year 2019/2020, parents and children/adolescents were informed by teachers about the goal and the procedure of the intervention and the study. The intervention "Safe & sound" was offered to all children/adolescents in the participating classes. Children/adolescents of one class participate together in a session one hour each week within a fixed schedule. If children/adolescents were considered for the individual sessions, parents were informed and asked for their approval. Individual sessions were indicated when teachers report psychological (anger, stress, anxiety, sadness) or physical (sleeplessness, pain) problems. Children/adolescents received questionnaires at T_0, T_1, and T_2. Furthermore, music therapists and teachers were interviewed at T_0, T_1, and T_2. After every music therapy session (both classroom sessions and individual sessions), music-therapists completed a questionnaire on treatment integrity (see Figure 1).

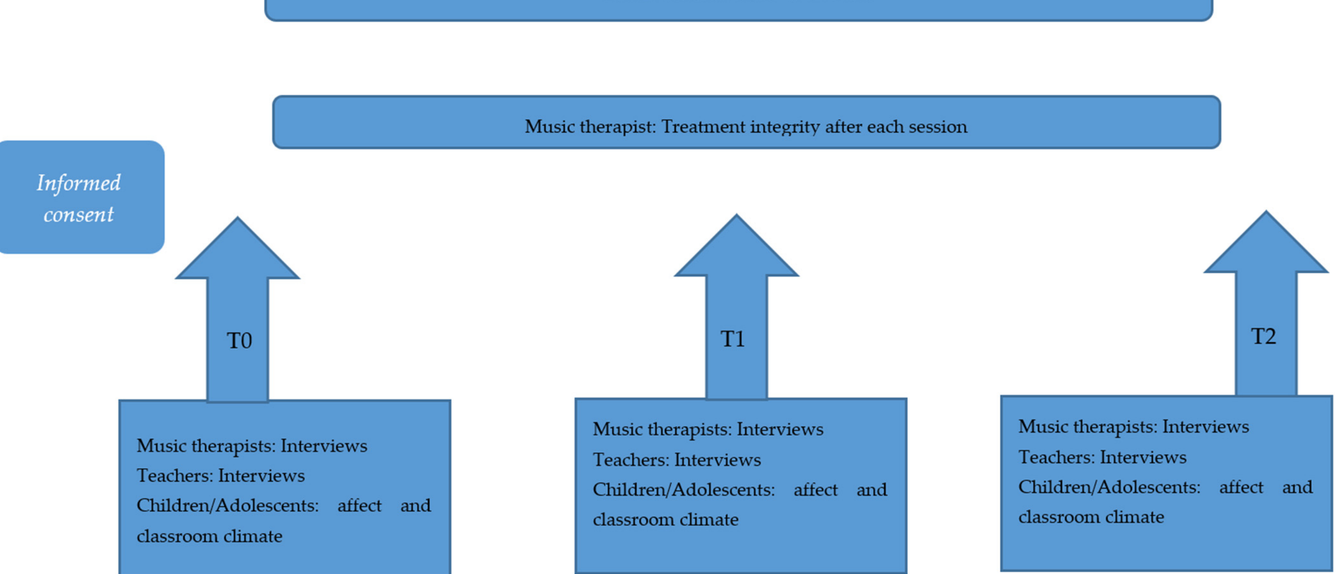

Figure 1. Procedure.

2.5. Data Collection Methods

2.5.1. Interviews

Semi-structured interviews were conducted with teachers and music therapists to gain more insight in the process of embedding the intervention and its results in the participants' perspective. Interviews focused on the group and individual part of the intervention. The interview questions were based on the guideline for process evaluations of Movisie [27]. The main topics for the teachers were appreciation, experiences, the scope, and the influencing factors for treatment (success and failure). Topics of interviews for music therapists focused on the execution of the intervention of "Safe & Sound" and its results. The interviews were audiotaped and transcribed for analyses.

2.5.2. Measurement Instruments

In order to evaluate the experiences of participating children and adolescents, a possible language barrier was taken into account by using simple language, conforming to the principles of "Easy language" [28]. In order to allow the participation of children and adolescents with different cultural backgrounds and a broad age range (6–17 years), we selected instruments with a visual attractive format and piloted the items and answer methods in a subsample of refugee children and adolescents. Based on this, we decided to limit the number of items, to include items on somatic complaints, and to include visuals, see Appendices A and B.

- Visual analogue scale to measure positive and negative affect

The visual analogue scale (VAS) is a psychometric measurement method designed to document the characteristics of emotions and symptom severity. In the present study, children/adolescents were shown a horizontal line (10 cm) and asked to mark their level of positive and negative affect on the line ([29] VAS, Appendix A). On the left side is the minimum score (*"don't feel the emotion at all"* = 0), and on the right is the maximum score (*"feel the emotion really strongly"* = 10). The score on the VAS is the number of centimeters (with one decimal) between the minimum score and the line indicated by the participant. A high score on the VAS means that the emotion is experienced to a high degree. Acceptable psychometric properties have been reported for a digital VAS for measuring anxiety [30]. In the present study, six items were investigated for negative affect (headache, stomach ache, angry, easily angered, sad, annoyed, anxious) and two for positive affect (happy, pride).

A CFA was conducted in R version 4.1.2 with the lavaan package, version 0.6–9 [31]. A correlated two-factor model with negative and positive affect as two correlated factors were modeled for each time point separately, which resulted in three CFAs. CFI, RMSEA, and SRMR were used as fit measures, with $CFA > 0.90$, $RMSEA$ and $SRMR < 0.08$ as cutoff values for adequate model fit. The correlated two-factor models showed very poor fit (see Table 1). *CFI* was highest for T1 ($CFI = 0.82$), and substantially lower for the other time points. RMSEA and SRMR were all well above the threshold of 0.08. An inspection of the performance of each item showed that item "easily angered" loaded poorly (below 0.2) on negative affect at every time point. The removal of "easily angered" improved the fit somewhat, with SRMR getting closer to an adequate threshold, but overall, the model fits were poor. The poor fit is reflected in the low reliabilities of the scales. McDonald's omega was low for positive affect (around 0.45), and just about acceptable for negative affect (between 0.63 and 0.68) [32]. Therefore, we only used negative affect in the subsequent analyses.

Table 1. Fit measures and McDonald's omega for the VAS variables positive and negative affect.

		χ^2(df)	CFI	RMSEA	SRMR	ω Positive Affect	ω Negative Affect
Model 1 (all items)	T0	54.39(19) ***	0.737	0.131	0.089	0.442	0.592
	T1	49.10(19) ***	0.816	0.121	0.085	0.453	0.599
	T2	68.64(19) ***	0.715	0.156	0.100	0.438	0.605
Model 2 (without "easily angered")	T0	45.76(13) ***	0.754	0.153	0.088	0.450	0.663
	T1	39.84(13) ***	0.832	0.138	0.083	0.444	0.683
	T2	60.09(13) ***	0.713	0.183	0.105	0.450	0.629

*** = $p < 0.001$.

- Special Education Classroom Climate Inventory

The special education classroom climate inventory (SECCI, see Appendix B) was designed to assess the classroom climate in schools for special education, secure residential care, and youth prisons. In the present study, we only used six items to investigate overall classroom climate on six topics, i.e., support, growth, repression, atmosphere, environment, and safety. Items were rated by refugee children and adolescents using school grades according to the Dutch school system on a 10-point scale ranging from 10 = *outstanding* to 1 = *very poor*. The questionnaire has shown to be valid and reliable for use in Dutch special education [33].

2.6. Treatment Integrity

A questionnaire was used to investigate treatment integrity and to show to what extent the intervention was implemented as intended. This questionnaire consisted of eight questions. Questions focus on: (1) the degree of how music therapists followed the instruction manual, (2) feelings of competence, and (3) applied reflective questions on feelings, emotions, and talents. Each question needed to be answered with a percentage

between 0–100. This questionnaire was filled in after each group session and each individual session. Treatment integrity was considered sufficient when both therapist adherence and competence reached a percentage of >60% at group level [34].

2.7. Data Analyses

Separate analyses were performed for the qualitative- and quantitative data. After that, the results were integrated in order to answer the research questions (see discussion).

2.7.1. Qualitative Data Analysis

The interviews were analyzed by means of qualitative content analyses [35], according to the constant comparison analyses method (CCA) [36]. A process of inductive reasoning resulted in salient categories of meaning and relationships between categories. By means of the CCA, relevant data were deductively grouped in the category with the best fit. One researcher (VB) started inductively open coding of the teacher interview data. After reading the transcripts, text fragments that were relevant for the research question were marked and provided with an open code. Initially, "in vivo codes" were used, which entails the text fragments labeled in the words or short phrases of the respondent as far as possible. Subsequently, together with a second researcher (TS), these codes were compared and grouped in the category or subcategory of best fit.

Secondly, the qualitative data of the music therapists were analyzed. By means of a deductive approach, text fragments were coded, by making use of the already developed coding tree for the teachers. Several subcategories were added to the coding tree. During the process of analyzing the codes, categories and subcategories were constantly compared with each other to be refined. Furthermore, memos were used considering the research process and the content. During the analyses, the research questions were demarcated to the intervention on group level. The reason is that the interview data provided insufficient insight in the process of the individual part of the music intervention "Safe & Sound".

2.7.2. Quantitative Data Analysis

The questionnaires of the children were analyzed using hierarchical multilevel regression modelling in order to investigate differences over time with regard to negative affect of the child or adolescents (VAS) and the climate in the class (SECCI). Analyses were performed in R version 4.1.2 [37]. The mice-package [38] was used for missing value imputation. The nlme-package, version 3.1–153 [39], was used to conduct the multilevel regression analyses. Time points were nested within individuals. Negative affect was modeled as a criterion variable, as were the six SECCI variables: support, growth, atmosphere, environment, repression, and safety. For each criterion variable (eight in total), four sequential multilevel models were tested: (1) the 'null' model, (2) a growth model with random intercept-only, (3) a growth model with random intercept and slope, and (4) a model including school-type as a predictor. All models were fitted using maximum likelihood estimation. To decide upon the best model, a combination of indicators was used. The AIC of models were compared. Lower AIC indicates a better model fit, and as such, models with the lowest AIC were preferred. In addition, the difference in deviance (-2LL) between nested models were tested with a chi-squared test with the difference in degrees of freedom (df) between the models as the chi-squared df. A significant difference in deviance combined with a lower AIC than the compared models was used to determine if a more complex model of two compared models could be preferred. The scores on the treatment integrity items were analyzed using descriptive statistics. In calculating mean scores, we only used the scores of the music therapists who did not apply the intervention previously. By excluding the scores of the music therapist who developed the intervention, we prevented a response bias.

2.8. Trustworthiness

The credibility of the qualitative analysis was ensured by using different sources of information concerning the same events: the interviews with music therapists and teachers in different schools (*data triangulation*). In addition, throughout the analysis of the qualitative data, two different authors reflected on the research process to identify areas for further investigation and analysis (*investigator triangulation*).

To validate the outcomes, the results of the process of analysis were discussed with the research team, including one music therapist (SvG) who functioned as the linking pin between participating music therapists and teachers (*member check*). Furthermore, credibility was sought by using multiple methods of data collection, both qualitative and quantitative (*methodological triangulation* [40]). One of the authors (TS) provided guidance on whether the analysis of the qualitative data was in line with accepted standards (*dependability*) and supervised the analysis process of the qualitative data and transcripts for accuracy (*confirmability*).

Throughout the research process, meetings on a regular basis reviewed the scientific and organizational aspects of the project (*peer debriefing*). Finally, *transferability* was ensured by providing descriptive data of the study context (*thick description*) to enable readers to evaluate whether the findings are transferable to other care contexts.

3. Results

3.1. Participants

108 children and adolescents were included. Their age ranged from 6 to 17 years (*Mean* = 11.63, *SD* = 2.79). 50 boys and 50 girls were included; for eight participants, gender information was missing. The children and adolescents came from 35 different countries, most of them from Syria (*N* = 28), Iran (*N* = 11), and Eritrea (*N* = 8). At the time of the start of the intervention, 47 children lived in their own home and another 28 in an asylum center; the information of 33 children on their living situation was missing. In addition, all teachers (*N* = 7) involved and all music therapists (*N* = 3) that applied the intervention were interviewed.

3.2. Qualitative Results

Results of the qualitative analyses indicated that the intervention strengthens the process of social connectedness, resulting in a “sense of belonging” (Figure 2). The *process of social connectedness* and the results of this process was influenced by several factors (Figure 2), which will be discussed further.

3.2.1. Strengthening the Process of Social Connectedness

The intervention “Safe & Sound” has shown to strengthen the *process of social connectedness*, which is referred to as the experience of belonging and relatedness between people. Social connectedness can be based on the present results, defined as the process of social bonding between the children/adolescents during time. Both teachers and music therapists report social connectedness in terms of breaking out of their shell, communicating and sharing emotions, listening to each other, discovering each other’s talents, involvement in relationships, and sharing positive experiences. A participating teacher reported: “*That new girl at (says teacher’s name) class, yes, she then immediately joins (says student’s name) and (says student’s name) and yes she doesn’t really want to leave there*.” Another teacher said: “*I think learning to listen to each other, so learning to listen to what someone else is doing or saying or playing, that is a very good skill*”.

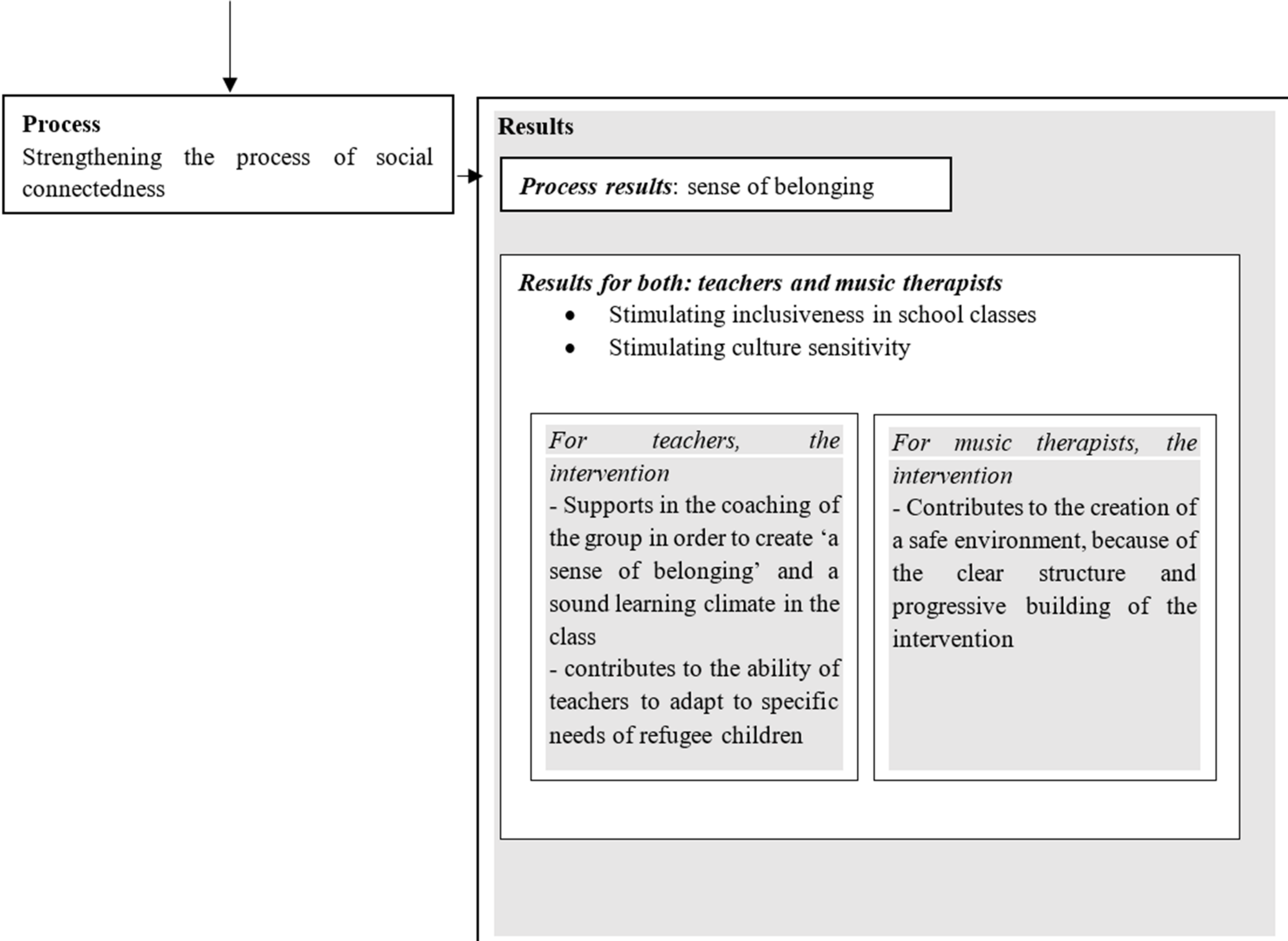

Figure 2. Process and process results of the interventions Safe & Sound.

These social interactions were visible between all children/adolescents of the group, irrespective of culture, language, age, gender, behavior, and whether or not they are new in the group. This suggests that the intervention may stimulate inclusiveness at school. A teacher reported: "*In this group, there are children who have more problems or display more disturbing behavior. But I see that those children are not only included by the therapist, but also by other children. It looks like they care for each other and have an attitude of 'let him be, we understand, come here, we'll get along*".

The process of connectedness is intensified around a joint music activity which results in a collective musical product, perceived as positive and attractive by the children/adolescents. A teacher said: "*The fact that children can make themselves heard in a way without the need for language. With an instrument. I think that is very strong and that children also get control. They play something on an instrument and the other children clap it. Then you see children really grow, hey, children really like that too. I think that's a really successful experience.*". Another teacher mentioned: "So, each child has his own input in the song and together that is a group whole. So, we are responsible for that song together as a group. Mmh, and

everyone has their own voice in that. Yes, I always like that very much." Additionally: "*To make that song together at the end, yes, I find that a magical moment, a very, yes, a very beautiful part. That connects the group, and it results in an end product in which everybody can be his own 'self' in that, and show that, let themselves be heard.*" (teacher).

3.2.2. Process Result: Sense of Belonging

The results of the "process of strengthening social connectedness" can be summarized as a "*sense of belonging*", which refers to the psychological feeling of belonging or connectedness to a social group or a community [30,31]. Teachers and music therapists describe that children/adolescents show feeling connected to the group, feeling seen and heard, feeling accepted and valued, and display emotions of pride and self-esteem. A participating teacher reported, "*I noticed that when they listen to the song they have recorded, they recognize each other and give each other more compliments than they do regularly. They are conscious that they are a group and the song is from them as a group.*". A participating music therapist reported, "*I did not expect that the song did so much, I noticed that it created a sense of belonging. The class started spontaneously with a small hand game together, I've never seen that before*".

A teacher said the following: "I thought that it already was a fairly close group, but yes a few children who then fall out a bit, but yes I do think it has strengthened them somewhat in the group feeling and I certainly felt that when they were composing that song. Then, you noticed that, yes that there was a good flow and cooperation between the students, yes.". One of the music therapists mentioned signals of self-esteem in one girl: "There were also students who discovered their talents, for example a girl who didn't really know what her talent was, but writing was a talent, she said as she went along in the process. And in the end, she even rapped and took the lead and suggested making a music video for it. Yes, it was as if she, how do you say, blossomed."

A music therapist reported results on solidarity within the group: "But maybe it is for them that sense of solidarity and be a part of something for the first time in a new land, so they see it from a different perspective". A teacher mentioned: "So, that it seems as if they look out for each other a little bit that they are a bit like well leave him but yes, we understand that come on here, we'll take you under our arms. In the class of (says teacher's name) of this group yes, yes and I think that's nice behavior, almost protective uhm, what parents also do with their children.".

In addition, teachers and music therapists reported that the intervention was successful regardless of language, musicality, age, or cultural background. In that regard, the intervention stimulates inclusiveness in the classroom. One teacher mentioned: "*Also the most arrhythmic one, can still join*". Another teacher said "*Children who are actually very timid, do get a chance to express themselves and to show something. And that, I think is the beauty of it. That is more than in a lesson situation where they are constantly judged on whether you say that sentence correctly in Dutch. Nothing is judged there at all, so you give them room to come out of that shell and I think that's very beautiful*".

Second, the intervention provides room for cultural differences and teachers reported the stimulation of a culturally sensitive approach. One teacher said: "that moment I started looking for the music of her country I saw a revival", and a music therapist mentioned, "*Uhm, so they're really looking for that connection. Of course I also searched with them for what is a theme that connects you? And then we colored that with things like cultures, respect for each other, what do you think is important about friendship, what is valuable? What do you find difficult*?".

Teachers mentioned that the interventions support supervision in order to create a "sense of belonging" and a sound learning climate in the classroom (see also Figure 1). One quote of a teacher illustrates this: "*Now that I have seen how he (music therapist) has tackled that and how the children react to that, I think yes, that is a completely different approach than from a school perspective*". Teachers also reported that the intervention contributes to the adaptation to specific needs of refugee children/adolescents: "*I also like to include the findings of the*

music therapist if you want to map the behavior of a child. To take him there as an outsider with a different view on the starting point and to ask for advice".

Finally, music therapists stated that the clear structure and progressive building of the intervention can contribute to building a safe environment.

3.2.3. Influencing Factors

The process of social connectedness and its results can be strengthened or hampered by the following factors: the initial situation regarding the level of social connectedness or learning climate in the group (at the start of the intervention); the possibility of meeting the prerequisites of the intervention; the professional competence and experience of the music therapist; and the amount of collaboration between all professionals involved.

- Initial situation

The initial situation describes the initial level of social connectedness or climate in the group during the start of the intervention. The initial situation is related to the extent and the type of psychosocial problems of the individual children/adolescents; the diversity of cultures and personalities; the extent to which children/adolescents feel safe to communicate and express themselves; the age category of the group; the competence to understand the instructions given; the group size; and the stability of the group. Major differences in age, as well as a diversity in cultures and/or intellectual level within the group might be a barrier for adequate adaptation of the intervention in the group. In addition, high levels of social connectedness in the group at the start of the intervention were related to a smaller range to improve connectedness or climate. A participating teacher remarked: "*I think it was already a relative close group with a few people who were socially excluded to some extent. I think it has strengthened them in their sense of belonging to a group*". Another teacher mentioned: "*In this group I think it plays a part that the mutual relationships are very disturbed anyway and it is a younger group so you notice that as well in the music session.*".

- Possibility to meet prerequisites of the intervention

The prerequisites for the intervention were the number of group sessions, the duration of the sessions, the embedding of the music therapist in the group, and whether the instructions and indications for additional individual sessions were clear.

Teachers reported that the eligibility criteria for children/adolescents to participate in the individual sessions were not clear. The ambiguity and lack of transparency in the communication regarding the access to the individual sessions, to children/adolescents, parents, and other professionals were reported as a point for improvement. A participating teacher remarked, "*Sometimes it is difficult to explain why one child can get individual sessions and the other one doesn't. They all could use it.*".

Furthermore, the music therapists reported that the number and duration of the group sessions during this study were insufficient. Several music therapists experienced that, due to the limited time spent in the group, they were not able to support the process sufficiently. They expected that a more structural and prolonged presence in the group would contribute to building relationships within the group. A participating music therapist responded: "*I find it difficult what to expect in a few sessions, so you cannot expect a lot. That is a difficult one, what can you do in such a short period?*".

- Professional competence and experience of musical therapist

Conducting the intervention requires certain competences of the music therapists, such as the ability to adapt the themes and activities to the age of the children/adolescents, the climate in the group, and current events that have taken place in the group. Two music therapists reported that gaining experience in conducting the intervention is important in order to be able to tailor the intervention to the group. A participating music therapist reported, "*At the youngest group I brought up the themes talents, emotions and difficult events. But they just didn't understand me. Difficult events did not concern them. So I had to go back to very basis programs.*": This is also a topic which was discussed during the intervision

between the music therapists. Safe & Sound consists of three phases to build up safety. If the therapist is working too fast, children have problems in understanding the therapy and the music therapist has to take one step back.

- The collaboration between professionals involved

The collaboration between the professionals involved concerns the communication between the music therapists, parents, and teachers. It is essential that involved teachers and music therapists meet on a regular basis in order to monitor changes in the learning climate and in (the behavior of) individual children/adolescents. In daily practice, the opportunity for mutual consultation is limited due to restrictions in time. The communication between these professionals is related to the initial situation, to choices regarding appropriate and appealing themes, to the division of tasks and roles, and to the communication with parents and stimulating them to participate. A participating teacher remarked, "*One moment I felt I had to intervene in the group but then I thought: the music therapist is working and I don't want to be in the wheels of the therapist. Yes, we didn't make clear agreements about this before we started.*". A participating music therapist remarked, "*When I look back, I see I didn't make clear agreements beforehand with the teachers. I think I needed more communication with the teachers, but I couldn't have done it differently because I know more now. So if I had to do it again, I would have done it differently, but some things I didn't know when I started. I didn't know it was my task in the beginning. Now I would have communicated with the teachers every two to three weeks*".

3.3. Quantative Results

Prior to analysis, scores for all variables were examined for accuracy of data entry, distributions, univariate, and multivariate outliers. Two cases with extremely high z-scores ($z > 3.29$) on negative affect (T_2) and one case with extremely low z-scores ($z < -3.29$) on atmosphere (T_0 and T_1) were found to be univariate outliers. The case with two univariate outliers on atmosphere T_0 and T_1 was also identified as a multivariate outlier based on the Mahalanobis distance ($p < 0.001$). All three cases containing the univariate outliers were removed from the analysis. Missing values were found in all items and were imputed with predictive mean matching based on all research variables. The completed data from the research variables are summarized in Table 2. Shapiro-Wilk's tests for normality of distributions indicated that all variables other than negative affect at T0 deviated from the normal distribution and were positively skewed ($p < 0.001$).

Table 2. Means and standard deviations of VAS-negative affect and classroom climate.

	T_0		T_1		T_2	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*
Negative Affect	2.08	1.98	2.18	1.86	1.47	1.50
Support	9.32	1.09	8.82	1.71	8.99	1.46
Growth	9.15	1.25	9.13	1.15	9.12	1.20
Atmosphere	8.32	2.13	8.24	2.21	8.29	2.05
Environment	8.44	2.02	8.51	1.56	8.36	2.12
Repression	8.83	2.05	8.12	2.38	8.37	2.13
Safety	8.76	1.95	8.81	1.70	9.06	1.63

3.3.1. Negative Affect

A hierarchical multilevel regression analysis was performed on negative affect. The addition of time (model 2) as a predictor significantly improved upon the null-model (model 1), ($\Delta deviance(1) = 4.977$, $p = 0.026$). The random slope for time was not a significant improvement of model 3 over model 2 ($\Delta deviance(1) = 1.516$, $p = 0.218$). The addition of school-type did not significantly improve the model ($\Delta deviance(1) = 0.272$, $p = 0.602$), nor was it a significant predictor of negative affect (Model 4) ($B = 0.200$, $t(106) = -0.735$, $p = 0.464$). Both model 3 and model 4 had higher AIC than model 2. For these reasons, model 2, a growth model with only a random intercept, was chosen as the "final" model.

In model 2, negative affect decreased significantly over time ($B - 0.31$, $t(215) = -3.18$, $p = 0.002$, see Table 3).

3.3.2. Classroom Climate

A hierarchical multilevel regression analysis was performed on six different aspects of classroom climate: support, growth, repression, atmosphere, environment, and safety. Only support was found to significantly change over time; all the other classroom climate variables were not significantly different over time (see Table 4). Except for support, the addition of time as a predictor, either with random-intercept only, or random intercept and slope did not significantly improve model fit (Δdeviance(1) < 3.841, $p > 0.05$) or result in higher AIC-scores, and in none of these models was time found to be a significant predictor of classroom climate.

For support, the addition of time (model 2) as a predictor with only a random intercept did not significantly improve upon the null-model (model 1), (Δdeviance(1) = 2.329, $p = 0.127$). However, allowing for random slopes for time significantly improved model 3 over model 2 (Δdeviance (1) = 4.680, $p = 0.031$), and was the model with the lowest AIC of all four models. The addition of school-type did not significantly improve the model (Δdeviance(1) = 0.607, $p = 0.436$), nor was it a significant predictor of support (model 4) ($B = -0.239$, $t(106) = -1.137$, $p = 0.258$). Because of the lowest AIC found in model 3 and its significant improvement over model 2, model 3, a growth model with random intercept and slope for time was chosen as the "final" model. In model 3, support decreased significantly over time ($B = -0.17$, $t(215) = -2.099$, $p = 0.037$, see Table 4).

3.4. Treatment Integrity

The music therapists followed the instruction manual most of the time. For the group sessions, the mean score was 92% (range over the session 50–100%) and for the individual sessions this was even higher, i.e., 99% (range over the session 80–100%). No therapeutic techniques were added in the individual sessions. In the group sessions, techniques were added in nearly 80% of the sessions. The music therapist felt competent to apply the intervention (95% for the group sessions and 97% for the individual sessions). In nearly all sessions, music therapists applied reflective questions on emotions, i.e., in 85% of the group sessions and in 88% of the individual sessions. Questions on talents were asked in about half of the sessions, 51% and 57%, respectively.

Table 3. Unstandardized coefficients and model fit indices for the four multilevel models predicting negative affect. Model 1 = intercept only, Model 2 = random intercept for time, Model 3 = random intercept and slope for time, Model 4 = random intercept for time. Level 1 = time, level 2 is student.

		Model 1			Model 2			Model 3			Model 4		
		B	**SE**	***p***	**B**	**SE**	***p***	**B**	**SE**	***p***	**B**	**SE**	***p***
Negative Affect	Intercept	1.911	0.133	<0.001	2.522	0.233	<0.001	2.522	0.253	<0.001	2.599	0.256	<0.001
	Time				−0.305	0.096	0.002	−0.305	0.097	0.002	−0.305	0.096	0.002
	School-type										−0.2	0.272	0.464
	Deviance	−632.144			−627.167			−625.65			−626.895		
	AIC	1270.288			1262.334			1263.301			1263.789		
	p Δdeviance				0.026 [1]			0.218 [2]			0.602 [3]		

NOTE: [1] Model 2—model 1, [2] model 3—model 2, [3] model 4—model 2.

Table 4. Unstandardized coefficients and model fit indices for the four multilevel models for each classroom climate construct. Model 1 = intercept only, Model 2 = random intercept for time, Model 3 = random intercept and slope for time, Model 4 = random intercept for time. Level 1 = time, level 2 is student.

		Model 1			Model 2			Model 3			Model 4		
		B	**SE**	***p***	**B**	**SE**	***p***	**B**	**SE**	***p***	**B**	**SE**	***p***
Support	Intercept	9.045	0.106	<0.001	9.383	0.189	<0.001	9.383	0.167	<0.001	9.475	0.187	<0.001
	Time				−0.169	0.078	0.032	−0.169	0.08	0.037	−0.169	0.08	0.037
	School-type										−0.238	0.209	0.258
	Deviance	−561.326			−558.998			−554.318			−553.711		
	AIC	1128.653			1125.996			1120.635			1121.422		
	p Δdeviance				0.127 [1]			0.031 [2]			0.436 [4]		
		Model 1			**Model 2**			**Model 3**			**Model 4**		
		B	SE	*p*	B	SE	*p*	B	SE	*p*	B	SE	*p*
Growth	Intercept	9.133	0.085	<0.001	9.16	0.159	<0.001	9.16	0.163	<0.001	9.263	0.177	<0.001
	Time				−0.014	0.067	0.837	−0.014	0.07	0.842	−0.014	0.07	0.842
	School-type										−0.263	0.173	0.131
	Deviance	−502.511			−502.489			−502.232			−501.081		
	AIC	1011.021			1012.978			1016.464			1016.162		
	p Δdeviance				0.884 [1]			0.612 [2]			0.235 [3]		

Table 4. *Cont.*

		Model 1			Model 2			Model 3			Model 4		
		B	SE	p	B	SE	p	B	SE	p	B	SE	p
Atmosphere	Intercept	8.284	0.155	<0.001	8.312	0.279	<0.001	8.312	0.279	<0.001	8.705	0.299	<0.001
	Time				−0.014	0.116	0.905	−0.014	0.116	0.905	−0.014	0.116	0.905
	School-type										−1.01	0.303	0.001
	Deviance	−684.236			−684.229			−684.228			−678.881		
	AIC	1374.472			1376.457			1380.455			1367.762		
	p Δdeviance				0.932 [1]			0.973 [2]			0.021 [3]		
		Model 1			Model 2			Model 3			Model 4		
		B	SE	p	B	SE	p	B	SE	p	B	SE	p
Environment	Intercept	8.438	0.135	<0.001	8.522	0.254	<0.001	8.522	0.25	<0.001	8.693	0.273	<0.001
	Time				−0.042	0.108	0.699	−0.042	0.114	0.715	−0.042	0.114	0.716
	School-type										−0.44	0.273	0.111
	Deviance	−654.281			−654.206			−652.434			−651.154		
	AIC	1314.563			1316.412			1316.868			1316.307		
	p Δdeviance				0.784 [1]			0.183 [2]			0.081 [3]		
		Model 1			Model 2			Model 3			Model 4		
		B	SE	p	B	SE	p	B	SE	p	B	SE	p
Repression	Intercept	8.441	0.146	<0.001	8.904	0.303	<0.001	8.904	0.289	<0.001	8.897	0.325	<0.001
	Time				−0.231	0.133	0.082	−0.231	0.134	0.085	−0.231	0.133	0.083
	School-type										0.018	0.3	0.952
	Deviance	−708.66			−707.136			−706.333			−707.134		
	AIC	1423.319			1422.271			1424.666			1424.268		
	p Δdeviance				0.217 [1]			0.370 [2]			0.966 [3]		
		Model 1			Model 2			Model 3			Model 4		
		B	SE	p	B	SE	p	B	SE	p	B	SE	p
Safety	Intercept	8.877	0.118	<0.001	8.58	0.243	<0.001	8.58	0.255	<0.001	8.588	0.273	<0.001
	Time				0.148	0.106	0.164	0.148	0.110	0.181	0.148	0.11	0.181
	School-type										−0.019	0.242	0.937
	Deviance	−636.887			−635.909			−635.407			−635.404		
	AIC	1279.775			1279.818			1282.814			1284.807		
	p Δdeviance				0.323 [1]			0.479 [2]			0.477 [3]		

[1] Model 2—model 1, [2] model 3—model 2, [3] model 4—model 2, [4] model 4—model 3.

4. Discussion

The present mixed-method study aimed to set the first steps in the implementation of the music therapy intervention "Safe & Sound" and to get insight in the process of implementation, its process results, influencing factors, and the perceived effects of the intervention in refugee children and adolescents. The results of the process evaluation indicated that the intervention Safe & Sound strengthens the process of social connectedness, resulting in a "sense of belonging", which refers to the psychological feeling of belonging or being connected to a social group or a community [41]. This can be interpreted as an early stage of resilience [42]. This was reported during the interviews by both teachers and music therapists. Teachers reported that the intervention can stimulate inclusiveness in schools and culturally sensitive attitudes. The quantitative results indicated that refugee children and adolescents showed a decrease of negative affect during the time of the intervention and is in line with the qualitative results of teachers and music therapists in this respect. It is plausible to suggest that the Safe & Sound intervention stimulated a number of protective factors for the children in the classroom, such as maintenance of cultural identity, social support, belonging, and safety. These factors are protective for mental health problems and psychological functioning in refugee children [42]. This was also seen in our study since children and adolescents showed a decrease over time in negative affect. Peer support, the education system, and "acculturation" have been shown to be protective factors in especially positive adjustment [42,43].

The results of the interviews further indicate that teachers mentioned that Safe & Sound helped them in creating a sound learning climate and to better adapt to the specific needs of refugee children. Music therapists stressed the contribution of the intervention to a safe environment because of the clear structure and progressive phasing of the intervention. These beneficial results on the classroom climate were not seen in the experience of the refugee children and adolescents. They did not experience a better classroom climate, such as a better atmosphere or more safety in the classroom. However, ceiling effects were seen on all variables regarding classroom climate and on all measurement time points. Even for one element of the classroom climate, i.e., support of the teacher, a decrease was seen over time. This could possibly be explained by contextual factors (Christmas holidays, changes in constitution of the children in the class), but also by the fact that results proceed a regression to the mean as high scores at the first measurement will likely decrease and be closer to its mean. It should also be taken into account that the description of this item, "support", refers to teachers and not directly to the intervention itself.

A second aim was to identify influencing factors for the implementation of the intervention. Results have shown that the initial situation in the classroom, the possibility of meeting the prerequisites of the intervention, the professional competence and experience of music therapists, and the collaboration and communication between the involved professionals can be seen as influencing factors. First, the level of social connectedness or learning climate in the group at the start of the intervention was highly influenced by the diversity of cultures, age, language and personalities, feelings of safety, the size, and the stability of the group. Major differences in age, as well as a diversity in cultures and/or intellectual level within the group might be a barrier for adequate adaptation of the intervention in the group. Second, the possibility of meeting the prerequisites of the intervention was mentioned as an important factor in the process. In this regard, the importance of equivocal and transparent communication by and between teachers and music therapists were mentioned, in particular, regarding the access to the individual sessions. Additionally, the number and duration of group sessions were seen as insufficient. Results showed the importance of a structural and prolonged presence of the therapists in the group. This would contribute to building stronger relationships within the group. This is in accordance with a dose–response relationship that was previously found in music therapy [32]. Third, conducting the intervention requires certain competences of the music therapists, such as the ability to tailor it to the specific needs of the group and its heterogeneity. The music therapists that conducted the intervention for the first time reported sufficient treatment

integrity and felt competent enough. Nevertheless, during some sessions the scores were lower (<60%), which was explained by music therapists by difficulties in proper tailoring to the group, events, or individuals in the group. Training and discussing these themes during intervision were seen as very helpful. Last, it is seen as essential that teachers, music therapists, and parents are adequately aligned on the psychological functioning and mental health of the child or adolescent. In daily practice, the opportunity for mutual communication between teachers and music therapists is limited due to restrictions in time.

These influencing factors lead to several recommendations for implementation of this (or a comparable) intervention in the future. First, it is important to make room and time available for communication between teachers and music therapists. Music therapists could join the weekly meetings of the teachers or a specific meeting on mental health could be introduced. Second, before starting the intervention, it is desirable that the music therapist is introduced to the functioning of the class in order to get insight in the initial situation. Third, it is recommended to elaborate on the specific eligibility criteria for the individual session. Fourth, the training and intervision process could be strengthened, so music therapists are better able to tailor the intervention. Lastly, the number of sessions implemented could be more flexible and, if needed, more sessions could be offered.

Strength and Limitations

There are some methodological considerations. A strength is this mixed-method design, which made it possible to get insights from different perspectives, i.e., teacher, music therapist, children, and adolescents. The qualitative research appeared to be a successful method to investigate an area where research is still sparse [44]. The strength of the qualitative results lies in the richness of experiences as expressed by the participants.

The sampling strategy can be characterized as convenience sampling [44]. All participating music therapists and teachers were involved in the data collection. Working with a small number of participants in the interviews enabled us to examine their responses in depth. The actual research started the analysis with the interviews with the teachers. Data saturation occurred after about half of the interviews with the music therapists, which means that no new categories emerged. The qualitative analysis of the last interviews served to confirm the results. This process that was seen in this study was context-dependent, so it is important to replicate this study in other schools. The present study provides initial insights into the implementation process.

Further limitations of this study were the sample and the lack of a control group, which makes it impossible to exclude other factors than the intervention when interpreting the quantitative results. Therefore, this study needs to be considered as a first step in studying Safe & Sound among refugee children. Future studies should focus on further implementation of Safe & Sound in order to increase the generalizability, as well as investigating the feasibility of the study with a proper control group. Additionally, multiple single-case experimental designs on the individual sessions should be planned as a next step in order to get more insights into the effects of the individual part of the intervention.

5. Conclusions

This study presents the first results of the implementation of the intervention Safe & Sound. Safe & sound has a resilience-focused approach and includes elements that have been shown to be protective for mental health in refugees. When implementing the intervention in schools, it is important to take into account the initial situation in the classroom, the prerequisites for the intervention, the professional competence, the experience of music therapists, and the collaboration and communication between the professionals involved. Future research should shed more light on the effects of further implementation of music therapy, especially on the longitudinal protection of trauma-based problems in refugee children.

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Informed Consent Statement: Written informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are available on request from the corresponding author.

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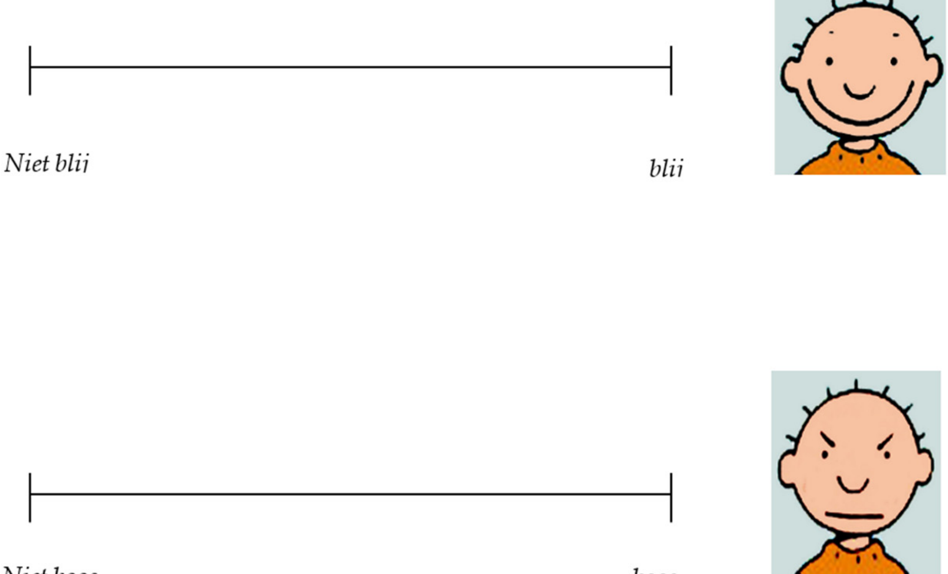
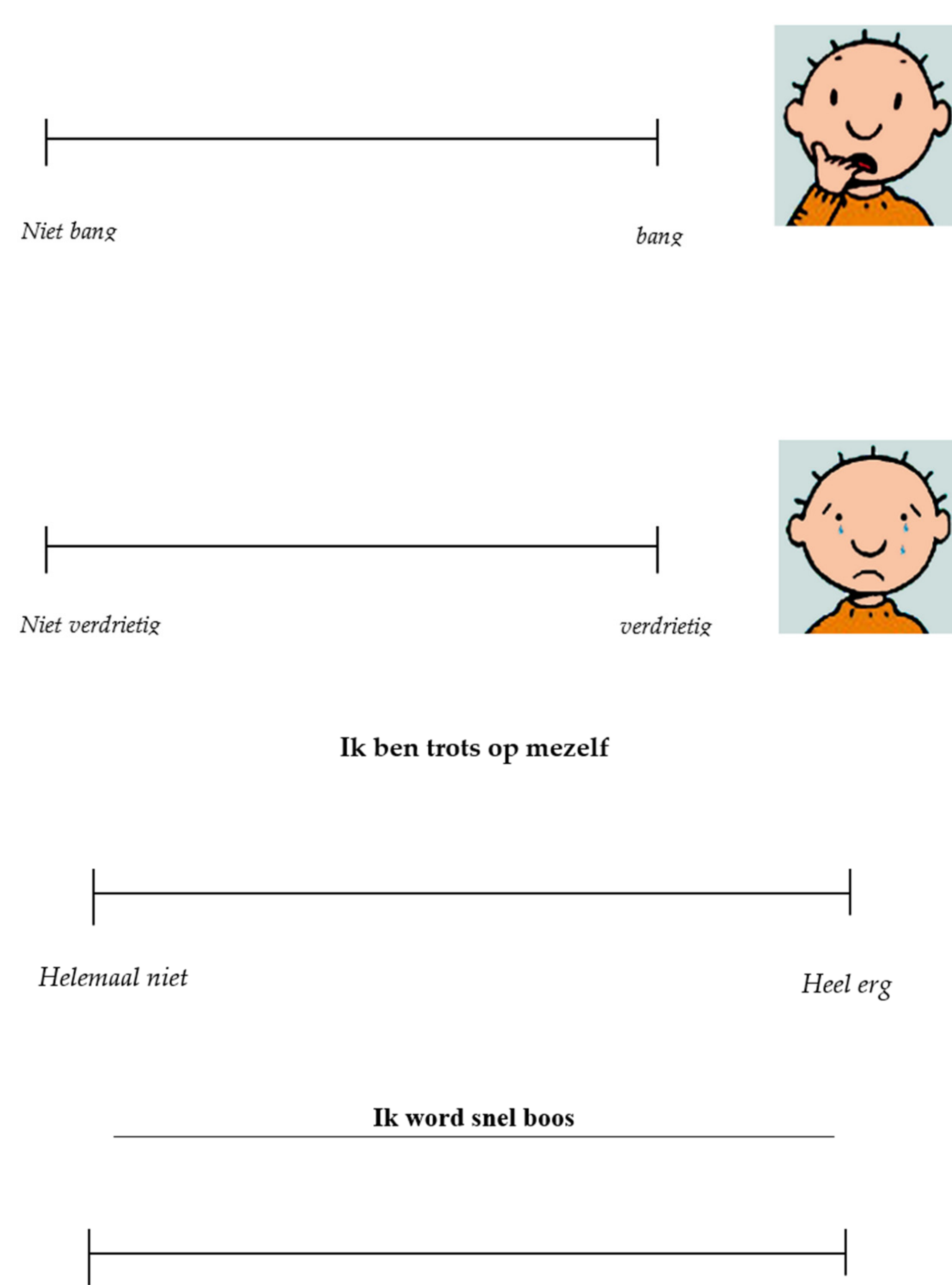
Appendix A. Visual Analogue Scale





Ik voel me op dit moment

Niet bang — *bang*

Niet verdrietig — *verdrietig*

Ik ben trots op mezelf

Helemaal niet — *Heel erg*

Ik word snel boos

Helemaal niet — *Heel erg*

Climate Questionnaire

Appendix B. Classroom Climate Questionnaire

Rapportcijfers geven voor de klas

Geef een cijfer voor:	Cijfer:	Waarom vind je dit?
De hulp die je krijgt van de docent		
Wat je leert op school		
De sfeer in de klas		
Hoe het er uit ziet in de klas		
De regels in de klas		
De veiligheid op school		

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Article

Artmaking in Elementary School Art Therapy: Associations with Pre-Treatment Behavioral Problems and Therapy Outcomes

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Abstract: Engaging in artmaking is one of the key components of art therapy. Theoretical conceptualizations posit that artmaking is not only influenced by the mental state of the artmaker, but can also modify it. The quantitative longitudinal study reported here examined these assumptions in the context of school art therapy. Seventy-seven elementary school students in art therapy in Israel completed the Art Based Intervention Questionnaire (ABI) three times during the therapy year. Their parents and homeroom teachers reported on the students' behavioral and emotional problems on the Child Behavior Checklist (CBCL for parents, and TRF version for teachers). The results indicated an inverse correlation between the students' externalizing and mixed problems before starting treatment and these clients' experiences of artmaking during the first month of therapy. A regression model for predicting gain scores on the TRF internalizing problem indices was significant, whereas the significant regression predictor was the students' experience of artmaking at T1. These findings provide initial support for an association between the experience of artmaking and mental state, and an improvement in mental state, and are discussed in relation to the context of school art therapy.

Keywords: school arts therapies; behavioral problems; experience of art making

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1. Introduction

Child art therapy provides a protected space for self-expression, self-inquiry, and dealing with distress through artmaking in a safe relationship [1]. Studies present evidence regarding the beneficial value of art for mental well-being in children [2,3]. Clinicians and art therapy theorists posit an association between the mental and emotional state of the artmaker, and the experience of artmaking in therapy, e.g., [4]. However, the nature of this relationship is complex, and its characteristics have not been sufficiently researched. The study presented below enhances recent attempts to investigate the influence of therapeutic factors on the success of art therapy [5] through the examination of elementary school children's experiences of artmaking in therapy, and the relationship between these experiences and their condition before therapy started and with therapy outcome measures. The overarching aim was to better understand the associations between the experience of artmaking and emotional state, and between the experience of artmaking and treatment success.

1.1. Artmaking, Distress and Mental Well-Being

One of the key assumptions underlying art therapy is that individuals in distress are motivated to engage in artmaking, to express and deal with their difficulties [6,7]. This assumption was originally related to Freud's conception of artmaking as the expression of repressed content in neurotics who are dealing with powerful pressures originating in the Id [8], and evidence that artists cope with their distress through art, e.g., [9–12]. Findings from studies on the association between mental distress and the drive to engage in artmaking, e.g., [13–15] also support this assumption.

Other theorists and researchers [16–18] argue that playfulness, creativity and artistic endeavor are more closely related to well-being than to distress. Winnicott, for example, considered that artmaking, creativity and playfulness are the visible counterparts of mental health. These manifest in the encounter between the inner world and outer experience, and contain elements from both worlds, such as emotions, experiences, and inner fantasies, all of which are expressed and can be processed in the real world [19]. According to this view, well-being engenders greater playfulness and creativity, as also found in artmaking. Similarly, attachment theorists have suggested that exploratory and playful activity which are part of the artistic endeavor [19,20] are enabled when there is a sense of security that derives from secure attachment, and an ability for emotional regulation. For example, as can be seen in the Strange Situation [21], exploratory activity is delayed until emotional regulation of distress is achieved, which allows the child to return to play [22]. A number of studies examining the relationship between creativity and playfulness, as well as mental well-being and the ability to regulate emotions, lend weight to this assumption, e.g., [23,24]. For example, in a study of 61 kindergarten to fourth grade girls, Hoffmann and Russ found that participants who were better able to manage their emotions were also more comfortable engaging in the play task and showed higher levels of imagination and organization while playing [25]. A study that examined the expression of attachment patterns among adults who played the mirror game found that individuals with secure classification expressed more ease and flow in their movements [26].

These differences in interpretations of the nature of relationship between artmaking, creativity and mental state are probably related to the complexity of this relationship [27–31]. Researchers and theorists have stressed the importance of the definition of mental distress, its characterization [32,33] and intensity [34], in the process of understanding the association between these variables. The characteristics of the association between these two variables are also related to definitions of creativity and artistic endeavor, since these are close but not identical concepts, and different studies use different operationalizations to evaluate and measure them [29,31]. Finally, the way in which the relationship between the variables is investigated also plays a role in the variability in the association [35–37].

The different associations between the artmaker's mental state and the experience of artmaking in various situations also raises questions about the role of artmaking in the therapeutic process with children. Drawing on the theoretical idea that artmaking stems from distress, children who are sent for treatment for emotional distress and behavioral problems are assumed to be attracted to artmaking. By contrast, the notion that artmaking is an expression of wellbeing suggests that clients need to feel relaxation, security and well-being before they can engage, enjoy and express themselves through art materials.

The present study examined the relationship between the behavioral manifestations of children referred to art therapy in the education system before the start of treatment, and their responses to artmaking over the course of treatment.

1.2. Artmaking during Therapy

This study also examined whether treatment outcome could be predicted through assessments of the child's experiences of artmaking during therapy. The theoretical premise of a relationship between artmaking and distress implies that artmaking can provide support and can contribute to enhancing the artmaker's mental well-being, e.g., [2,3,38]. In children, artmaking provides a fun and natural way to express content from their inner world [1,39–43]. The inviting presence of the art materials and the enjoyable opportunity to create establish a safe space for the development of the therapeutic relationship [42]. The art materials and the blank sheet of paper transform into an esthetic expression of the artmaker's inner world, while containing the pain. Observation of the esthetics of the artistic creation conveys the message that the clients' painful experience can be thought about and contained [1]. This externalization of painful experiences, and their organization by the artmaker in ways exterior to the self within the artistic space also impact the

artmakers, who can then reflect on their work [44]. Consistent with these claims, there is growing evidence for the effectiveness of art therapy for children, e.g., [3,41,45,46].

Within this process, the positive and pleasurable aspects of artmaking appear to play an important role. Artmaking can produce a positive experience and engender positive emotions [47–49]. Art therapy clinicians, e.g., [47,50–54] have reported that the positive features involved in artmaking enables artmakers to experience 'flow,' an experience of full involvement, enjoyment and focus on the process [55,56]. Positive psychology posits that the experience of flow and positive emotions such as pleasure, interest, hope and love enable the continued organization of the self and psychological growth [57,58]. Art therapists suggest that esthetic, creative, and enjoyable experiences are often an essential component of creative developmental processes [59] because they provide the artmakers with the motivation to cope and bear the painful parts of therapy, and explore themselves in a positive and enjoyable way [60]. The notion that a positive experience of art in therapy would have a positive impact on treatment success was explored in this study by examining whether children's experiences of art during therapy could serve as a predictor of improvement in school art therapy outcomes.

1.3. The Current Study

This study examined the relationship between the experience of artmaking in art therapy, and the child's condition in the context of art therapy in the school setting. Art therapy in educational settings has developed exponentially in recent years [46,61]. In Israel, art therapists work in almost every educational setting, thus making treatment accessible to many children who would not otherwise have access to therapy [62]. School art therapy is intended to support children's integration in school, and their ability to engage in the learning, educational and social activities that take place in the educational framework. School art therapy has the further advantage of teamwork made possible by treating clients in the location where they are studying [63]. To include the educational context in which the treatment took place, the children's emotional conditions were assessed by their teachers and parents reports on behavioral problems before and after therapy. A comprehensive literature review on thirty-seven studies from 2020, showed that art therapy for children and adolescents with psychosocial problems can lead to improvement regardless of the type of art materials and therapeutic intervention method [64]. The children's experience of artmaking in art therapy was measured using a self-report questionnaire that includes a number of questions about the respondent's experience in the last therapy session [65].

Two hypotheses were formulated: 1. Parents' and teachers' reports of behavioral problems before treatment would be inversely correlated with experiences of artmaking in art therapy after the first month of therapy. 2. Improvement in the child's condition, as assessed by differences in parents' and teachers' reports on behavioral problems before and after therapy could be predicted from the child's experience of artmaking in art therapy, i.e., more positive responses to art would predict higher gain scores.

2. Materials and Methods

This quantitative longitudinal study is part of a broader project examining art therapies in the education system from 2015 to 2017 to better characterize the processes involved [66–70], the conditions for treatment success [71] and therapists' well-being [72]. Since this study aimed to capture a naturalistic setting, it should be seen as pseudo-experimental.

2.1. Participants

Seventy-seven art therapy clients in the Israeli elementary school system, their home-room teachers and their parents completed self-report questionnaires during one year of therapy. The students involved were all eligible for special education services in regular education (integration hours) or as part of a special education class in regular education, and were referred for treatment in the school setting. None were receiving any other form of additional psychotherapy. They were treated by 48 art therapists who consented to

participate in the study for one year. The sample was composed of 55 boys and 22 girls enrolled in first to seventh grade. They ranged in age from seven to 13 (M = 10.07, SD = 1.53). Forty-six were defined as middle SES, 19 as low SES, and nine high SES. Sixty-eight were Jewish and nine were Muslim; 28 received one-on-one therapy, 36 were in group therapy, nine in a dyadic setting, and for four, no type of setting was noted. The referrals for therapy were typical to the school system in general, and consisted of social difficulties, emotional difficulties, low self-esteem, behavioral disorders and attention deficit disorders that impaired the students' ability to learn.

2.2. Measures

2.2.1. Art-Based Intervention Questionnaire

This self-report questionnaire [65] examines individuals' creative experiences working with art materials. The respondents indicate the extent to which each Likert-type statement corresponds to their experience with art materials on a scale of 1–7. The 41 original items cover four categories, with 10 subscales: 1. Feeling and thoughts preceding the artistic process, which includes the positive excitement, confidence, and aversion subscales; 2. Feeling and thoughts during the artistic process, which includes the pleasantness and therapeutic value, competence, difficulty in carrying out the artistic task, and playfulness subscales; 3. Attitudes toward the artistic product, which has one subscale; and 4. Attitude toward the material, which includes the meaningful and pleasantness subscales. In the current study, a short 15-item version adapted to children with items from categories 2 and 3 was used. The ABI was administered to the children at the start (T1), middle (T2) and the end of one school year of therapy (T3). Table 1 lists the 15 items.

Table 1. ABI-child version.

ABI Items
I felt I could keep on going for hours
I felt I was being creative
I had a difficult time executing my ideas *
I felt I was good at this kind of activity
I felt I needed to make a considerable effort *
I encountered lots of technical difficulties in performing the artistic task *
I had a hard time sitting still and wanted to get up and move around *
I enjoyed working on my art project
I found it pleasant to be creating something
Working on my art project, I felt a sense of inner peace and warmth
I felt it was OK to make mistakes
I wanted to keep what I had made
I was excited to see what I had created
I was surprised by what I had made
I wasn't satisfied with what I had made

* reverse scored.

A high score on this scale expresses a positive experience and enjoyment of artmaking. Good reliability of the subscales has been reported by the authors ranging from 0.45 to 0.91, with a reliability of 0.91 for the overall score [64]. In the present study, the reliability of the overall score was found to be good on all three measurements (αT1 = 0.73; αT2 = 0.75; αT3 = 0.75).

2.2.2. Child Behavior Checklist

The Hebrew version of the two scales was administered. It evaluates students' behavior and functioning, as well as changes over time and/or after the intervention. The Teacher's Report Form (TRF) is made up of 113 items. The parents' form, the Child Behavior Checklist (CBCL), is made up of 109 items. Respondents circle "not true of him/her" (0), "sometimes true" (1), or "always true of him/her" (2) for each item to indicate the presence/absence of the problem. The items are divided into eight subscales in both

checklists. These can be grouped into three larger subscales: internalizing problems (the anxiety/depression, introversion/depression, and somatic complaints subscales), mixed problems (the social problems, cognitive problems, and attention problems subscales) and externalizing problems (the aggressive behavior and delinquent behavior subscales) [73]. In the current study, only the composite scales (internalizing problems, mixed problems, and externalizing problems) were administered. The Child Behavior Checklist was filled in by the homeroom teachers and parents at the beginning of the year (pre-intervention questionnaires), and at the end of the year at the conclusion of therapy (post-intervention questionnaires). The Cronbach's alphas for the homeroom teachers' and parents' scales, pre- and post-intervention, ranged from 0.61 to 0.95.

The gain scores were calculated as the pre-score minus the post score to obtain a positive different index: the higher the difference score, the more positive change between the first and second measurement.

2.3. Procedure

Therapists were contacted to take part in the study and the Israeli Association for Creative Arts Therapies (YAHAT) posted calls to participate. Art therapists were asked to select one or two of their 1st to 7th grade clients and their parents who had consented to take part. The data were collected on Qualtrics software. A research assistant helped the students fill in the questionnaires after coordination with the school and the therapist. The teachers and parents filled out the questionnaires after receiving a link from the experimenter at the beginning of the year, and again at the end of the treatment.

2.4. Professional Ethics and Confidentiality

The therapists and parents were informed by the consent form that they could withdraw from the study at any time and that withdrawal would have no detrimental effects. The students were informed orally of their rights and that withdrawal would have no effect on the continuation of therapy. In order to maintain anonymity, each client was given a code that was used on the questionnaires for identification purposes.

3. Results

3.1. Preliminary Analysis

Examination of the data distribution showed that most of the ABI, CBCL and TRF scales were normally distributed. Calculation of the difference between pre-therapy measurement and post-therapy measurement on the TRF and CBCL showed that the gain scores of the outcome measures were positive, but low. Thus, it may be said that there had been some, but not major improvement in the outcome measures following treatment.

3.2. Correlations between Children's Behavioral Problems Prior to Therapy and Their Evaluation of Artmaking in Therapy

The correlations between the children's behavioral problems before starting treatment as reported by the parents' and teachers' assessments, and the children's responses to artmaking were calculated using Pearson's *r*, with a Bonferroni correction for multiple correlations.

As shown in Table 2, there was a significant inverse correlation between clients' response to artmaking at T1 and the parents' and the teachers' assessment of externalizing problems (r, CBCL = -0.374, $p < 0.002$; r, TRF = -0.409, $p < 0.001$), and mixed problems (r, CBCL = -0.313, $p < 0.012$; r, TRF = -0.361, $p < 0.003$). In other words, the more the children were characterized as having externalizing and mixed problems by their parents and teachers, the less positively they perceived the experience of artmaking at T1, after one month of therapy. By contrast there were no significant correlations between parents' and teachers' reports of the children's condition prior to therapy on these scales and the children's responses to artmaking in the middle and towards the end of therapy (T2, T3), or for the parents' and teachers' reports of internalized problems before treatment and the children's responses to artmaking at any of three time points.

Table 2. Matrix correlates between response to artmaking and behavioral problems.

Children's Condition before Therapy		ABI—Children's Artmaking Experience		
		T1	T2	T3
TRF	Externalizing problems	−0.409 * $p < 0.001$	−0.311 $p < 0.012$	−0.194 $p < 0.127$
	Internalizing problems	−0.153 $p < 0.223$	−0.146 $p < 0.246$	−0.069 $p < 0.591$
	Mixed problems	−0.361 * $p < 0.003$	−0.240 $p < 0.054$	−0.175 $p < 0.171$
CBCL	Externalizing problems	−0.374 * $p < 0.002$	−0.192 $p < 0.128$	−0.249 $p < 0.049$
	Internalizing problems	−0.251 $p < 0.046$	−0.103 $p < 0.416$	−0.034 $p < 0.792$
	Mixed problems	−0.313 * $p < 0.012$	−0.141 $p < 0.266$	0.009 $p < 0.943$

* $p < 0.016$.

3.3. Predicting Improvement in Outcome Measures through Responses to Artmaking

To test the second hypothesis, a linear regression was calculated to predict the gain scores using the ABI score at each time point. This test was run six times, to test the ability to predict the internalizing problems, externalizing problems and mixed problems separately for parents' and teachers' reports. To correct for the effect of each child's initial condition, the pre- measurement score in the predicted index was also entered into the predictors.

The regression model for predicting gain scores in teachers' reports of internalizing problems was significant [F (4,56) = 6.21, $p = 0.000$] and explained 30.7% of the variance in improvement in internalizing problems. Aside from internalizing problems before starting treatment, whose contribution to the equation was predictable but non-significant with respect to the research questions, the only other significant regression predictor was the child's response to art at T1 ($\beta = 0.335$, $p = 0.014$).

In the regressions to predict gain scores from the parents' reports of internalizing, mixed, and externalizing problems, and teachers' report of mixed and externalizing problems, the only factor that contributed to the significance of the model was the pre-measurement score in the predicted index.

4. Discussion

This study examined the relationship between children's experiences of artmaking in art therapy, and behavioral problems as reported by the clients' parents and teachers. The hypotheses as to the possible correlations between children's behavioral problems as reported by parents and teachers before treatment and the child experience of artmaking in therapy, and with respect to the ability to predict improvement in behavioral problems based on the children's experience of doing art in therapy, were partially confirmed.

In terms of H1, there was a negative correlation between children's externalizing problems and mixed problems before treatment, as reported by both teachers and parents, and children's experience of artmaking at T1, after approximately one month of therapy. Specifically, the more social problems, cognitive problems, attention problems, aggressive behavior and delinquent behavior were described by parents and teachers, the less enjoyment the children reported in artmaking at T1, about a month after the start of treatment. This correlation between measurements from two different sources that were blind to each other's responses may hint at a possible association between clients' mental states and their experiences with art materials, and support the theoretical assumption that mental well-being and emotional regulation [19,22] impact the ability to enjoy creative and artistic pursuits. This idea is consistent with findings suggesting that creativity is enhanced by positive mood states [23,74].

However, the correlation between children's behavioral problems before treatment and responses to artmaking during the first month of treatment was unrelated to internalizing problems, based on the parents' and teachers' reports. In other words, the presence or

absence of anxiety/depression, introversion/depression, and somatic complaints were not related to the children's experience of working with art materials in therapy. This may support previous claims as to the importance to precisely define mental state when examining its association with and responses to artmaking [32,33].

The findings can be interpreted as indicating that children with externalizing problems may feel that working with art materials is challenging because it can require siting on a chair and focusing; therefore, the greater their distress, the less they enjoy engaging in artmaking. On the other hand, it is possible that treatment that involves more physical activities and the release of body tension and movement would be more appealing for these children [75]. This is in line with an Iranian study of 30 adolescent girls aged 14–18 who were given 6 sessions of art therapy. These researchers reported a statistically significant improvement in the 15 girls with internalizing problems compared to the control group, but no improvement in the 15 girls with externalizing problems [76]. However, alongside this possible explanation, it is worth noting that there is also ample evidence of the power of art when working with children with externalizing problems, e.g., [43,77,78]. Furthermore, since art therapists in the education system often work under inappropriate conditions which do not always allow for movement, or a regressive and liberating use of materials [62,71], they may not be able to intervene in an appropriate manner to deal with children with externalized behavior problems.

The differences in correlations between children with externalizing and internalizing behavioral problems and their response to artmaking in therapy may also be related to their overall scholastic experiences. Studies show that in primary school, externalizing behaviors have been systematically found to be associated with lower levels of behavioral engagement in school activities [79,80]. This raises the possibility that art making in therapy in children with externalizing problems may be experienced as another unwanted activity in school, which may explain the decline in enjoyment of art in therapy as the level of externalizing problems of this type increases. In contrast, for children dealing with internalizing experiences of depression and/or anxiety, emotional distress may not influence the experience of artmaking, and other factors such as the relationship with the therapist, love of art, articulation, or artistic talent could have a greater impact on their artistic experience in therapy.

No correlation was found between behavioral problems in the parents' and teachers' reports prior to therapy and the experience of artmaking in the middle and towards the end of therapy, at time points 2 and 3. It is likely that as therapy progressed, other factors influenced the way the children experienced the artistic endeavor. For example, the learning of the artistic language over the course of treatment may have had an effect on the degree of enjoyment of the artistic activity. Alternatively, children's state may have gradually improved as a result of therapy, and their reaction to the artwork may have been influenced by their current condition and not the condition at the start of the treatment. Another possibility is that the developing therapeutic alliance with the therapist acted as an additional factor that affected motivation for artmaking, and the enjoyment of the experience. A previous study reported a positive relationship between therapeutic alliance and response to artwork in a simulation in which 34 female students played the role of therapist, and 37 female students played the role of the clients. The findings showed that the stronger the therapeutic alliance, the more positive the client's response to the creative experience and attitude towards the artistic product [81]. The relationship between therapeutic alliance and response to artmaking in art therapy has not yet been investigated in children, but for children the strengthening of the therapeutic alliance with the therapist throughout the year may become a motivating factor influencing the creative experience.

In terms of H2, the regression model predicting the gain scores in the internalizing problems indices, as assessed from the teachers' reports and the children's responses to artmaking at the three time points was significant, and explained a third of the variance in child improvement. The regression predictor that was found to be significant was the child's experience of artmaking at Time 1. This finding is interesting in light of the fact that

the children's response to artmaking was not correlated with the children's condition in terms of internalizing problems at the beginning of treatment. It is possible that for these children, artmaking as a form of self-expression of the inner psychic world and content has a relatively greater value that can have a positive effect on their mental state and thus on the success of treatment. This finding supports the assumption of the theoretical concept of flow, regarding the beneficial value of enjoyment from creating, and focuses on the value of the positive experience of artmaking for children with internalizing problems [57,58].

The fact that the art experience at T2 and T3 was unrelated to changes in the clients' internalizing problems may suggest that the initial experience of artmaking at the beginning of therapy, which is less affected by the development of the therapeutic alliance and treatment, may provide more salient information about the relationship between the experience of art making in therapy and improvement in mental well-being. These issues call for further research.

5. Conclusions

These findings show that the critical importance of gaining a better understanding of the potential associations between externalizing and mixed behavioral problems and responses to artmaking. Along with maintaining that art can be a beneficial tool in therapy for anyone and everywhere [82] art therapists also concede that occasionally, the use of art materials in therapy can be challenging, as some children have difficulties engaging in the artistic process. This raises questions of how to encourage children to be involved in art, which sometimes ends in a referral to a therapist working in another medium (e.g., drama), particularly in schools where there are therapists with different specialties. Understanding that a negative experience working with art materials may be related to the severity and nature of the child's behavioral problems may help cope with this challenge. In addition, evidence from previous studies suggests that this relationship has two facets, and that enjoyment of the art in therapy may become a positive anchor that has a positive effect on the child's experience at school [83].

The findings with respect to the relationship between the experience of engaging in artmaking in therapy and an improvement in internalizing problems, depression, anxiety and somatic problems following treatment underscore the importance of a positive experience of artmaking and raise interesting questions about the factors that create this positive experience. Future work should concentrate on these questions.

6. Limitations and Suggestions for Further Research

This preliminary longitudinal study points to possible associations between the experience of artmaking in therapy and the amelioration of elementary school children's behavioral problems. However, to understand the nature of this relationship, further investigations are needed. Studies could examine a larger sample, address other intervening variables that can account for the relationship between the experience of artmaking in school art therapy, and behavioral problems and the improvement of behavioral problems after treatment. These could be related to mental well-being, the school experience, the child's involvement in school activities, the development of the therapeutic alliance, attitude towards art in general, and others. In addition, this study did not administer sub-scales of the CBCL or the TRF, which might have provided a sharper perspective on the relationship between the variables. The experience of artmaking was investigated as a single variable, without taking the components that constitute the artistic experience and its development into account, or the therapists' point of view, which future works could assess through observational and interview-based research. Since psychotherapists and art therapists' conceptualization, theoretical knowledge and understanding are critical to understanding change processes in therapy [84,85], future research should include interviews with art therapists in schools, who can provide new insights on how mechanisms of change differ among children coping with externalizing problems, children coping with internalizing problems and children coping with mixed problems.

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Informed Consent Statement: Informed consent was obtained from art therapists, parents and teachers involved in the study. The children's consent to participate in the study was given verbally, according to the requirements of the Chief Scientist's Office of the Ministry of Education.

Data Availability Statement: The datasets for this manuscript are not publicly available to protect participants' confidentiality.

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Case Report

Art Therapy Open Studio and Teen Identity Development: Helping Adolescents Recover from Mental Health Conditions

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Abstract: Adolescent identity development is driven to a significant degree by peer interaction. However, when mental health conditions (MHC) or other crises separate teens from their peers, their identity development can be slowed or arrested. We developed a unique open studio intervention (OS-ID) that could facilitate identity development in teens recovering from MHC, and incorporated this intervention into a therapeutic day school catering to our target population. We utilized qualitative case study research to explore these students' experiences. Over the 10-month period of our intervention, we saw positive changes in the participants' identity development. Key elements in OS-ID include the therapists' commitment to supported autonomy; the absence of participatory demands; the emphasis on creative process over product; the use of setting and materials to promote the healing process; the facilitators' and participants' witnessing the process; the privatization and protection of the participants' creations; and the ubiquitous presence of non-threatening significant others. This OS-ID modality could be an effective mechanism for assisting socially isolated teens to manage their social anxiety, develop their identity, and transition back into their peer environments.

Keywords: OS-ID; art therapy; open studio; adolescents; identity development; supported autonomy; social anxiety

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1. Introduction

Adolescence is the decade-long journey that begins at puberty's onset (around age 10) and lasts until adulthood (age 20) [1]. Throughout this decade, healthy adolescents experience dramatic physical, cognitive, and emotional changes, along with the development of more sophisticated social skills and awareness of their individual identity. Adolescents navigate through their identity development by sifting through who they do and do not want to be, and examining the values and behavior of those who positively or negatively impact their lives [2]. Mental health professionals increasingly emphasize the role played by a teen's positive environment in encouraging emotional growth, social adjustment, self-awareness, and identity [3]. While teens' positive and negative interactions with adults influence their identity, peer group interactions are even more impactful [4].

The United Nations Human Rights Council replaced the term "mental illness" with "mental health conditions" (MHC). This new terminology is part of a larger shift in emphasis, from pathology to recovery. It represents a transition from a medical approach to one focused on wellbeing (Tuaf & Orkibi, 2019) [5]. When mental health conditions (MHC) (or other crises (for example: war, natural disasters, pandemics, and chronic illness) separate a teen from their peer group, or when the adults and peers in their environment are not healthy themselves, then their developmental opportunities may be compromised, and the teen may miss out on significant emotional and social growth [6]. Their identity may be amorphous, conflicted, or embryonic [7]. The APA Dictionary (n.d.) defines identity as: "an individual's sense of self defined by (a) a set of physical, psychological, and interpersonal

characteristics that is not wholly shared with any other person and (b) a range of affiliations (e.g., ethnicity) and social roles.”.

Therapeutic interventions may be needed to foster these teens’ identity development. Generally, therapists facilitating teen identity development have employed exclusively verbal forms of psychotherapy. However, some teens recovering from MHC might use words to hide, and may retreat to the verbal realm to conceal conscious or subconscious psychological injuries. Additionally, some experiences and emotional states are beyond words: depression, trauma, loss, and anxiety are just a few examples of emotional states and experiences that are difficult to express for teens struggling with MHC [8].

When a teen recovering from MHC requires more than words, or something different from words, practitioners may introduce the use of semiotics and symbols as an alternative method of conceptualizing and expressing emotions and experiences. As Lakh et al. posit, “Symbols are images representing our mental content in a tangible form” [9]. This is where art therapy can sidestep therapeutic obstacles rooted in verbiage [10]. Art therapy is a form of psychotherapy that uses art media as its initial mode of communication. Art therapy circumvents the initial need for words. Image-making, and the viewing and subsequent discussion of those images, prepares participants to find words to describe their experiences [11]. However, little research has been done on the use of art therapy specifically for the development of identity in teens suffering from MHC. This is our focus.

Art therapy Open Studio (OS) is a Humanistic form of group art therapy where there is no explicit goal to accomplish, and which focuses on process over product. The OS is based on the ‘art as therapy’ approach, that emphasizes the healing quality of the creative process itself [12]. OS does not require individuals to actively interact with other group members. In OS, no project directives are given, and the model adjusts to the participants’ needs and context. Unlike some forms of group art therapy, OS allows participants to be the interpreters of their own work and the ones who determine when their process is finished [13]. Importantly, OS insists upon the individual’s focus on their own creative process within a group setting. This constitutes one of OS’ crucial priorities and strengths [14], and raises the question of whether it could be a first-tier intervention for identity development in teens suffering from MHC.

Anxiety-ridden teens may find focusing on themselves in a one-on-one therapeutic setting confrontative. They may prefer the comradery, protection, and identity that a peer group can offer [15]. However, traditional group therapy may not provide teens recovering from MHC with enough emotional safety. In contrast, OS simultaneously facilitates self-exploration and peer interaction, but without activating debilitating anxiety levels [16]. Like traditional group practitioners, OS practitioners consider how long each session should extend, and they design their respective programs focusing on clinical considerations, like group composition, the therapist/s’ role within the group, and the therapist/s’ perception of the clients.

Some of OS’s many healing elements include experiencing a variety of art materials, image-making, reparative side-by-side play, and/or mutual aid. It always includes the participants’ efforts and creation being witnessed by the therapist [17]. When therapists bear witness, they not only acknowledge the participant’s experience; they also affirm that experience’s reality, and grant it meaning and significance.

OS may help heal using another mechanism as well: The process of working with artistic materials itself exploits brain plasticity. Multiple studies demonstrate that physical actions and sensory experiences modify neural development, potentially accentuating identity development [18]. All these factors encouraged practicing OS with teens whose identity development was compromised by MHC.

2. Programmatic Elements of OS-ID

The Open Studio Identity Development (OS-ID) intervention we will present in this article was incorporated into a therapeutic day school catering to the unique needs of students who were recovering from MHC. (The first author served as principal facilitator of

the OS. The second author served as supervisor of the OS) The school followed a ten-month academic year. Students were between 13–17 years old, came from different socio-economic backgrounds and were mostly female. In total, 13 students experienced OS-ID within this 10-month period, and eight students consistently attended OS-ID weekly for a full ten-month academic school year Table 1. This school was created for teens who had lost their academic standing, either because of hospitalization, truancy, or being homebound. Some were removed from their original schools because of psychiatric hospitalization; others did not require hospitalization, but their psychiatric issues made it impossible to thrive in a mainstream school; and still others removed themselves by refusing to leave their bedrooms for extended periods of time Table 2. Each student lost months or years of consistent school peer group interaction and identity development, making them an ideal cohort for our OS-ID intervention.

Table 1. Case Study Demographics.

Category	Number
n of schools or regions targeted	(*n* = 1)
n of total students participating in OS-ID within a 10-month period	(*n* = 13)
n of students participating in OS-ID for the full 10-month academic school year	(*n* = 8)
Time scale of students' lost academic standing	3 months to 4 years
Reason for previous lost academic standing: Homebound	(*n* = 4)
Reason for previous lost academic standing: Hospitalization	(*n* = 6)
Reason for previous lost academic standing: Truancy	(*n* = 3)

Table 2. Student Demographics.

Student ID	Gender	Age	Months Attending OS-ID	Reason for Previous Lost Academic Standing
S1	Female	13	10	Homebound
S2	Female	14	3	Hospitalization
S3	Female	14	10	Truancy
S4	Female	15	10	Truancy
S5	Female	16	2	Hospitalization
S6	Female	16	10	Hospitalization
S7	Female	17	10	Homebound
S8	Female	17	10	Hospitalization
S9	Female	17	2	Homebound
S10	Male	14	10	Hospitalization
S11	Male	16	1	Truancy
S12	Male	16	10	Hospitalization
S13	Male	17	8	Homebound

Therapy did not only take place in the OS-ID setting. The school's goal was to prepare students recovering from MHC for transition back into community life, and so it approached every aspect of the day with a therapeutic mindset. Student activities like meal preparation, dining, kitchen clean up, animal-assisted therapy, individualized education, field trips, and community service were all choreographed to provide therapeutic benefit, just like OS-ID sessions.

We chose a qualitative research format to explore how and why OS-ID impacts its participants, rather than the frequency of specific outcomes in a client population [19]. In keeping with qualitative research principles, we focused on the students' interactions with the setting, their peers, the therapists, and above all on their experiences with the art materials and their creations. Our case study illuminates one healing path for students recovering from MHC and subsequent delayed identity development, even though it cannot definitively establish the relative effectiveness of OS-ID versus other modalities.

Our OS-ID model is built on the artist Edward Adamson's previous work. Adamson established the first OS inside a psychiatric hospital in the mid-20th century [20]. Since Adamson's primary aim was to facilitate patients' self-expression through art, he provided no guidance nor direction during the patients' creative OS experience [21]. Additionally, Adamson did not interpret his participants' image making. Rather, he provided a calm and patient environment with appropriate materials to help facilitate the group's creative process [19]. This contrasts with OS facilitators who model the creative process by creating alongside the other group members [22].

The OS-ID method is open-setting, i.e., the therapist provides a setting with minimal instructions. The therapist does designate the intervention's time and place, and chooses which materials will be available, but everything else is up to the participant. OS-ID meets minimally once a week for 1.5–3 h. As in all art therapy programs, the therapist conducts an initial, one-time session in which students co-author a contract, detailing what they need to feel safe and secure in their group setting. As the therapist solicits from the students' phrases describing what they need to feel safe within the OS-ID group, the students write these phrases on one large piece of cardboard. Our students wrote phrases such as: "even mistakes are beautiful", "accept me for all my colors", and "see me without judgement". However, once the OS-ID sessions commence, there are no ceremonies, i.e., session introductions or wrap-ups. Beyond the singular guideline that participants cannot damage themselves, others, the setting, or anyone's art creations, there are no expectations. This idea that everything-can-be-explored links OS-ID to Adamson's early model of OS. The goal in providing such freedom and opportunity for introspection (and resulting identity development) is to construct an accessible bridge for these teens from hospitalization to community integration.

Minimally, OS-ID requires co-therapists. This permits one therapist to supervise the session even if a student is triggered and requires special attention. The therapists set up a buffet of different art materials in the middle of a table large enough to accommodate all students and therapists. The therapists also set up additional tables and chairs around the room to accommodate those students who may choose to create alone or in pairs. The room should have a sink for water so that the students won't hesitate to use messy materials, and so that they may remain within the liminal space for the duration of the session. The art material buffet should include the same basic art-making materials each time, such as lead and colored pencils, markers of all sized tips and colors, white glue, oil pastels, gouache and paint brushes, clay and plasticine, scissors and magazines for collage, and papers of assorted sizes and colors. This sort of reliable environment subtly cultivates the students' sense of security, which in turn facilitates self-exploration and affirmation. Ideally, the buffet also includes specialty items, such as glitter, ingredients for slime, rocks and shells, assorted materials with needles and thread, glue guns, plaster casting strips, and wood.

We chose to secure more dangerous materials (like wood carving tools). These materials were held by one therapist and distributed only to those who would sit near this therapist. All dangerous tools had to be returned and counted before the session ended to ensure everyone's safety. Additionally, woodworking had its own designated area in the room; so did sewing, and so did the hot glue gun.

We did not encourage students to show each other their work. Rather, we cultivated a tacit agreement, an unstated understanding, that the art creation is personal and represents some aspect of its image maker. As students got to know and trust each other, they increasingly shared their work and their reflections with each other voluntarily.

The therapists did not ask the students to help set up or clean up. As the relationships between the therapists and the students became warm, empathetic, and sincere, students spontaneously came early and stayed late to be with each other and the therapists as they set-up and cleaned-up together.

To expand opportunities for identity development, our intervention embraces a principle we dubbed 'supported autonomy'. Making personal choices contributes to identity [23] and therefore people should be given as many choices as possible within a safe, contained environment. The OS-ID model echoes this mindset. Each student learns how to be resourceful, make positive choices, select materials, and determine how to use them, as discussed below in our case studies. They also choose to work alone or in a group. This is crucial for students with MHC struggling with identity development, as it maximizes opportunities for the students to introspect, discover, and act upon their preferences. We do not need to interrupt long moments of silence, as they may suggest that students are having an internal dialogue to contemplate and choose how they want to express themselves. Indeed, Winnicott [24] posits that one's ability to be alone while being with another person is a significant marker of emotional maturity.

We included several structural elements to minimize the inherent power imbalance between teens and adults. For example, facilitators and students focus on learning from each other through the creative process within this transitional space [25]. The OS-ID model reduced this hierarchy even further: OS-ID facilitators and students are not equal foci of the process. The facilitators are the students' assistants and support-staff. They function as the third hand and witness for these teens, providing guidance, emotional and creative support, empathy, and guarding the setting to ensure physical and emotional safety [17].

Some students may know what materials they want to use and projects they want to make. Others may take their time exploring materials or watching what others create. Some may want facilitator interaction or suggestions, while others may not. No one is required to interact with anyone else, but anyone could. If a student leaves before the end of the session, one of the therapists should gently encourage the student to return.

Developing identity requires taking the (often courageous) step of affirming our choices. OS-ID therapists support this emotional process by protecting the privacy of the choices made by each student: The OS-ID is the students' time to speak without words, to open their wounds to themselves and, only if they wish, to each other or to the facilitators. OS-ID therapists handle the students' creations as one would handle a therapeutic dialogue: respectfully, with consideration and confidentiality. Therefore, after every session, the students' creations are carefully packed away by the therapists. The OS-ID students' silent dialogues between their art creations and themselves remained private within this therapeutic environment, as did their tumult, quiet times, jokes, rollicking and laughter. By making it safe for these students recovering from MHC to be themselves in OS-ID sessions, both in their art and in-session conduct, OS-ID facilitates identity development.

The therapist's role in OS-ID is not obvious to the untrained eye. OS-ID is not an art class, and the therapist is not an art teacher. OS-ID therapists seek to establish a safe, calm, and patient environment by approaching their clients with warmth, acceptance, and empathy. They guide their clients in establishing a contract that will enhance their feelings of security and safety. They encourage supported autonomy, and they guard their clients' moments of silent contemplation. They help clients appreciate that their art creation is personal and need not be shared with anyone. It is a therapeutic dialogue between the client and their art creation, and therefore deserves confidentiality and preservation. The therapist attends to the process of preserving the art creations in a safe and private space until the clients' departure from the school or treatment facility. If a client is triggered or expresses a desire to prematurely end an OS-ID session, their therapists provide emotional support and help the client return to their creative explorations. OS-ID therapists fulfill this role to help their clients discover and develop their own identities.

3. Case Studies

The two case studies below illustrate the OS-ID model, its potential strengths, and its applications. Student names and non-essential background details have been changed.

3.1. Ethan

Ethan is a tall, physically fit 16-year-old who was raised in a small, urban apartment with his mother and father, aunt, and two sisters. Like his mother, Ethan suffers from depression, anxiety, and subsequent low self-esteem. Further, Ethan's masculine identity development lagged. At age 12, he claimed that male peer interactions brought on his anxiety attacks. According to Ethan, he first attended school only sporadically and eventually dropped out to avoid same-sex social interactions. He retreated to his bedroom for the next two years. He had psychiatric hospitalization twice during this two-year period due to suicide ideation. His psychiatrist prescribed anti-depressant and anti-anxiety medications to help with his daily functioning and to ameliorate his emotional instability. At age 16, Ethan transferred from the hospital's outpatient day school to our school.

Ethan spent his first OS-ID session standing silently at the studio's doorway while wearing his backpack and clenching his fists. He asked me if he could bring his guitar for the next session, explaining that music is artistic too and that he didn't like working with art materials. His request felt to me like a defense mechanism, a way to remain safely distant from engagement. I encouraged Ethan to bring his guitar to the next session. When Ethan arrived for session two, he chose to place his guitar in the corner of the room and sat with the group. He still hesitated to engage in art creation himself, but spent the session observing his peers interact with their chosen materials.

By the third session, Ethan chose to work with soft materials, such as pipe cleaners and yarn, braiding colorful bracelets and tiaras as gifts for the female students. Later, he confided that, even though he enjoyed working with soft materials, he wanted to experience the powerful feeling of carving wood. We discussed this option and decided to bring wood and carpentry tools into the OS-ID. Students who wanted to carve wood using these tools needed to sit near the therapist who was responsible for guarding and distributing carving tools. For the next several sessions, Ethan sat with this therapist and carved his name and other symbols into wood. More students joined them, including some male students, and Ethan seemed comfortable with them. As Ethan started exploring different materials, such as dripping wax from lit candles onto large pieces of translucent Bristol board or encapsulating flowers into hot glue, we noticed his social behavior begin to change. Despite his previous hesitance to socially interact with male peers, he confided to me that now he "hangs out with the boys," and he stopped creating gifts for the female students. Ethan seemed to be successfully challenging his own anxiety over interacting with males.

One of Ethan's last creations was dripping wax across a 23 × 33 cm Bristol board (Figure 1). When Ethan said he was finished, I asked him if we could lift the board up towards the light. He agreed. Ethan and I gazed at his art creation together. I reflected that this technique reminded me of stained glass. One of the male students noticed us poring over Ethan' creation and blurted out, "It looks like sperm!" Ethan turned to him in shock. There was a moment of nervous contemplation, and then he muttered, "Oh, uh huh," shrugged his shoulders with resignation, and gave everyone a look of acquiescence. It was as if he had been accused of displaying masculinity and he tentatively concluded that doing so would be okay. But then he may have had second thoughts. Ethan delayed leaving the OS-ID until his friends were outside. Then Ethan put his art creation down on the table, said "throw it out," and headed toward the door. I gently reminded him, "We keep everything we create". He stopped and turned towards me, looking back and forth between me and his art creation. I reassured him, "At the last session, we can sort through what you want to keep, what you want to discard, and how you want to discard it". "I know, but why?" he inquired. "Everything you create is a part of you," I explained, "and we accept all of you here." Ethan seemed to settle back into comfort with his masculinity.

He walked back to the table, picked up his art creation, and handed it to me. "Thank you", he said, and then he joined his friends outside the OS-ID Table 3.

Figure 1. Ethan's wax drippings on Bristol board.

Table 3. Summary of Ethan's ten-month OS-ID process.

Session	Event Summary
Session 1	Ethan stood silently at the studio's doorway while wearing his backpack and clenching his fists, did not participate with the group, and asked to bring his guitar to the next session.
Session 2	Ethan brings his guitar, but places it in the corner of the room and sits with the group. He spends the session observing his peers interacting with their chosen art materials.
Session 3	Ethan working with pipe cleaners, a soft material, and creates gifts for the female students. He requests from the therapists to work with wood, a harder material.
Session 4	Ethan sits next to the male therapist and starts to explore wood carving. Other students join them, including two male students.
Next several sessions	Ethan continues to carve wood alongside the male therapist and other students. Ethan explores other materials too, such as wax dripping, and hot glue. His social behavior begins to change. He stops creating gifts for the female students and prefers to socialize with the male students.
One month before ending	One of Ethan's dripping-wax creations is challenged by one of the male students, noticing that Ethan's wax drippings look like sperm. Initially, Ethan seems threatened by this confrontation, but is comforted by the female therapist reminding him that all parts of him are accepted here in OS-ID.

This was a significant, but small step on Ethan's road to recovery. At the end of our OS-ID intervention, Ethan's psychiatric profile remained complex. Nonetheless, OS-ID helped Ethan ease back into the world of male companionship.

3.2. Liora

Liora is a 15-year-old girl who lives with her mother, father, and four younger siblings in a large house at the edge of a farming community. When Liora was seven years old, her mother was diagnosed with borderline personality disorder (BPD). Her mother's struggles with BPD included periods of self-isolation, verbally abusive outbursts, and suicide attempts that were followed by lock-down hospitalization. Even from a young age, Liora served as a parental substitute, feeding and bathing her siblings, cleaning the house, cooking, washing the laundry and dishes, and organizing her mother's medical appointments and medications.

Liora was unique in our population insofar as she excelled at peer relationships. She was not an extrovert, but exuded social confidence and friendliness, despite her low self-esteem. She maintained many peer friendships and enjoyed group activities. Her challenge in developing identity was her parents' near-total absence. Her mother's psychiatric disorder, and her father's frenzied efforts to manage that crisis, left her without enough significant physical or emotional support at home. That, combined with her own learning disabilities, cultivated anxiety. Because she couldn't manage mainstream school academically and emotionally, Liora dropped out at age 15 and enrolled in our therapeutic day school. She not only needed a therapeutic and academically personalized environment to help her cope; she needed to develop her own identity by relating to reliable adult role models.

Liora was artistic and appreciated the opportunity to express herself using different materials. In her first OS-ID session, she chose a graphite pencil to draw a 18 × 24 cm picture of herself tied up and alone (Figure 2). People in pursuit of control gravitate toward graphite pencils, and it isn't hard to imagine why someone raised without enough parental protection and guidance might intuitively try to control her environment. The theme of being bound and alone appeared in many of her subsequent art creations. For example, she constructed a jail cell using plaster casting and paper mâché, and a broken heart using colored paper and wood. These themes are consistent with a child's experience of having to run a household on her own. During her OS-ID process, the theme of her art creations transitioned away from entrapment, and she started using paint to illustrate homes. Additionally, while her early art creations consisted only of images, her later creations segued toward the verbal, including words from popular poems and lyrics. It was as if she was discovering, for the first time, the words to express her trauma.

Not surprisingly, Liora initially showed no interest in the two therapists. Without reliable parents in her life, Liora learned not to expect emotional support from adults. Her teachers taught her. Her school principal disciplined her. Her psychiatrist medicated her. But adults didn't empathize or befriend her, and to her that seemed normal. She saw no reason to bond with us. Unlike other students who would even arrive early or stay later to talk with the therapists, Liora rarely spoke with or established eye contact with the therapists even during the OS-ID.

However, after months of OS-ID sessions Liora turned a corner. She picked up her painting materials and started to walk out of the OS-ID room, calling to me, "I am going to paint outside". OS-ID encourages students to remain part of the group, so I responded, "Can you paint outside, but on the porch, so you can still be with me?". Liora paused, looked at me directly for the first time, smiled warmly and said, "I'll paint with you here, inside". She perched herself on the windowsill with her art materials and painted an 18 × 24 cm picture of the houses she could see ensconced in the hillside (Figure 3). Then, as if to reiterate to us her interest in the relationship, Liora stayed after the OS-ID session. She helped me clean up and spoke to me about her ideas for her next painting (Table 4). Perhaps her witnessing other students increasingly trusting us built Liora's own sense of

safety and trust. In this way, the OS-ID provided Liora a safe space to decide when and how to approach us. She used art to connect to us. Her anxiety, at least with her OS-ID therapists, was ameliorated.

Figure 2. Leora's drawing of a girl bound and alone.

Figure 3. Liora's painting of houses in the hills.

Table 4. Summary of Liora's ten-month OS-ID process.

Session	Event Summary
Session 1	Liora chooses a graphite pencil, an easily controlled art material, to draw a picture of herself tied up and alone.
Next several sessions	Liora constructs a jail cell using plaster casting and paper mâché, and a broken heart using colored paper and wood.
After four months	The theme of Liora's artwork transitions away from entrapment, and she starts using paint to illustrate homes (a more fluid material).
After seven months	Liora includes poetry and lyrics from popular poems and lyrics. Liora begins to show interest in socializing with the therapists.
After eight months	Liora picks up her painting materials and states that she is going to paint outside. Instead, she chooses to stay with the group and paints inside. She makes eye contact with the therapists and speaks directly to them. Liora stays after the OS-ID session, helps clean up, and discusses her ideas for her next painting with the therapists.

4. Discussion

Social anxiety is common among teens with MHC, especially those who have been isolated from their peers for an extended period [26]. The OS-ID model attempts to ameliorate this and other social anxieties by minimizing social demands. Participants remain part of the group, even if they resist being emotionally open and decline to share their thoughts, feelings, and art creations. Social interaction and participation become a choice, not an unwritten obligation. Teens can choose to create relationships with others through their mutual interactions with the materials and the image-making process, without the peer pressure to emotionally engage [27].

The OS-ID model also attempts to ameliorate anxiety with its unique approach to "significant others". A "significant other" is an individual, specifically a peer or parental figure, who profoundly influences another person's identity and socialization [27]. Significant others can enhance someone's sense of self and reduce anxiety by providing mutual validation. However, for teens struggling with MHC, a significant other can create spoken and unspoken obligations and precipitate anxiety [28]. The OS-ID model presents this vulnerable population with non-threatening significant others: The OS-ID therapists constitute adult significant others, and the other students become the peer significant others. Both provide mutual validation, but without any associated social demands.

Reducing anxiety within the OS-ID is a means to an end, that end being identity development. Our program encourages students to explore and affirm their identity. Within an environment of supported autonomy, OS-ID invites students to ask themselves what they would like to create, and how they would like to create it. Students discover the answers to these questions by contemplating what they want and therefore who they are. Artistic freedom thus primes the process of self-discovery and therefore encourages identity development.

In OS-ID, materials and art creations are not always the active ingredients stimulating identity development. Sometimes, just the social setting is reparative. Ethan had an attenuated masculine identity, which he attributed to having neither male friendships nor a bond with a familial adult male. He shied away from bonding with adult males, and explained that this was out of concern that they would mock him for being effeminate. Despite gravitating toward females, Ethan expressed a desire to establish male friendships. In OS-ID, Ethan discovered he could find acceptance and validation from male peers. His integration into a male peer group was his choice and proceeded under his control and at his pace. Ethan saw aspects of his own personality in the male therapist, and therefore he felt that the male therapist truly understood him [29]. This twinship helped Ethan feel valued and boosted his self-esteem. Ethan's burgeoning self-esteem reduced his social anxiety and stimulated his identity development.

In other cases, materials and art creation are more central to and illustrative of a student's reparative process. When Liora first entered the OS-ID, she created entrapment symbols (chains, handcuffs, prison, etc.), and she did so using resistive materials. The contrast between her early art creations and her later creations suggested internal changes: She segued to painterly depictions of houses, using fluid media. According to Hinz' Expressive Therapies Continuum, using resistive materials is associated with more cognitive experiences, while using fluid materials is associated with more affective experiences [30]. According to this theory, Liora's transition from resistive to fluid materials implies a modal transition from cognitive to affective experience. This could be significant if emotional involvement is prerequisite to identity development.

After prisons became homes, her art creations changed again: Liora began incorporating words into her images, inserting poetry and lyrics that conveyed hope, passion, and belonging. She transitioned from expressing herself exclusively with images to expressing herself with images and others' words. This may have been a precursor for her eventually describing her feelings using her own words.

Even in Liora's case, however, the OS-ID social setting was also a reparative element. Liora arrived at our school lacking trust and interest in relating to adults. Her BPD mother distanced her with caustic insults, and her father was too overwhelmed caring for his wife to give Liora adequate encouragement and affection. Because Liora was both her siblings' and her own primary caretaker, she grew up in a home that, from her perspective, lacked parents. Therefore, adults had no place in her familial model. To develop meaningful relationships with adults, Liora needed to experience consistently safe and supportive interactions with adults.

During the span of this OS-ID program, we saw two types of change in our students: They experienced varying levels of recovery from psychological wounds, as suggested by changes in their art creations and behavior. For example, a student who feared male-bonding developed the self-confidence to join a male peer-group; and a student who initially viewed herself as a prisoner found freedom. Second, their social anxiety lessened, which allowed them to interact with significant others while exploring their creative process.

Although Ethan and Liora had different developmental challenges, OS-ID proved sufficiently broad and flexible to simultaneously serve both of their therapeutic needs.

Limitations

The literature describes the ideal OS session as being longer than the common 50-min clinical session. This allows the artmaking experience to progress naturally toward conclusion, as opposed to being artificially truncated by scheduling limitations. It also permits the participant to engage in the creative process more fully. However, this school could not accommodate OS-ID sessions longer than 1.5 h. A program providing a longer OS-ID session might produce experiences and outcomes radically different from those we observed. This calls for an in situ longitudinal study. Additionally, the OS-ID program only convened once a week. It is possible that students would have been more impacted by meeting more often.

Because ethical concerns prevented us from including a control group in our study, we cannot distinguish the impact of our intervention from the impact of the client-therapist relationship, the school's larger therapeutic environment, influences from home, and the potentially positive impact of the passage of time. Future studies could focus on developing ethical approaches to contrasting the impact of OS-ID with the impact of these other factors.

5. Conclusions

To summarize, there were several key elements in Ethan's and Liora's OS-ID healing experience: their freedom to contribute to the therapeutic contract; the therapists' commitment to supported autonomy; the absence of participatory demands; the emphasis on creative process over product; the use of setting and materials to promote the healing process; the facilitators' and participants' witnessing of the process; the privatization and

protection of their creations; and the ubiquitous presence of non-threatening significant others Table 5.

Table 5. Eight key elements in Ethan's and Liora's OS-ID healing experience.

	Key OS-ID Elements
1.	Freedom to contribute to the therapeutic contract
2.	The therapists' commitment to supported autonomy
3.	The absence of participatory demands
4.	The emphasis on creative process over product
5.	The use of setting and materials to promote the healing process
6.	The facilitators' and participants' witnessing of the process
7.	The privatization and protection of their creations
8.	The ubiquitous presence of non-threatening, significant others

During the span of this OS-ID program, we saw two types of change in our students: Individually, they experienced varying levels of recovery from psychological wounds. For example, a student who feared male-bonding developed the self-confidence to join a male peer-group; and a student who initially viewed herself as a prisoner found freedom. Their social anxiety lessened, which allowed them to interact with significant others while exploring their creative process. We saw evidence of these individual and social changes in both their art creations and their behavior.

The OS-ID model described here constitutes a tool worthy of consideration for helping teens who have been separated from their peers develop their identities and socially stabilize. We are writing in the shadow of the COVID-19 pandemic, and one can only wonder what the effects will be of isolating millions of teens from their peers during lockdowns and school shutdowns [6]. Educators and therapists may seek interventions to assist these youth in managing their social anxiety, developing their identity, and transitioning back into their peer environments. This OS-ID modality could be an effective mechanism for this and similar crises.

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Article

Creative Arts Therapy in the "Remote Therapeutic Response" Format in the Education System

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Abstract: Many creative arts therapists work in the education system on a regular basis. As a result of the pandemic, all have had to treat students in a "remote therapeutic response" format. The aim of the present study was to map creative arts therapists' perceptions of the "remote therapeutic response" in the education system. Semi-structured interviews were conducted with 15 creative arts therapists who participated in the study. The consensual qualitative research approach yielded seven domains: (1) the emotional experiences of transitioning to a remote therapeutic response; (2) the implementation of the remote therapeutic response; (3) benefits of remote creative arts therapy; (4) challenges in remote creative arts therapy; (5) remote contact with parents; (6) working in the educational system; (7) insights and recommendations. Although the findings show that creative arts therapists believe that remote creative arts therapy will never be a fully satisfactory replacement for most clients, remote work, despite its many difficulties and challenges, has also opened the door to new possibilities in the world of creative arts therapy in the education system.

Keywords: creative arts therapy; online psychotherapy; COVID-19; education system; remote therapeutic response

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1. Introduction

1.1. Remote Psychotherapy

Online psychotherapy has existed since 1961, when online group therapy was first proposed as a solution for clients living in isolated areas far from treatment centers [1]. Since then, online therapy has become more prevalent as a solution for clients who find it difficult to leave home because of illness, mobility issues, or as a way to continue treatment after moving, and has been found to be effective and beneficial [2]. Most studies on online psychotherapy have dealt with adult clients, but there are also a few findings on psychotherapy with children and adolescents. For example, Nelson and colleagues [3] compared CBT treatment to reduce symptoms of depression in children in a video versus a face-to-face format. The results, based on the assessment of 28 8- to 14-year-olds, indicated that video psychotherapy was effective and that changes occurred even faster than in face-to-face psychotherapy. There are also several case studies in the literature describing the online treatment of children and adolescents that were successful. For example, remote psychotherapy that included individual and family psychotherapy was provided to a child coping with depression [4], and there are reports of remote psychotherapy for children and adolescents with anxiety disorders [5].

1.2. Remote Creative Arts Therapy

The transition to remote creative arts therapy is particularly complicated, beyond issues related to the setting and therapeutic alliance, since it is based on the use of art materials, musical instruments, or theater props. This has prompted queries as to the suitability of creative arts therapy for online purposes, the nature of the triangular relationship (therapist, client, arts), and the effectiveness of the treatment [6,7].

Datlen and Pandolfi [8] described the transition of an open studio group for young adults with Intellectual Developmental Disabilities to the virtual space during periods of COVID social distancing. They created a WhatsApp group where the participants could share their artwork. The group was composed of five 17- to 23-year-olds. Most reported that the format was helpful as a substitute for face-to-face sessions. Shaw [9] described another format where an art therapy group took place via video calls. In this case, a group of three adolescents diagnosed with Anorexia received therapy based on free artmaking followed by verbal exchanges. The article discusses the art therapist's feelings when the materials normally available to her clients could not be used [9].

A 2009 study described music therapy via Skype, which involved writing songs with an adolescent on the autism spectrum. Compared to face-to-face therapy, the adolescent was able to maintain eye contact for a longer period of time during remote therapy and demonstrated more creativity and self-confidence [10].

Kate Hudgins [11] described a successful form of remote psychodrama using the Therapeutic Trauma Spiral Model (TMS) and reported that many components of psychodrama are appropriate for online therapy, including the creativity and spontaneity that characterize psychodrama and the concept of surplus reality.

Shuper Engelhard and Furlager [7] presented case studies of remote dance and movement therapy with children. The difficulties in the online setting were related to the partial visibility of the body and the inability to provide the client with a sensory experience. However, the authors noted that the clients' choices of which parts of the body to display on the screen informed the therapist as to their inner experiences. Another case study [12] described a number of group dance and movement sessions with adults coping with depression who were forced to switch to remote or open-space sessions because of COVID. The therapists listed the factors that contributed to the success of the treatment, including thinking outside the box, the clients' previous familiarity with the therapist's ways of working, the movements and the music, and the realization that remote sessions have become the norm.

1.3. Creative Arts Therapy in the "Remote Therapeutic Response" Format in the Education System

Creative arts therapies in the education system exist in many countries in different forms [13]. Recent studies in this field point to the contributions of the integration of creative arts therapies to the education system [14–16]. The COVID pandemic has led to sudden changes in the ways a therapeutic response can be provided by creative arts therapists in the education system when students cannot attend school or when there are interruptions in the therapeutic sequence as a result of lockdowns. This reality has forced therapists to shift, in conjunction with the entire education system, to distance therapy and adapt themselves to a new treatment format, which was rare before the pandemic. The present study was designed to map creative arts therapists' perceptions of the "remote therapeutic response" in the education system. The term "remote therapeutic response" was used because in the early stages of the pandemic. It was not clear even to the therapists themselves whether the response format corresponded to real therapy or was merely a temporary therapeutic solution.

2. Materials and Methods

2.1. Participants

Fifteen creative arts therapists providing a "remote therapeutic response" in the education system took part. They ranged in age from 30 to 63 (M = 46.47) and had worked in the education system for 10 months to 25 years (M = 15.59). Eleven participants were also supervisors. The participants worked in various settings in the education system, from kindergarten to high school, in special education schools, and in regular schools where students with a variety of difficulties are integrated. Two worked in schools in the Arab society of the education system. The participants specialize in various creative arts therapy modalities (Figure 1). Only three had any previous experience with remote creative arts

therapy or remote supervision. To respect the privacy of the participants, no table detailing their demographic characteristics is presented. In the acknowledgments section, we thank the participants who agreed to be mentioned by name.

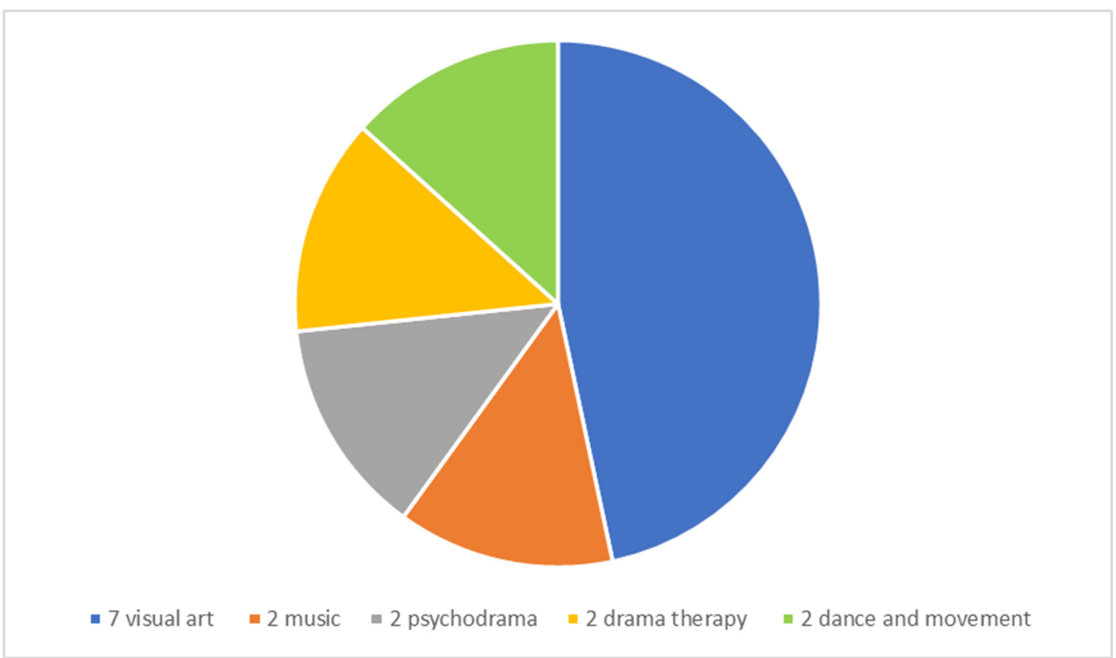

Figure 1. Instruments.

Semi-structured interviews were conducted based on pre-prepared questions but were subject to change and open to expansion and adjustment according to the dynamics of the interview and the information that emerged [17]. The purpose of the interview was to obtain an initial assessment of the state of remote therapeutic responses in creative arts therapy in the education system during the first year of the COVID pandemic, its advantages and disadvantages, and the nature of the therapists' remote relationship with the education system and parents. The interview was also designed to learn more about how the creative arts therapists worked, which approaches were successful and which were less so, their personal experiences when working remotely, and recommendations to enable therapists to adapt and feel more confident when engaged in remote arts therapy.

2.2. Procedure and Ethics

A letter of request to participate in the study was sent in October 2020 by one of the researchers to 28 creative arts therapists enrolled in advanced training in a course entitled "Remote Therapeutic Response in the Creative Arts Therapies". Each therapist decided freely and anonymously whether to agree to be interviewed and if so, signed an informed consent form. The interviews, which lasted about an hour, took place via Zoom and were audio recorded solely for purposes of documenting the conversation. All information was collected anonymously. To do so, the participants were instructed not to mention any detail that could identify themselves or any other person. In cases where a person was inadvertently identified during the recording, the data were deleted from the recording immediately after the interview. The data were stored on protected platforms, and consent forms were kept separate from the transcripts of the interviews. This study was approved by the Ethics Committee of the Faculty of Welfare and Health at the University of Haifa (425/20) and by the Chief Scientist at the Ministry of Education (11451).

2.3. Data Processing

The data analysis was based on the principles of consensual qualitative research [17,18], which relies on phenomenological elements and aims to understand participants' subjective experiences. Here, the process consisted of three stages. In the first stage, each researcher conducted a preliminary analysis of three interviews separately to identify and define the main domains that emerged from the data. Then the researchers met to reach an agreement on the key domains. In the second stage, all the interviews were coded according to these domains. In the third stage, the three researchers conducted a cross-sectional analysis to identify and define the core ideas, at which point all the data were reanalyzed according to these core ideas, with reference to their frequency.

In what follows, "most cases" describes a notion expressed in over 75% of all interviews, "some cases" refers to instances found in 25–75% of the interviews, and "a few cases" or "several cases" corresponds to fewer than 25% of the cases [17,18].

3. Results

3.1. The Emotional Experiences of Transitioning to a Remote Therapeutic Response

3.1.1. The Creative Arts Therapists' Experiences at the Beginning of the Pandemic

Eleven interviewees described feelings of confusion, shock, and stress during the transition to the remote therapeutic response at the beginning of the first lockdown. These feelings were possibly related to the rarity of a government injunction to limit people's freedom of movement. Some linked their reactions to frequent fluctuations in the Ministry of Education's guidelines for creative arts therapists, which could change overnight with no warning during the initial period: "There was so much pressure to adhere to the instructions . . . all of a sudden at ten o'clock at night you get new instructions for the next day, and you have to start from scratch in the morning". Others attributed their panic to the need to learn new techniques quickly and the switch from their familiar creative arts therapy rooms to a computer format: "I did not know how to use Zoom or send a link, all these technical issues... it really stressed me out" (Table 1).

Table 1. Creative arts therapy in the "Remote Therapeutic Response" format as reported by participants: Domains and core ideas.

Therapists' Emotional Experiences	Implementation of Remote Therapeutic Response	Benefits of Remote Creative Arts Therapy	Challenges in Remote Creative Arts Therapy	Remote Contact with Parents	Working in the Educational System	Insights and Recommendations
Beginning of the pandemic The adaptation process Continuing instability	Modes of remote therapeutic response • Phone and WhatsApp • Video call sessions • Limits of the remote response The therapeutic act • Essence of the relationship • Treatment management • Therapeutic contract • Setting • Initiating the therapeutic process	Benefits for the client Benefits for the creative arts therapist	Technical and logistical challenges Resistance Lack of close contact and less body language Maintaining group therapy Being a creative arts therapist during this period	Closer connections than usual Parental contribution to managing therapy When parents are not available	Contact with the educational staff Contact with officials in the Ministry of Education	Internal strengths and resources contributing to the therapists Self-worth and professionalism Recommendations

Five creative arts therapists discussed the chaos related to the state of emergency in Israel: "I felt it was more of an emergency situation, like when a war breaks out . . . . than remote therapeutic work". These feelings prompted some therapists to engage in a rapid

learning curve: "I turned the bedroom into an art therapy room during the day. It was a form of survival, it was either not working at all or making a change and that's what I did". Other therapists described their need to continue working and their sense of enthusiasm: "There was some joy at being able to respond, a lot of enthusiasm and strength".

3.1.2. The Adaptation Process

Many creative arts therapists realized that they needed to adapt to remote therapy because COVID was not going away any time soon. "Last year people were saying it would soon be over. This year people have realized that therapeutic thinking and planning have to be different." The therapists described how in different ways, they quickly learned how to engage in remote therapeutic methods. Seven participants described how they searched for inspiration independently: "I'm a collector of any activity that goes online via Zoom". Five therapists described learning from colleagues, for example, in supervision groups: "There were therapists in different modalities, each one contributed their own ideas, or their personal tricks of the trade, and games". Some therapists described how they practiced the new activities, alone or with colleagues: "We practiced with each other. We started typing, testing the options, overcoming obstacles together".

Eleven creative arts therapists said they gradually adjusted to the technology, which enabled them to feel more relaxed with respect to the remote therapeutic response in general: "If you had asked me half a year ago to deal with Zoom, it would have been beyond me. Then I learned how to operate it and it got easier". Beyond the technological adaptation, five creative arts therapists also described their emotional process that included acknowledging the need to process events and find a breathing space: "I had to go through the initial shock... and afterwards, I felt I was really freer to pause and think about it". The adjustment allowed some therapists to also enjoy learning a new skill: "It taught me new things that I find very interesting, I really enjoyed the success and being able to learn".

3.1.3. Continuing Instability

Two creative arts therapists expressed frustration and burnout as time went by, which was also affected by the frequent alternations between face-to-face and remote work: "The experience of working remotely was exhausting and frustrating and I really can't do this anymore. It has lasted too long".

3.2. The Implementation of the Remote Therapeutic Response

3.2.1. Modes of Remote Therapeutic Response and Their Implementation

Using the phone and WhatsApp. Thirteen creative arts therapists reported using the phone or WhatsApp at various stages after switching to a remote therapeutic response or with certain clients. Six therapists said they began by using phone calls and texting at the start of the transition to remote therapy: "Before I started Zoom sessions, I did two weeks of WhatsApp conversations. I devised the infrastructure". Five therapists noted the differences in therapeutic work between the first lockdown that began in the middle of 2019–2020 school year and therapies that began the next year (2020–2021): "Last year most treatments were over the phone because that's what most kids had. They did not have access to a computer. This year it's more often on Zoom, they know how to use it better". Four therapists said that the therapeutic relationship was maintained even later by phone and WhatsApp when clients did not have access to computers at home: "In observant households some families have computer technology and others do not, so that the only thing left is phone calls". Five therapists stated that in some cases, the decision to use phone calls or texting was related to the clients' preferences or their ability to use Zoom: "One child I tried to treat through Zoom didn't work because he was unable to sit down. So occasionally we talked on the phone or recorded messages".

Six therapists stated that when they could not meet clients face-to-face for sessions or were hard to reach via Zoom, therapy was reduced to support: "Messages, phone calls, just to say that I'm available. That I understand, and are there to listen to them". The

same was true for preschoolers or clients with complex disabilities: "I would record myself reciting stories and songs, I would wear a costume and hold props up to the screen, then assign a task at the end of the activity, and they loved listening to it again and again". Some therapists sent recordings, photos, and videos on WhatsApp even when Zoom sessions were taking place.

Video call sessions. All the creative arts therapists mentioned holding video call sessions via Zoom or WhatsApp. Fourteen therapists reported how they incorporated various arts and games: "We played on the screen, she had the game and I had the game, we showed each other the cards". All the creative arts modalities were implemented. For example, in music therapy, a therapist noted: "With one child who had no musical instruments available, I asked him to take a pencil and we made rhythms". Similarly, in dance and movement therapy a therapist commented: " I asked them to dance with their parents, look at their bodies and communicate something". In psychodrama, a therapist noted that: "I took dolls out of the regular therapy room and dressed them up, I told the student to do the same and I was able to get the dolls to have a conversation, her doll and my doll". In art therapy: "I did the mirror exercise several times: I draw a line and they make a line". The creative arts therapists described how they coped with the shortage of art materials in their clients' homes: "We also did fine with pen and paper. The clients used what they had". Two therapists described how they actually traveled to their students' homes to deliver art materials to the door: "I brought them materials, I took a canvas and acrylic paints to a client".

Eleven therapists also described capitalizing on the built-in features of Zoom or using other creative apps to incorporate arts and games into sessions. In particular, the therapists described the use of the screen and whiteboard sharing techniques for play or artmaking: "We tried to draw on the Zoom whiteboard. The client would select an image that interested her, we would put it on the screen and try to draw at the same time," and some described incorporating interactive games. Three therapists said they combined the physical and digital formats: "I told the client to actually paint, not while in front of the computer, take a picture of it and send it to me and I would make a short film or sticker." Three creative arts therapists nevertheless stated that they rarely used the applications in remote work: "I have not used the digital environment at all... I have never worked like this".

The techniques implemented by many creative arts therapists also depended on the client's environment. In some cases, the therapists asked them to use objects from home: "The children showed me objects and devices they had at home. We talked about them; 'You have this kind of ball and you have this kind of other object'." In other cases, the therapist was part of ongoing events at home during the session. Sometimes the therapists only interacted with the client by: "being with him in the room while he was playing. I watched and asked questions". At others, the therapist was mixed into the entire household: "He really can't sit still, so I got to know all the nooks and crannies of the house and I was even at the family dinner because he suddenly decided to sit down at the table".

Many creative arts therapists also noted that verbal communication increased in remote therapies. Some described meaningful conversations and therapeutic work: "A client told me he could not make friends... it was a very exciting session, in one Zoom session we came a long way towards understanding this issue." Some said that the exchanges remained limited to the game they were playing: "When the game isn't there, he does not communicate, but when involved in the game, he communicates easily with me".

Limits of the remote response. Despite the incorporation of the creative arts in the remote therapeutic response, 11 interviewees still felt frustrated by the narrow scope of artistic activities. The visual art therapists talked about how hard it was to engage in art materials with the client: "I haven't found a good method for joint painting yet, or a way to do satisfying artwork together." Others talked about how little material there was to work with, in particular in three dimensions such as clay: "The fact that it is impossible to work with plasticine and clay and three-dimensional objects is also difficult. It detracts from therapy." Music therapists said it was complicated to play and sing together on screen: "Playing together or singing simultaneously really does not work out, it comes out a big

mess, it is impossible to synchronize the rhythm." In dance and movement therapy, the therapists struggled with the fact that only part of the body is visible on the screen: "Therapy when you only see part of people's bodies... I feel that a lot of information I normally get is no longer there." This was also true in psychodrama, where one therapist talked about having to overcome obstacles to work symbolically from a distance: "The discourse became much more verbal and challenging in the sense of symbolically expressing things".

3.2.2. The Therapeutic Act

The essence of the relationship. The sudden change in the format of the therapeutic response to students at the start of the pandemic raised a series of new questions as well as more general issues for the creative arts therapists. Many wondered whether the remote therapeutic response was indeed "therapy" or whether it was simply a way to maintain the relationship and support: "Do we still call it therapy, is it therapeutic support, to me they are different".

Treatment management. Many creative arts therapists mentioned enacting major changes in treatment management. For example, one interviewee described the differences in her level of activity compared to a face-to-face session: "The variety in the art therapy room that you can choose from and access as you move around are not available remotely; I need to be more active." Six therapists said that remote therapy needs more advance planning: "I see I need to sit and review my list of possible interventions, to see what will work and be interesting this time." A few therapists reported that at times, despite their planning, the child brought something else to the online session: "(in a group) one child kept on talking excitedly, he showed all sorts of things and was so active that at some point I just dropped what I had planned and flowed with it." Six therapists said that working with remote technology, which was new to both them and their clients, led to a more egalitarian relationship: "I felt we were trying to solve issues together—it would have been easier if I had known how to use the technology beforehand".

Therapeutic contract. Some creative arts therapists mentioned issues related to the fundamentals of the therapeutic relationship, such as the therapeutic contract, coordination of expectations with clients and their parents, and the reflective discourse on the sessions: "Last year we had to digest all the changes and transitions. This year we put these contingencies into the contract." The issue of coordinating expectations also arose with respect to the choice of format for the sessions: "We discuss it until we find what works for both of us so that the treatment will feel like treatment." Some therapists noted that remote therapy also gives clients more control over when they start a session so that the responsibility for the relationship becomes more equally divided in some cases: "They were more responsible for their treatment because they could decide not to come (by not connecting to Zoom for example)".

Setting. Many creative arts therapists noted that the boundaries of time changed during remote work, for example, in terms of the frequency of the sessions: "There was a daily conversation, sometimes only a few minutes, just to say hello." The duration of the sessions was also affected by the transition to remote work: "We worked with them for shorter periods of time. If certain children did not want a session, the goal was just to keep in touch. A five-minute chat: 'how are you', and that's it." By contrast, three therapists said that the change in setting and treatment boundaries opened up new possibilities, for example, when working with adolescents: "They would send texts, and the fact that they could do so whenever they wanted and the therapist could respond at any time, was good for some clients".

Another important component was finding a suitable environment for treatment in the students' homes: "We needed to be much more careful about finding a quiet place, where you hear well, see well". This was also true for the therapists' homes: "I have a white wall behind me and bright light. But sometimes I have to find a quiet corner for myself. Be attentive to my setting so I will not be distracted." Seven therapists noted that clients may not have any sufficiently private place in their homes for sessions: "The student does the session in the living room because she doesn't have her own room." Sometimes the therapist realized that

there was another family member listening in on the conversation, which clearly interfered with the child's privacy in therapy: "His mother is always there, you can hear her in the background, and I knew I could not ask all kinds of questions ...". Ten therapists said they also had problems defining a private space in their own homes: "My son constantly interferes when I am on Zoom, no matter how much I explain to him that he shouldn't." Two therapists also raised the issue of uncontrolled exposure of the clients' environment: "Suddenly I saw what her bedroom looked like, I saw family dynamics, things she did not want me to see." However, many therapists noted that these glimpses of the clients' environment also led to a better understanding of their worlds and relationships at home: "Seeing the child in his real environment and how the mother really behaves".

Initiating the therapeutic process. Some creative arts therapists discussed the issue of starting a new treatment remotely: "It's basically learning how to build trust and relationships on screen" compared to a therapeutic relationship that began in the arts therapy room and then switched to the digital space: "They felt we just translated it. It was not a new group, which is why it was less challenging".

3.3. Benefits of Remote Creative Arts Therapy

3.3.1. Benefits for the Client

Thirteen creative arts therapists noted that the remote therapeutic response allowed new events and insights to emerge within treatment: "I find that there is certain content that [emerges] precisely when the client is at home; it gives a sense of security." Three therapists considered that this was particularly relevant to children on the autism spectrum: "Their experience is such that there is a screen between them and the other, which is transparent but still a screen. On Zoom they are in a safer place, and they reveal more of themselves." Clients may also manifest abilities that do not appear in face-to-face sessions and are more willing to experiment; for example, in play and art: "Some children who refuse to draw on paper were willing to draw on the whiteboard where things can be erased... it is less committing." In some cases, verbal communication was facilitated by the remote setting: "When we met face to face, it was less verbal. In the remote sessions, there was more discourse, it had more space." This change at times persisted after the return to face-to-face sessions.

Some creative arts therapists noted that the remote therapeutic response helped maintain the continuity of treatment, by contrast to the fragmentation of the academic school year caused by lockdowns, illnesses, and quarantines: "I think the advantage is to keep in touch with the client, to convey a space of discourse, interest, caring, concern. Not to vanish." Four therapists described how this later contributed to the continuation of face-to-face therapy: "It was very surprising and unexpected, something that leveraged the treatment when we returned to the therapy room".

3.3.2. Benefits for the Creative Arts Therapist

Some creative arts therapists indicated that working from home suited them at the time: "There was something in general about this period that suited me . . . this break in routine. It gave me some time to dwell on ideas." Another interviewee said she felt freer when working remotely: "My creativity had more space to expand because I had more room to maneuver, I did what seemed right to me...". Two therapists said that they felt that the new reality enabled them to develop professionally: "We had to acquire new tools. It forced us to think differently, to be mentally flexible." This was also made possible by the larger number of advanced training courses: "I listened to a lot of lectures on Zoom during the lockdowns".

3.4. Challenges in Remote Creative Arts Therapy

3.4.1. Technical and Logistical Challenges

Most creative arts therapists reported challenges associated with technical problems on Zoom, such as being cut off, sound malfunctions, and internet crashes that affected the course of treatment: "The fact that there are 'yes you heard me; no, you did not hear me'

malfunctions is an intrusion into the space of discourse." Young children or clients with complex disabilities sometimes found it difficult to understand that they had to turn the camera toward their faces: "Some parents simply gave their phone to the child, so there were issues with muting or turning off the camera".

Some interviewees reported that their home equipment was not adapted to Zoom: "You have to work with the computer you have at home, with your internet, with your chair. It is financially difficult anyway. It requires a lot of logistics, which is not very therapeutically oriented." Many therapists also described technical issues associated with their clients' lack of equipment: "Some people do not have a computer", or in cases where the clients were not able to operate Zoom well: "The younger the children, the more they needed someone to connect to Zoom, and the times for the sessions needed to be set according to the availability of the people who could help them technically." Sometimes these situations caused a real disconnect from the clients: "There was a student who did not have internet access anywhere in her neighborhood. I could not contact her, she was completely disconnected".

Another logistical challenge for most interviewees was time management because they could theoretically hold treatment sessions throughout the entire day: "You can't set a time, it's just spread over the whole day and it's awfully hard... I found myself on Zoom from morning to evening, in front of the computer, phones." This problem was related to the expectation that therapists in the education system would make themselves more available to cope with the emergency situation, in particular at non-routine hours: "I make an appointment and the student tells me two minutes before 'I can't because my cousins just arrived, can it be postponed until...' and I was very flexible so I let her postpone it to five o'clock... " Four creative arts therapists described having to chase after the clients to have the sessions as scheduled. Eight therapists described time management as a major challenge, which also affected the treatment: "Hours that are not school hours, and sessions, and conversations with parents from morning to night... so there is really no let up from work." Three interviewees also said that working on Zoom was physically tiring: "It's terribly tiring. I try not to look away [from the screen] because it might be interpreted as abandonment by the client. Fatigue and great commitment".

3.4.2. Resistance during Remote Creative Arts Therapy

Many interviewees reported clients who were not interested in remote contact at all, which created a disconnect during the lockdowns and quarantines: "One child was not even willing to talk to me on the phone when he was in quarantine. It was a complete disconnect." Several therapists noted that remote creative arts therapy had become just another Zoom session in a full day of classes and had lost its special qualities: "Some students refuse to connect, and you do not know if it is because of Zoom or not . . . The therapy session became like another class, as if I were a teacher." Twelve creative arts therapists said that some clients, especially adolescents, refused to turn on their cameras or orient it at their faces: "(The client) was embarrassed about talking to me on the computer, so he turned the camera to the side, was not in the frame and then talked to me. It's hard, not seeing eyes, or the face." Five therapists also talked about distractions on the computer: "I realized that he was only half with me and that he was playing a game at the same time. We were able to maintain the connection but it was not like in the room".

3.4.3. Lack of Close Contact and Body Language

Fourteen creative arts therapists described the lack of close contact or observation of body language as major challenges in remote therapy: "There is a great lack of a sense of closeness, or access to non-verbal communication and body language. Often, I can sense clients even without them talking, but on Zoom I just can't." Another therapist talked about starting therapy on Zoom: "My first session with some students was on the screen, and I found it difficult to sense them". Two interviewees also commented that the lack of physical presence made it difficult to remain silent during a session: "It's not like in

a face-to-face session when a child chooses to be quiet, where I allow that quiet moment to unfold by just being there. On Zoom you can easily be disconnected”. This issue was particularly pronounced with clients who found it difficult to express themselves verbally: “A student who sometimes finds it difficult to say hello can turn her head towards me to signal ‘Look, I’m here’. For low functioning children or those who do not speak Hebrew fluently, Zoom is problematic: “I have one client who speaks Hebrew but I’m not entirely sure he understands everything. I feel like I can’t get through to him on Zoom and reach the painful places”.

3.4.4. Challenges in Maintaining Group Creative Arts Therapy

Some therapists noted that in remote group creative arts therapy, clients can interfere with the session: “There was one client who really ruined it for everyone else. This can happen in class, only here you can’t send [the student] out to chill, get a drink of water and come back.” In addition, some children found it difficult to stay attentive during remote group creative arts therapy: “In the group I felt they were not there, not involved, not attentive to each other”

3.4.5. The Challenge of Being a Creative Arts Therapist during This Period

Some interviewees felt deprived of their skills and toolbox as a result of the transition to remote sessions: “Suddenly all your tools, your language, your modality [are gone]. Like someone pulled the rug out from under your feet.” Many therapists had to struggle to maintain sessions: “How do I keep on doing this for one whole hour? After all, in therapy the client is told that s/he can’t leave, and that if s/he is bored, s/he goes on being bored. On Zoom I can’t say that.” Some of the interviewees felt diminished: “I felt that my creativity and spontaneity had declined, even my listening was not the same.” Two therapists commented on the issue of creating a mental separation between home and therapy: “In my art therapy room I am more of a tabula rasa than at home”.

3.5. Remote Contact with Parents

3.5.1. Closer Connections than Usual

Ten creative arts therapists commented that during the COVID period, there were more exchanges with clients’ parents compared to routine work: “Some parents who were never in touch suddenly asked about the child and talked about themselves every week.” One interviewee said that the parents, in fact, replaced the teacher as the link between the creative arts therapist and the student: “The Ministry of Education did not encourage much contact with parents in the past; we tended to be in closer touch with the educational staff. Suddenly parents have become the facilitators for their children, they are more involved.” Many therapists noted that parents were more available as a result of the changes in session format and flexibility in hours: “I was very happy to see that in the intakes it was really easy to set a time, because suddenly it was possible in the evening, suddenly both parents could attend.” Eleven therapists said that they attempted to support parents during this period: “I was in close contact with all the parents of the younger clients, including giving parental guidance on Zoom”.

3.5.2. Parental Contributions to Managing the Remote Therapeutic Relationship

Seven interviewees stated that communicating more frequently with parents helped them understand the background to their children’s behavior: “When I could not always reach the client, at least I heard from the parents how he was.” Having the sessions in the home environment also made it possible to involve the parents in therapy: “She asked to include her father in a session because it was very difficult for them... this was made possible by Zoom and by being at home.” However, six therapists noted that parents sometimes intervened without coordination or invitation: “She intervened in the session when it was not needed. She did so out of interest but I felt it was a bit of an invasion of the child’s privacy as well”.

The novelty of the situation and the more intense communication with parents made many interviewees realize the importance of coordinating parental expectations and establishing a type of contract with respect to privacy during sessions, meeting times, help organizing materials, and other issues: “They are the only ones who can give their child privacy. They are the ones to allow the child to have art materials in the room. It requires cooperation.” This coordination with parents was even more important with very young children or clients with complex disabilities: “The parents of kindergarten children, we depended on them to start the Zoom session . . . The parents were in the background and helped technically and to focus the child.” A number of interviewees also said that the parents helped get the child ready for the session: “His mother sent me a text that she told him he would make music with me and he said that he was interested.” Compliance from adolescents was more complex. The nature of the relationship between clients and their parents affected their ability to help them: “It’s no longer a small child having problems that parents are responsible for solving... There are all sorts of other things related to the child-parent relationship”.

3.5.3. When Parents Are Not Available

Some creative arts therapists described parents who were completely uninterested in contacting them during this period: “Some parents told me ‘talk to the child’, like, what do you want from me,” or were very busy handling the needs of several children. Sometimes this attitude affected the treatment sequence: “A student I worked with... nothing can be scheduled with her mother. I was able to work with her once or twice... I could not maintain a sequence”.

3.6. Working in the Educational System

3.6.1. Contact with the Educational Staff

Many creative arts therapists said that their relationship with the school and the staff became stronger as a result of remote accessibility and the sense of urgency. This closer connection made joint thinking and teamwork possible but also provided a time to vent: “We were in touch, all the time. Any time there was a problem, the teachers or the principal would turn to me and we thought about what to do, the division of roles.” A few therapists noted that the special education teams were in closer contact than teachers in regular education and that the relationship was less reciprocal: “In regular education it is different, the teachers have enough on their minds. They do not always understand the nature of creative arts therapy.” In another aspect, many therapists noted that working remotely made it much simpler to hold staff meetings, and even attend meetings that they usually missed because of technical constraints or work in several frameworks: “If there is a kindergarten staff meeting, I take part on Zoom if it is not my day at the kindergarten, instead of running from place to place”.

3.6.2. Contact with Officials in the Ministry of Education

Many interviewees noted the importance of their interactions with their supervisors at the Ministry of Education who provided technical and emotional support: “It was really powerful. I learned a lot on Zoom from my supervisors. They were really there for us and supported us during supervision, through courses, there was really a lot of moral support and reassurance”. The supervisors agreed: “So far, they have given me a free hand to supervise. It has been an amazing containment because we meet every week, work with art materials and develop methods.” However, two creative arts therapists felt that the supervision was not sufficient: “There were sessions with my supervisor but it did not meet my needs. I think that holding, supporting and accepting what was happening were missing”.

Two creative arts therapists and supervisors noted issues related to the bureaucracy of the Ministry of Education as a supervisory body, which intensified during this period: “There is something called a follow-up form. During the previous lockdown we were home, but once it expanded to work at school as well, I felt like it was ‘Big Brother,’ it’s

very burdensome, it generates a sense of mistrust." According to a number of interviewees, some clients had to cancel in order to adjust their schedules to pandemic regulations. This meant that, at times, it was impossible to meet work requirements for hours of therapy: "You are committed to working and you understand what they are going through, and you do not want to increase the stress and burden ... So sometimes instead of working six hours you work less".

3.7. Insights and Recommendations

3.7.1. Internal Strengths and Resources Contributing to the Work of Creative Arts Therapists during This Period

Most creative arts therapists indicated that flexibility enabled them to make the sudden change to remote therapy: "I understood that there was no other solution, the world has changed and I had to adapt. This made me very intent on my work." Flexibility was also expressed in relation to the setting: "I realized that there are a multitude of possibilities. Therapy is not restricted to a permanent and very rigid setting as Freud or others stipulated, we are in another era where the outside goes inside and vice-versa." Other factors mentioned were creativity, optimism, and the ability to learn from experience: "The therapists, thanks to their creativity and playfulness were able to take advantage of the situation and insist on treatment and it won over the hearts of parents and children." Three interviewees said that it was very important to maintain boundaries during this period and be able to listen to oneself in order to be able to work remotely: "Mostly keeping things tidy, that's also boundaries. That's the thing that saved me in all the chaos. I'm flexible but I tried to keep my working hours".

3.7.2. Feelings of Self-Worth and Professionalism

Six interviewees said that the success of remote creative arts therapy strengthened their sense of confidence as therapists: "I learned to trust myself. I felt valuable, that I was able to conduct most treatments that way, that I knew what I was doing." Two therapists also described the ways this was reflected outwardly, in terms of feeling more appreciated by the staff: "Awareness of the profession has grown. There are more demands, from the kindergarten teacher, from the occupational therapist, from the speech therapist for our presence as creative arts therapists".

3.7.3. Recommendations

Three creative arts therapists referred to the need to adopt new perspectives and to learn from other professions to shift optimally to a remote setting: "I sometimes feel the need to get out of the box, and look at other fields." Two interviewees suggested incorporating technology in the future in face-to-face creative arts therapy: "I have no doubt that we will take some of the technological tools back to the arts therapy room." Twelve interviewees stated that they would prefer to work face-to-face in the future: "My initial preference is always face-to-face," but also said that remote creative arts therapy would be useful in some cases, for example, when a client does not come to school occasionally: "It's worth thinking about a sick child... there are children who have school anxiety. It also makes it possible to reach out to them," or for health reasons: "People in hospitals who are really isolated, for example children with cancer who do not have an immune system." Two interviewees also commented on the possibility of continuing sessions during vacations, when schools are closed: "Working in the summer with special education children, which is exactly the time when no one is watching over them and they are at risk".

4. Discussion

This study was designed to map creative arts therapists' perceptions of the "remote therapeutic response" in creative arts therapy in the education system. The findings indicate that the onset of the pandemic was characterized by complex emotions, alongside a massive mobilization on their part to find creative ways to continue therapy. The interviewees

mentioned that independent learning, as well as help and consultation with colleagues and supervisors, contributed to their adjustment process. Recent studies have shown that supportive relationships with colleagues can enable therapists to better make the transition to online work [19]. The interviewees' investment enabled therapy to take place, but their enormous dedication along with the ongoing instability that characterized the period sometimes led to feelings of burnout. This sense of burnout was acerbated by insufficient technological resources. The interviewees reported that they had to use their home equipment, which was not always up to date or adapted to Zoom. This suggests that a dedicated budget should be devoted to providing creative arts therapists with the appropriate equipment. In addition, the interviewees stated that their busy agenda and the intense intersection of work and home was extremely problematic. Clearer definitions of work hours and agendas should be considered in future guidelines.

The findings also showed that the transition to a remote therapeutic response restricted the creative arts therapists' use of the arts, which sometimes undermined their confidence as therapists. Similar feelings have been described in other reports and case studies. For example, Shaw [9] described her feelings as an art therapist during the transition of a group of adolescents with Anorexia to remote art therapy. She felt it was harder for her to produce a containing feeling when she lacked the traditional tools of art therapy. However, the present study also pointed to a variety of ways in which therapists integrated the arts in all modalities. The literature also shows that the arts can be successfully integrated into remote therapy with appropriate adjustments. For example, a survey of music therapists found that pre-recording music was useful to the therapists in the sessions [20]. The therapists also reported a number of important components that helped them establish a therapeutic relationship remotely, including greater motivation on their part, a clear contract with respect to the setting, and defining appropriate boundaries in terms of time, the nature of the relationship, and place. Case reports and other studies have underscored the importance of the setting in remote therapies. For example, a survey of art therapists in the U.K. found that adjusting the therapeutic contract to remote therapy and clearly defining it around issues of time and location of therapy, the format, and communication between sessions, were particularly important and meaningful [19].

The findings also pointed to new opportunities that emerged in remote therapy, such as promoting greater confidence and self-expression in some clients, for example, for clients on the autism spectrum. This finding also emerged in another study that examined music therapy for a boy on the autism spectrum, which found that in remote therapy, compared to face-to-face therapy, the boy maintained more eye contact and expressed more self-confidence and creativity [10]. In the context of the benefits inherent to remote therapy, a recent preliminary study found that clients perceived their therapists as more empathetic and supportive than in standard therapy [21]. These preliminary findings hint there may be additional benefits of this mode of treatment.

The remote setting also changed the therapists' relationship with their clients' parents. Previous studies on the integration of creative arts therapy in educational settings have found that contact with clients' parents is often unsatisfactory given their low level of commitment or availability coupled with the dearth of resources allocated for this purpose, such as dedicated therapists' working hours. Some therapists only see parents at the beginning and end of the school year, and these parents do not play a significant role in the therapy process [22]. However, the relationship with parents took a significant turn during the first year of the COVID pandemic, when parents were responsible for enabling the therapy to take place. The video calls provided new possibilities for contact, and the therapists were willing to engage in continuous and supportive exchanges. Hence remote contact with parents could be considered as a solution in the future but should be budgeted and regulated. In systemic work, alternatives were devised to allow therapists who work in multiple establishments to take part in staff meetings remotely. Proper budgeting of remote call hours would allow therapists to attend staff meetings on a routine basis.

This study reinforces previous findings showing the significance of online therapy in instances where face-to-face therapy is not possible and its effectiveness in crisis situations [2,23]. The changing situations make it clear that the online format can be an advantage in cases of inaccessibility, illness, and emergencies. It would therefore be worthwhile to define a range of situations in which the use of a remote therapeutic response is authorized and budgeted.

Limitations and Suggestions for Further Research

This preliminary study only examined a specific time period from the beginning of the pandemic and the transition to remote creative arts therapies up to the end of the second lockdown in October 2020 in Israel. Since then, changes have taken place in the field in terms of medical breakthroughs and in society, such that further research should examine how they have influenced remote therapy. This study also provided a broad overview of creative arts therapists' perspectives who all work in educational settings, although the populations in question are very diverse. Further research should focus more deeply on specific populations to better understand their characteristics and needs. Finally, the present study examined the perspective of creative arts therapists. Further conclusions about the significance of therapy and other factors that can promote it could be drawn from a study examining the experiences of clients and their parents.

5. Conclusions

These findings raise numerous questions about the nature of remote creative arts therapy in general and how it is conducted within the education system in particular. These questions touch on the shortcomings experienced by the creative arts therapists during the COVID period but also the innovations. The setting, degree of exposure, and extent of privacy underwent dramatic changes in the period described in the study and affected the nature of therapy in different ways. Sometimes they caused embarrassment, problems of intimacy, and fear of overexposure, while in others, they actually allowed a closer connection and observation of facets of the lives of clients that would not otherwise be revealed, which provided the therapists a chance to intervene in a new way. Recent articles have begun to discuss the ethical implications of using the Internet for privacy and confidentiality [24]. Future work should continue to explore this in various forums in the therapeutic world, including in training programs for new therapists. In some cases, ecological therapeutic work was made possible by the creative arts therapists in extensive collaboration with the educational staff and the clients' parents.

Although the findings suggested that the creative arts therapists believed that remote creative arts therapy will never be a fully satisfactory replacement for most clients, remote work, along with the many difficulties and challenges, has also opened the door to new possibilities in the world of creative arts therapy in the education system. The question as to the nature of the therapeutic response, whether it is therapeutic support or real therapy, continues to preoccupy the therapeutic field. What initially appeared to be an unsatisfactory temporary response was replaced by a growing understanding of the therapeutic implications inherent to it. Along with the long-awaited return to routine, it seems inadvisable to completely close this door without examining what is worth preserving.

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Article

Subjective Experiences of At-Risk Children Living in a Foster-Care Village Who Participated in an Open Studio

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Abstract: The open studio art therapy model offers a space for free creation; in this space, the art therapist supports the participants' art process. According to this model, the creative process is the central component of the therapeutic work. This qualitative study seeks to learn, through an analysis of interviews and artwork, about the subjective experiences of at-risk children living in a foster-care village who participated in an open studio. In addition, it seeks to identify changes in the artwork over time. This study involves a qualitative thematic analysis, while the analysis of visual data is based on the phenomenological approach to art therapy. The data include interviews and 82 artworks of five participants, aged 7–10 years. Five main themes emerged from the analysis of the visual and verbal data: (a) engaging in relationships; (b) moving along the continuum from basic, primary, art expressions (e.g., smearing, scribbling, etc.) to controlled expressions; (c) visibility, on a range between disclosure and concealment; (d) holding versus falling/instability; and (e) experiencing and expressions of change. The discussion expands on the themes in relation to key concepts in the field of psychodynamic psychotherapy and art therapy. It also examines the unique characteristics of this population in reference to empirical studies on developmental trauma and challenges of out-of-home placement. Finally, it discusses the study's limitations and presents recommendations for further research.

Keywords: at-risk children; open studio; art; foster care

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1. Children at Risk in Foster Care

The phrase "children at risk" underscores the threat of future negative consequences of risk factors, such as anxiety, depression, dropout from school, addiction, or early death [1]. Prevalent at-risk situations include abuse and neglect; these can have far-reaching effects on children's emotional, cognitive, and physical health [2]. Most at-risk children who are removed from their homes come from a background of serious family problems [3].

Out-of-home placements are interventions by the Ministry of Welfare designed to protect children from the risks of continuing to live with their harmful families. In Israel, 70.1% of out-of-home placements involve boarding schools (some in the form of foster-care villages) that provide a therapeutic and rehabilitative framework [4].

Studies have observed a high incidence of psychological, social, and educational problems among children in out-of-home placements in comparison to the general population, for example, a recent systematic review and meta-analysis of prevalence observed that suicide attempts were more than three times as likely in children and young adults that were in out-of-home care [5]. Health screenings of 122 young children in out-of-home care observed that 54% had behavioral/emotional problems (e.g., poor self-esteem, anxiety, grief, problematic interpersonal relationships, and depression), 33% had a speech delay, the hearing test for 30% was abnormal, and 28% failed their vision test [6]. Recent studies also underscored the higher prevalence of sleep problems as also related to mental health problems and crime among out-of-home care children [7] and young people who were in out-of-home care as children [8]. These findings may indicate that children who have

been removed from their homes have already experienced trauma, and that removal from the family may create unstable circumstances [9]. Houzel [10] coined the phrase "family envelope", which provides the experiences of belonging and connectedness, but also the permission to differentiate themselves and to form individual identities. He suggested that in cases of dysfunctional families, therapeutic services may provide a "widened envelope", by joint efforts of therapeutic professionals who provide a sense of belongingness together with the permission for children to differentiate themselves [10].

2. Childhood Trauma

Trauma refers to the effects of exposure to potentially extremely stressful events [11]. The direct or indirect exposure to abuse can cause physical, mental, and emotional trauma [12]. Trauma may change children's perceptions of themselves and alter their connection to their bodies and the world around them; it usually leaves them feeling anxious, vulnerable, lonely, helpless, and hopeless [12,13]. From a neurobiological point of view, experiences of maltreatment can impair the function of the prefrontal cortex (PFC) that controls limbic system responses via the PFC–amygdala–hippocampus network. Therefore, unregulated signals from the amygdala could cause high anxiety levels due to inadequate cognitive discrimination, ending in affect dysregulation [14]. In addition, since the right hemisphere is dominant during the first three years of life and processes information in the form of nonverbal signals, early traumatic sensory-motor experiences are stored in nonverbal form and are accessible through bodily expressions [15]. This neuroscientific knowledge of underlying brain functions can increase the effectiveness of art therapy for these children [16] and may explain why art expression as a therapeutic method for children at-risk has its advantages.

3. The Visual Art Medium as a Therapeutic Tool for Treating Children at Risk

Although expressive arts are a developmentally appropriate activity for children that enable their voice to be heard [17], and a high percentage of art therapists work with children, e.g., [18], art therapy research on traumatized children mainly constitutes case studies and qualitative research (see review [19]). Creative expression for traumatized children has been oberved to be an effective therapeutic tool [20,21] because children communicate their emotions and thoughts through nonverbal means [17,22,23]; moreover, through art expression, children gain greater knowledge and awareness of themselves, and develop their self-esteem as well as social skills [20]. Resiliency refers to the ability to adapt, despite experiencing deficiency and severe distress [24]. Art therapy may promote resiliency among clients who suffer from adverse life events [22,25]. Artwork may therefore allow clients to play an active role in their own personal therapeutic processes [26].

One of the main approaches in art therapy is the "art as therapy" approach, in which artwork is therapeutic in nature [27]. One model based on this approach is the open studio model [28].

4. The Open Studio Model

The open studio was developed to serve larger populations and communities in need, by making art-creative processes accessible [29]. A recently conducted systematic scoping review of the open studio model [28] revealed several core principles, including the central role of art, the experiential dimension of the creation of artwork, and the art therapist's/facilitator's role of holding a space to allow for a free creative process [28,30]. The open studio model seeks to offer a space that allows for the creative expression of the individual and the group [31,32]; it provides an egalitarian, nonhierarchical, open-minded, and community-like environment [30,33].

Studies that examined the impact of the open studio model on different populations found that studio work increased positivity, significantly strengthened self-esteem [34], and enabled the expression of personal and relational themes (e.g., [35]) and painful emotions through playfulness and pleasure [36]. The study of an open studio pilot project in Illinois, USA, involving more than 100 children aged 10–12 years found this model particularly suit-

able for at-risk children who grew up in a chaotic and violent environment [33]. However, according to the research, the open studio simultaneously brought participants face to face with painful feelings and experiences [33]. Although the unique setting provides an adaptable framework for populations in need of therapy, only few studies have been conducted on the effectiveness of the open studio model among children and adolescents [28].

The present qualitative study examined the experiences and artwork of at-risk children, aged 7 to 10 years, living in a foster-care village. The study had two purposes: first, to examine, as reflected in the central themes of their artworks and in their verbal descriptions, the subjective experiences of at-risk children who live in a foster-care village and who chose to create in an open studio. The second was to analyze the children's artworks with the purpose of identifying changes over time. Based on these goals, the two main research questions were: (1) based on their interviews and their artworks, what were the subjective experiences of foster-care village at-risk children who participated in an open studio? (2) Can we identify changes in the artworks over time, and if so, what was the nature of these changes?

5. Method

5.1. The Research Approach

The present study used a thematic analysis within a qualitative methodology [37]. A thematic analysis allows for the interpretation of various aspects of the research topic [38]. The analysis of the artwork was based on the phenomenological approach to art therapy, which involved a process of meticulous scrutiny of the content and formal features of the artwork [39].

5.2. Participants

The sampling method involved a deliberate selection [40] of five at-risk children (four girls and one boy) from a foster-care village in Israel, where an open studio operated three afternoons a week. The children regularly attended the open studio and their artwork was kept on the premises. A total of about 90 children attended the open studio over the year; the size of the groups ranged from five to fifteen children in a session of 90 min. The study participants' ages ranged from 7 to 10 years (mean age: 8.4 years). The number of artworks created by each child ranged from 21 to 109, while the average number was 53. Table 1 presents the children's age, gender, the number of times they attended the open studio during the year, and the number of artworks they created.

Table 1. Participants' age, gender, attendance, and number of artworks produced.

Pseudonym	Age	Gender	Number of Studio Sessions Attended	Number of Artworks
Dana	10	Girl	42	47
Tom	9	Boy	21	21
Keren	8	Girl	31	44
Tamar	7	Girl	41	109
Alex	8	Girl	21	44

5.3. Research Tools

Observation Rating Scales Sheet for Art Therapy Practice: Sections B1 and B2: Observation and analysis of drawings and three-dimensional artworks—sculpture/structure/textile [41].

This tool was used for art therapy education and practice; the rater is required to answer yes/no to a detailed list of formal and content features. The tool contained five main formal aspects: overall impression (for example, artwork with repetitions); line quality (for example, thick or weak line, and the presence of an eraser); color qualities (for example, and separated versus mixed colors); space (for example, the amount of space used and the presence of a frame); and finally, forms (for example, the presence of geometrical forms). In terms of content, the rater was asked to rate the artwork for its realism/abstraction and symbolism.

Analysis according to the Expressive Therapies Continuum model (ETC)—The Expressive Therapies Continuum [42,43].

We analyzed the artworks according the ETC hierarchical model, ranging from simple kinesthetic expressions to complex symbolic images. Specifically, there were three levels of artistic expressions, with each level being arranged in a continuum between two poles. Each level may demonstrate a different way to process information [44]. The first and basic level ranged from kinesthetic components (for instance, evidence of smearing or pressing on the material) to sensory components (for instance, evidence of direct touches on the material, such as finger marks on clay); the second level ranged from perceptual components (for instance, evidence of differentiated forms and colors, contour-lines, etc.) to affective components (for instance, evidence of the expressive use of colors); the third level ranged from cognitive components (for instance, the addition of written words) to symbolic components (for instance, the expression of a metaphor, the combination of realism and abstraction, etc.); and the fourth level was the creative level and demonstrated the integration between levels/poles.

FEATS: Formal Elements Art Therapy Scale [45]. We used the verbal definitions of twelve 5-point Likert scales for drawings only: prominence of color; color fit; implied energy; space; integration; logic; realism; problem solving (only for drawings that depicted a person that must overcome an obstacle or achieve a goal); developmental stage; details of objects and environment; line quality; and person. Each scale depicted a range of options starting from a non-existent phenomenon (e.g., in the prominence of color scale, a drawing executed solely in pencil) and ending with the highest point, which could represent a drawing in which the whole space was filled with color. For abstract drawings, we only used relevant scales: prominence of color, implied energy; space; integration; and line quality.

Two art-therapy students (the second author was one of them) and an experienced art therapist and researcher (the first author) practiced the ratings of the three research tools for this study, and for an additional study with adolescents [35]. After the raters had reached an agreement in regard to the phenomenological aspects of the artworks during analysis, via careful observation, analysis, discussions, and continued integration of the relevant theoretical models, the second author continued the rating independently, and the second author participated in the reduction process of the integration into themes. The data codes were inserted into an Excel table for further data analysis and integration.

5.4. Procedure

After ethical approvals were obtained from the Israeli Ministry of Education and the Ethics Committee of the Faculty of Social Welfare and Health Sciences at the University of Haifa, we reached out to the education staff and social workers of the foster-care village and asked them to invite children who attended the open studio to participate in a study that focused on their experiences and artwork in the studio. About 15 children agreed; however, parental consent was given in only five cases. These children's artworks were photographed for analytical purposes. The 255 artworks were classified into categories and a general phenomenological analysis was conducted for each category. Specifically, two-dimensional artworks were divided into three categories according to the materials from which they were made (liquid materials, controlled materials, and intermediates), whereas three-dimensional artworks were divided according to the following categories: structures; containers; figures; shapes; platforms surfaces; accessories; and a combination of categories. After this division, two to three artworks were selected from each category, and an in-depth analysis was conducted of 82 drawings using the three research tools. In addition, towards the end of the year, semi-structured, individual interviews were conducted with the children about their experiences in the open studio.

6. Data Analysis

The artworks were analyzed and implemented into a summary table based on the clinical observation sheets, the ETC model, and the FEATS rating system. The table addressed the following aspects in each artwork: a phenomenological description of the artwork; formal features; expression levels according to the ETC model; materials and

methods used; content; the subjective experience of the viewer; and changes noted in relation to previous artworks. The analysis of the works of art yielded categories that were then incorporated into the six-steps thematic analysis [37].

The analysis process followed these steps: (a) familiarization with the data through reading the interviews and a close phenomenological observation of the artworks; (b) creating initial categories for data, while actively looking for meaningful patterns and relationships within the visual expressions as well as between the visual and verbal expressions; (c) sorting the categories into potential themes; (d) review of themes in the search for consistency in meaning as well as discrepancies; (e) definition, naming, and detailed analysis of each theme and subtheme, as well as a description of the relationships between different themes and the connection between the theme and research questions; and (f) writing a thematic analysis in the context of the theoretical model, including the findings, and the study's validity and limitations.

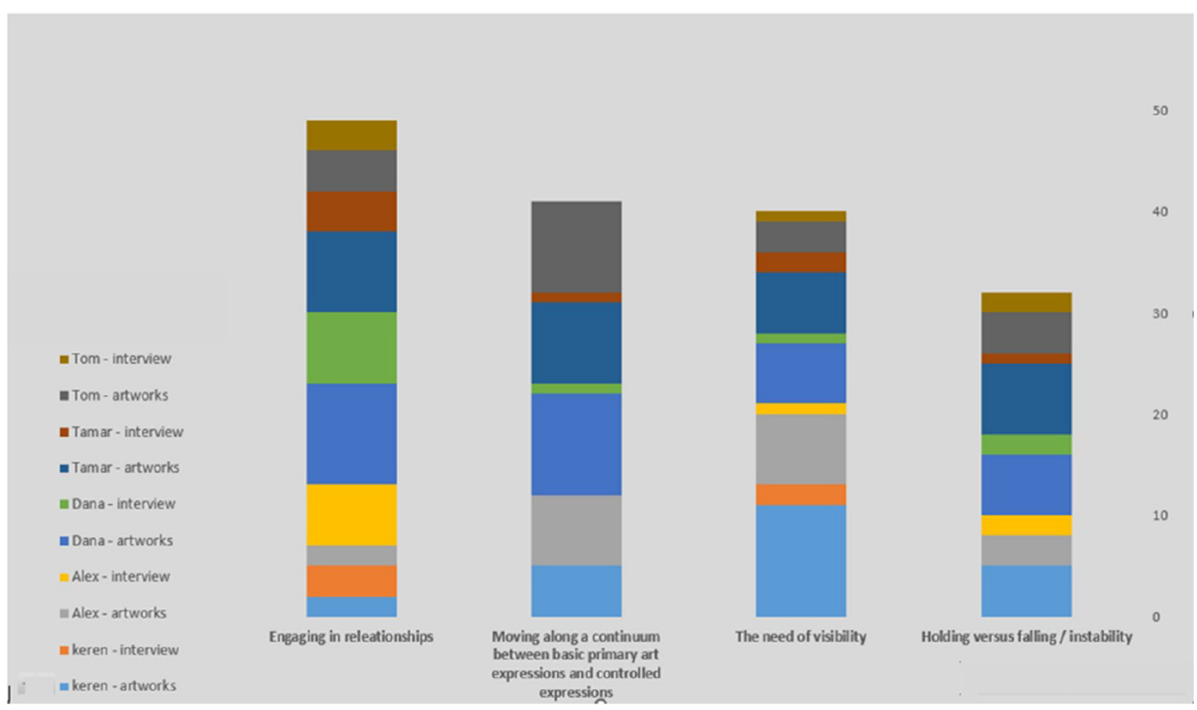
Finally, for the purpose of examining the artworks for changes over time, the authors observed the summary table and the individual summary of each child's artworks, and identified expressions of changes over time, including explicit verbal expressions in the children's interviews and visual expressions in their artworks that showed a change in formal art elements and/or content representations.

7. Findings

Interviews with the children occurred at the end of the academic year. Two participants were cooperative and spoke at length about their subjective experience in the studio, while the other three participants presented brief answers. The interviews lasted between 10–30 min.

Five major themes emerged from the thematic analysis of the five interviews and a meticulous phenomenological analysis of 82 artworks of participants who attended the open studio over the year. These themes were (a) engaging in relationships; (b) moving along a continuum between basic primary art expressions (e.g., smearing, scribbling, etc.) and controlled expressions; (c) the need for visibility, on a range between disclosure and concealment; (d) holding versus falling/instability; and (e) experiencing and expressions of change. Bar Chart 1 illustrates the evidence of each of the four themes as they were detected in each child's verbal and artwork expressions.

Bar Chart 1. About here.



7.1. Engaging in Relationships

This theme is the dominant theme, and was identified 57 times in the artworks and interviews (19 references in the interviews and 38 in the artworks, constituting 46% of the works analyzed in the study). The three subthemes were close relationships, loneliness, and relationships within the studio.

7.2. Close Relationships

There were 24 references to the subject of close relationships (7 artworks relating to the subject and 17 references in the interviews). Four out of five participants depicted a connection to a parental figure in their artwork. For example, the love for a mother was expressed through the use of transparent and scattered pieces of material (Figure 1: with the word "Mom" and a heart made of pieces of transparent and red materials). In some artworks, expressions of love were combined with aggression (e.g., artwork that contained nails), while in others, close relationships were related to pain and sadness (e.g., Figure 2: showing a crying figure). These artworks perhaps reflect the complex emotions felt towards family members.

Figure 1. Keren and Tamar. Warm glue and red material, 21/29.7 cm.

Figure 2. Dana. Pencil, 21/29.7 cm.

In the interviews, children described their relationship with family members, for example, Keren said: "My brother has a double bed and he's in the room alone with a TV,

and a computer and all sorts of things [. . .] And me and my sister are in the same room, it's a nightmare, even sleeping in the same room with her, waking up at night because she's taken my blanket [. . .] I take my mother's blanket and say thank you, goodbye".

It may be assumed that Keren is also speaking implicitly about experiences of place and lack of place, as well as being protected or not protected by her caregivers.

7.3. Loneliness

Loneliness appeared only in the artworks (specifically, in 15 of the participants' artworks) and not in the interviews; loneliness was expressed in several ways, such as single figures isolated from their environment, for instance, a lone figure on a blank sheet of paper (Figures 2 and 3). Loneliness was also connected to misery and strong emotions (see Figure 2, which features the word "alone" written on the drawn tears).

Figure 3. Dana. Paper, pencil, wooden frames, gouache paints, sequins, shells, and glue, 15/20 cm.

In some artworks, loneliness was also expressed through the character's relationship with the environment, e.g., a distinction and contrast between the figures and background (see Figure 4 showing a figure separated from the background or encapsulated).

Figure 4. Tamar. Gouache pencils, markers, and 70/50 cm sheet of paper.

Finally, in other artworks, the placement of figures emphasized the lack of communication between them (e.g., Figure 5 featuring many figures, but all facing different directions).

Figure 5. Alex. Readymade figures on a wooden surface, 20/40 cm.

7.4. Relationships in the Open Studio

This subtheme was present in 18 references. Interviews revealed that all participants perceived the relationship with the therapist in the studio as positive, supportive, and enjoyable. When asked about the work experience with the therapists in the room, the participants (Keren, Dana, Alex, and Tamar) answered: "Fun". In addition, the children described new and meaningful friendships they had formed during their work in the studio. The relationship with their peers seemed to create some challenge, as the participants spoke about the difficulties of creating within the group space. When asked if work in the open studio was frustrating, Dana answered: "The truth is, a lot of time, (laughing), there was one time, that someone, a girl took the piece I wanted to make, just took it from me without asking". This and other examples demonstrated the frustration felt when personal space was invaded; moreover, all participants mentioned that the noisy environment bothered them.

Relationships within the studio were also reflected in joint artworks: four of the five participants in the study experienced this method of working (see Figures 1 and 6).

Figure 6. Dana and Tom. Readymade materials, wallpaper, and gouache, 40/50 cm.

Different children sometimes worked on portraying the same image (e.g., two children drew the YouTube logo or copied a penciled drawing of an Indian god). Working on the same image can also indicate imitation, mutual influence, reciprocity, and interpersonal connections within the studio.

Moving Along a Continuum Between Primary Art Expressions (e.g., Smearing, Scribbling, etc.) and Controlled Expressions.

This theme was expressed in the artworks of all the participants and specifically in 41 artworks, i.e., half of the total number of artworks analyzed in this study, whereas only two references to this theme were noted in the interviews.

8. Control

Regarding the materials, we examined artworks that demonstrated control and the meticulous use of liquid materials. Tamar, for example, stated her preferences: "Oil pastels, markers, colored pencils, papers," but in contrast, her artworks were predominately created

with liquid materials (see Figures 1 and 4). Dana, on the other hand, showed a clear preference for controllable materials: 82% of her two-dimensional works were painted with materials of this kind, while her other artworks made with other materials also demonstrated control (see Figures 2 and 3). There were also artworks that expressed the need for control through their content, for example, the depiction of figures with special powers (see Figure 4, showing a figure wearing a crown and wand, symbols of power and control).

8.1. Characteristics of Order and Recurrence

Aspects of organization and order, such as symmetrical images and repetitive movements or shapes, were found in 15 artworks (e.g., Figure 6). Organization was also represented by division into blocks of color, order of colors, and meticulous coloring, and symmetry was observed in artworks where there were two similar parts that demonstrated the same use of color or shapes (see Figure 6). Repetition was demonstrated through the repeated use of colors, shapes, and strokes (see Figure 7).

Figure 7. Tom. Wood, gouache, and pencil, 30/60 cm.

The need for control also appeared in the interviews: three out of five participants (Tamar, for example) stated their preference for controllable materials, but their artwork reflected the use of liquid materials that were less controllable.

8.2. Primary Art Expressions (e.g., Smearing, Scribbling, etc.) and Expressions of Chaos

The Kinesthetic/Sensory level—the first level of the ETC model that involves primal developmental expression—was reflected in 19 artworks by 4 participants (see Figure 8 that features a plastic container containing a crumpled page that was colored with gouache paint).

Figure 8. Keren. Plastic container, paper, and gouache, 30/40 cm.

The prevalence of kinesthetic sensory artworks varied from one participant to another; some participants barely engaged with this level, while for others it comprised the main part of their body of artwork. The artworks dealt with the primary need for touch and

movement [46] and may reflect the discovery of the ability to leave a mark [47]. These needs corresponded to the needs of the infant and toddler in the early stages of life; participants created pre-formal artworks, i.e., abstract artworks created from movement and contact with the material, which may represent a return to a primal state where form still has no meaning, such as syllables that have not yet formed a word. Tamar's clay works show a transition from organization to disorganization, from form to lack of form, with the last work in the series being amorphous in nature (see Figure 9).

Figure 9. Tamar. A series of three objects, clay.

8.3. Visibility—Concealment and Discernibility

The theme of visibility was identified in 33% of all the artworks analyzed. Of these, 20 artworks directly presented the theme of visibility, while the other 33 works featured three additional aspects of visibility: secret (6), cover (15), and interior and exterior (12).

The analysis of the artworks revealed two main features of visibility. The first was the use of shiny materials, such as glitter, sequins, and golden copper (see Figures 10 and 11). These visual materials may symbolize the need to exhibit something, attract attention, or stand out.

Figure 10. Tom. Pencil case, sequins, and glue, 15/25 cm.

Figure 11. Keren. Ready-made materials, sequins, and beads on corrugated cardboard.

The second feature was apparent in the content that emphasized eyes, such as figures with highlighted eyes (Figure 12). In addition to emphasizing eyes, this theme was reflected in artwork that was made on or inside glass cases (Figure 10 contains these two features).

Figure 12. Tamar. Gouache, markers, paper, and $\frac{1}{4}$ sheet of paper.

8.4. Secrecy

The theme of secrecy appeared a total of six times in the artwork of four participants. Secrecy was presented as part of the visibility theme and was reflected in the choices of concealment and disclosure. The artworks that dealt with this theme were all three-dimensional, characterized by closed containers with hidden contents. In her interview, Dana openly dealt with the theme of secrecy: "I just thought, let's make a drawer: a drawer with all kinds of secrets inside" (Figure 13). By bringing the secrets into the studio in the form of artwork, the participants may attempt to share and work through their experiences with the staff and/or other children.

Figure 13. Dana. Readymade drawers, gouache, and beads, 15 × 25 × 5 cm.

8.5. Cover

Another aspect of the theme of visibility is covering. Four participants addressed the issue of covering in 15 artworks. This is a topic that was only expressed in the artwork, mainly in material form, i.e., one material covering other materials (see Figure 11). The cover may reflect concealment in the sense that one chooses to cover and hide certain layers or parts of the artwork. It is possible that the very preoccupation with cover expresses a need for a protective layer, or alternatively, a desire to be discovered through the removal of these layers. It could also represent unmanifested or unconscious mental aspects.

8.6. Interior and Exterior

Connections or contrasts between the interior and exterior were identified in 12 artworks. In some of the artworks, a tension emerged between the interior hidden layers and the visible, exterior layers. Most of these artworks were containers that presented a contrast between the interior and exterior: the exterior reflected harmony and a high degree of control over material and color, while the interior reflected contrasts, i.e., a mix of colors and chaos (see Figure 14).

Figure 14. Alex. Box of gouache, readymade materials, shells, cardboard, glue, and clay.

In conclusion, the theme of visibility is a dialectical one, and may reflect a tension between the desire for disclosure and visibility, and the wish to hide and conceal secrets, complex, uncontrollable, and primary elements.

8.7. Holding versus Falling/Instability

8.7.1. Holding

By holding, we refer to the emotional experiences of being held by the other/the setting/artwork, as described by Ogden [48] following Winnicott [49,50]. The experience of being held beyond infancy is described as the provision of a "place" in which the client

may gather himself/herself together, including all his/her different parts/aspects. Since metaphors of an envelope, a frame, or a container are often considered by therapists as describing some aspect of the holding function (e.g., [51]), it may be assumed that the multiple use of these elements in these artworks communicates the holding function, and/or the need to be held and integrated.

The holding theme was manifested in 18 artworks in two main ways. One was the presence of frames (Figure 2) and the other was the use of containers (Figure 14). The only frames that appeared to be complete in the artworks were ready-made frames.

Among the three-dimensional artworks, we found containers, such as boxes, purses, pencil cases, bags, bottles, and more. In many artworks, the container contained liquid/soft materials, such as clay, gouache, and even a combination of materials, including water (see Figures 8 and 14). In addition, some of the containers were food containers and their selection may indicate the primal need for nourishment, also connected to maternal holding.

8.7.2. Falling and Instability

Themes of falling, seepage, and instability were observed in ten artworks. Three-dimensional artworks reflected instability, while two-dimensional artworks depicted situations in which there was the danger of falling or collapsing (e.g., Figure 15, showing a butterfly falling downwards), as well as sky motifs and a lack of grounding (see Figure 4).

Figure 15. Dana. Gouache and 1/2 sheet of paper.

Other expressions of falling or seepage were observed in artworks with incomplete frames: in artworks where part of the frame was missing underneath the figure (e.g., Figure 4) and in artworks featuring incompletely outlined faces that flowed downwards. The frame within the artwork motif can indicate a need for holding or an attempt to hold different parts of the work.

8.8. Experiencing Change and Expressions of Change

All the children described the studio as a place that helped them regulate their emotions; specifically, they recalled experiences in which they arrived upset or frustrated and were calmer when they left. This is how Dana talked about the possibility of regulating anger and aggression by working with appropriate materials: "Yes, if I'm nervous, for example the task "Come Out on Top". I was upset with someone, and I just took a hammer and hammered the wood".

In the interviews, some children described the process they underwent while creating the artwork. For example, Tom said: "At the beginning [of the year] I was just scribbling and fooling around but then [towards the end of the year] I made signs".

An examination of the artworks over time revealed changes in regard to two subthemes: loneliness and the movement between primary to controlled modes of expression. In regard to the subtheme of loneliness, a progression was detected in the artworks of two participants, from depictions of a single object to artworks that contained relationships between several objects (e.g., Dana's first and last artworks, Figures 2 and 16). Additionally, in terms of holding, Dana's first artwork had a full frame made of wood with glass, while her last work used a partial frame made from textile.

Figure 16. Dana. Corrugated cardboard, bits of paper, markers, and ready-made materials, 21/29.7 cm.

Regarding the movements between poles of control and primary expression modes, an examination of the artworks revealed that two participants demonstrated an increased ability to control the material in the course of the year; for example, Keren's artworks demonstrated primary expression modes and a preference for liquid materials at the beginning and middle of the year, with better control and use of mediating tools (brushes, stencils, and writing) by the end of the year. It can be assumed that the children's ability to move between disorganization and control in their artwork (i.e., expressing internal chaos and regress to early developmental needs on the one hand, and the need for control over internal and external realities on the other) demonstrated that work in the studio enabled access to different and opposing experiences. The very movement between these situations can also indicate development and growth, and reflect changes in emotional experiences over time.

9. Discussion

The children who participated in this study were all coping with the loss of their home and family and with relational trauma as a result of maltreatment and neglect. They were all struggling to adapt to the foster-care environment, and the open studio was one of the therapeutic settings that they chose for themselves. The main findings of the present study are based on the nonverbal expression mode. The artworks were rich in terms of materials, techniques, forms, sizes, colors, and symbolic images. The fact that these participants created 255 artworks may show that they used the open studio for an ongoing and continuous journey. The discussion discusses the themes from the aspect of coping with loss and trauma, and the evolvement of an alternative envelope through the artmaking processes in the open studio setting. It also deals with this study's limitations and offers recommendations for further research.

9.1. Nonverbal Expressions of Trauma and Loss in the Open Studio

Trauma researchers agree that traumatic memories are primarily stored in the non-verbal part of the right hemisphere of the brain [15,52–54]. In addition, contemporary studies have found that talking about trauma can be a difficult experience at best; at worst, it reactivates the traumatic experience [55]. This is even more apparent when the trauma occurs within the child's home and she/he is not protected by caregivers.

The present study showed that participants were preoccupied with the theme of close relationships, and that this theme manifested itself mainly through art expression. For these children, close relationships can mean both the loss of family members as well as traumatic experiences in which family members were involved. Multiple artworks representing close relationships may thus demonstrate the children's efforts to work through memories of loss and trauma. Studies show that children in out-of-home placement reported a positive experience of their parents, despite significant reports of trauma as well as an intense longing for their biological family [56]. The intense longing for families of origin can be observed in artwork that expressed and emphasized the love that children have for family members (for example, artworks in which the word "mother" appears with a big heart).

In many foster-care services, the loss of parents and homes is frequently disenfranchised [57]; therefore, the grieving child should be helped in this respect. Therapeutically speaking, loss is an issue that should be addressed, according to the Two-Track Model of Bereavement [58]. Bereaved clients have two needs: to continue the relationship with their lost loved ones and to adapt to the new realities without them. From this clinical perspective, delegitimatizing the need to mourn and mentally preserve the relationship with the lost object may impair the process of adapting and functioning [58]. In a similar way, the Dual-Process Model (DPM) of coping with bereavement [59,60] asserts that a bereaved individual needs to deal simultaneously with loss-oriented and restoration-oriented stressors. We may thus assume that the children perceived the open studio as an enabling space for coping with and expressing the loss of family members in a nonverbal way. The research shows that art therapists perceive the art medium as a space for clients' grief work (e.g., [61]).

In this study, the loss of family members was bound together with trauma connected to familial relationships. The experiences of relational trauma are particularly hard to assimilate. The findings of this study showed that in the artworks representing close relationships, various materials or techniques reflected negative affect, such as aggression and sadness through technique (e.g., hammering on nails), the materials (e.g., metal nails), and/or by integration of art's content and form. These may reflect the children's attempts to process this subject through nonverbal means. Art enables the embedded and material expression of intense longing alongside complex feelings of anger and frustration [62].

In addition, the children's artworks reflected a profound experience of loneliness. Neglected children may heavily rely on themselves as a survival mechanism that helps them overcome the pain of loneliness [63]. Thus, the children's ability to create and communicate the experience of loneliness may be thea first step in their healing process.

In summary, we may assume that the art medium was chosen by these children as a space in which they could express and communicate painful memories and experiences relating to relational trauma and loss. These painful themes were then observed and witnessed by the art therapists and other children who simultaneously worked in the open studio, and may have prompted verbal sharing. The research has shown evidence that the expression of negative emotions related to risky environments and trauma may have a positive impact by reducing the effects of the cumulative risk load (e.g., [64,65]).

9.2. The Formation of an Alternative Envelope in Which the Need to Be Held, to Be Seen, and Move between Opposite Poles Is Expressed

Since all the participants in the current study were removed from home due to maltreatment and/or neglect, we can assume that many of their central developmental needs were not met, and that they had to cope with stressors relating to the loss of their family envelope [10]. In addition, the traumatic experience itself disrupted the continuity and

experience of life, as well as development [12,13]. The themes emerging in this study also indicate that the studio enabled the exploration of issues and dialectical moves. For example, through the creation of multiple frames featured in the artworks, which hold and contain the internal parts of the work, and through various containers that were used to contain liquid materials, the children were engaged in inserting something into a construct that was supposed to hold it, and were also engaged with the opposite pole—the collapsing of frames, the leaking of materials. These engagements may represent their need to be held, to belong, as opposed to being an outsider, being apart, or disintegrating, and the artistic enactments of their experiences as maltreated and neglected children. The studio and the children's experiences with the materials may have functioned as a holding mechanism for the children, as a place where the client can gather the different parts of the self into one place [48]. According to Farrell-Kirk [51], the container in art therapy is also a metaphor for the space of understanding created in the therapeutic relationship between the therapist and client.

Cohn [63] describes parental neglect as the failure to mirror the child. In therapy, these clients' experiences of being observed by the therapist may elicit negative emotions, such as embarrassment, shame, and humiliation [66]. The need to be noticed and to be observed that arises from the children's artwork (through prominent shiny materials, and motifs of seeing) may indicate that needs for mirroring, for being seen and found, were not experienced in the past. One of the prominent roles of the art therapist in the open studio is to witness the participant's art process and product [28]. In addition, displaying the artworks at the end-of-year exhibition adds a communal and social dimension to this process, and based on their comments in the interviews, the exhibition was probably a positive, corrective, and memorable experience for many of the children.

Contrary to the wish to be seen or found, various expressions of cover and concealment were present in the artworks. The participants used multiple layers to hide or bury objects within the materials, or covered initial drawings with multiple layers of paint. A clinical assumption may be that through burial and concealment, shameful parts and/or secrets or threatening parts of the self were symbolically kept safe [47].

In a recent study about the experience of adults who grew up in the shadow of a secret in their childhood, art-based representations included motifs of visibility, sight, and covering [67]. Children at-risk deal with familial secrets, as well as with events that they cannot fully grasp and understand. Indeed, relational trauma may leave the child with feelings of guilt and shame, and these feelings are particularly hard to articulate verbally [63]. Various acts of revealing and covering may be opportunities for the creator to explore this continuum. Similar to the movement between poles of visibility and holding, there was also movement between art expressions that conveyed control (e.g., a symmetrical graphic image) versus primary modes of expressions (e.g., smearing).

In terms of trauma, the prominent kinesthetic sensory dimension identified in the children's works indicated the promotion and restoration of movement, which is the opposite of the freezing process; in trauma, kinesthetic sensory work can release pressure, awaken the senses, cause embedded pre-verbal memories to resurface, and create a rhythm of healing [68].

At the extreme pole of primary modes of expression, the artworks expressed chaos, which may represent the children's emotional experiences of disorder in their life; primary developmental needs that were nor met; a sense of vagueness; mixed feelings; as well as the hope that in the open studio they might be welcomed and acknowledged. At the opposite pole, the findings show that the artworks reflect the need for control through motifs of order, repetition, and symmetry. This may express an attempt to bring order to a life experience of trauma and chaos, to control reality (at least in the drawing), and create a shield against helplessness.

When the children fail to develop a sense of control and stability, they become helpless [54]. This study found motifs of "superpowers" in some of the children's artworks,

represented by crowns or superheroes. This may reflect the children's preoccupation with planning, order, and control, elements that were lacking in their families of origin.

9.3. Experiences of Change in the Open Studio

Experiences of change came up in the participants' interviews when the children recalled entering the studio whilst feeling upset or angry, and leaving feeling calmer and/or content. This documents an emotion-regulation process that may be associated with the open studio setting [69] or/and the process of art making that is known as enabling fun for children in foster care [20,21], as well as a reduction in arousal and stress among a normative sample (e.g., [69]). Deficits in emotional regulation, as well as negative emotionality, are characteristic of maltreated and neglected children; thus, therapy must address these issues [70]. These repeated experiences of affect regulation in the open studio may demonstrate a new emerging ability among these children.

The artwork of all the study's participants revealed movement between different levels of expression according to the ETC model, which can indicate change and transformation [71]. Art therapists report the transition between expressive levels in therapy as part of the processes of transformation and change in their clients [68,72,73]. To summarize, the ability to move between chaotic primary expressions in art to more controlled perceptual expressions, and vice versa, may contribute to the enhancement of emotional self-efficacy as an important aspect of art therapy treatment for traumatized individuals [74].

An examination of the changes in the children's artworks over time revealed that, for two participants, there was a shift from works that expressed loneliness to works that contained relationships; however, these images were floating, without a background or ground. A study conducted in Mexico on children who were removed from the home and placed in boarding schools observed that the home was described as "almost home" and the staff and other children as "almost family" [75]. This can explain the representations of relationships in the artwork used in this study, which featured hovering figures, as reflecting the ability to "almost" be in a relationship, or in the process of establishing new relationships.

9.4. Limitations of This Study and Recommendations for Future Research

The main limitation of this qualitative study was its small sample size. At the same time, the significant and representative number of artworks (82) that were analyzed and chosen out of the 255 artworks strengthened the validity of the themes, which were refined through the thorough analysis conducted in this study. In addition, the study mainly relied on nonverbal expressions of the artworks; thus, subjective biases might have influenced the final analysis. To counter this bias, the researchers cooperated in the process of analyzing the data to ensure intersubjective validity [76].

Another limitation was the scarce interview content: the children's age or lack of mentalization skills made it difficult for them to expand on their experiences in the studio. To some extent, the richness of the artwork compensated for this lack, but increased our reliance on analysis and interpretation. In view of the limitations, we recommend conducting mixed-methods studies with larger sample sizes, and the integration of valid measures to assess the children's emotional and behavioral functions. We also recommend examining studio activities from the perspective of the therapists who can provide their impressions of their interactions with the children.

9.5. Practical Implications for the Research and Clinical Work

The many artworks created by the participants throughout the year present a profound and complex picture of their subjective experience in the studio and the issues that preoccupied them. The present study reinforced the importance of nonverbal expression as a research tool, especially with at-risk children who experienced trauma, and for whom this trauma was less accessible through verbal channels.

From a clinical perspective, the present study demonstrated that the open studio may serve as a meaningful therapeutic framework for at-risk children in foster care. The richness

of their artwork may reflect a good fit between participant needs and the open-studio setting. Through visual communication, children could have learned affect-regulation and gained access to their inner worlds, their own voices, and to vital partnerships with the other creators in that space, not to mention with the art therapists who held this space, witnessed the evolution of these artworks, and finally created the art exhibition, with the children as joint curators.

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Article

Exploring Change in Children's and Art Therapists' Behavior during 'Images of Self', an Art Therapy Program for Children Diagnosed with Autism Spectrum Disorders: A Repeated Case Study Design

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Abstract: (1) Background: 'Images of Self' (IOS) is a recently developed and evaluated art therapy program of 15 sessions to reduce difficulties in 'sense of self', 'emotion regulation', 'flexibility', and 'social behavior' of children diagnosed with Autism Spectrum Disorders (ASD). In this paper, it is explored whether change in the child's behaviors corresponds to the therapist's actions during IOS and 15 weeks later. (2) Method: In a repeated case study design, twelve children and seven therapists participated. Art therapists monitored their own and the children's behavior by applying two observation instruments: the OAT (Observation of a child with autism in Art Therapy) and EAT (Evaluation of Art Therapist's behavior when working with a child with autism). Child behaviors during art making were—individually and as a group—compared with therapist's actions at three moments during the program. (3) Results: Ten of twelve children showed a substantial or moderate positive behavior change considering all OAT subscales at the end of the program and 15 weeks after treatment. Improvement of 'social behavior' stood out. Halfway treatment art therapists most prominently showed support of 'emotion regulation', 'flexibility', and 'social behavior'. Clear one-on-one relationships between changes in children's behavior and actions of therapists could not be identified. (4) Conclusion: The study provides new insights in the AT treatment process by monitoring children's and therapists' behavior. The art making itself and the art therapy triangle (child, art making, therapist) offer opportunities to improve verbal and nonverbal communication skills of the child.

Keywords: art therapy; children; autism spectrum disorders; change processes; OAT; EAT

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1. Introduction

Children with autism-related problems are often referred to art therapy (AT) in the Netherlands [1]. Art therapies are recommended in the Dutch Guidelines for Mental Health [2]. The American Art Therapy Association [3] states that people with autism are an important target group for (research into) AT.

In the DSM-5 [4], persons with Autism Spectrum Disorders (ASD) frequently have social-communicative deficits and repetitive/restricted behaviors and interests.

Recently, several studies have indicated that AT can provide a successful treatment for children with ASD-related problems. In a systematic review [5], two single group studies reported improvement of the children to engage in social situations and improve ability to focus attention. The review also included an RCT that showed some favorable but not significant outcomes for the treatment group, compared to the control group. The lack in the RCT is not unexpected, because of the variety of ASD features in children [6–9], which

makes it hard to form a comparable treatment and control group. An extensive practice- and theory-based study evaluated the contribution of sensory experiences when touching art materials. This resulted in improvement of communication with the therapist [10]. Art making in AT supports the pleasure of the child and contributes to an improved therapeutic relationship. It also increases the range of patterns in the child's behavior and art expressions [11,12].

Until recently, there was a gap in the knowledge regarding behavioral changes of children with ASD in AT, the activities of the art therapist, and the relationship between the two [1,13,14]. To address this challenge, a series of studies was performed, resulting in the AT program 'Images of Self' (IOS). This title refers to the important role of art making in the triangular relationship between client, art work, and art therapist. Every art making process and every art product mirrors the experiences of the maker within this triangular relationship.

IOS was developed firstly with two studies examining knowledge from experienced art therapists as well as literature about AT practices with children diagnosed with ASD [15,16]. Based on these studies, the building blocks of the IOS program were further articulated as consensus-based typical elements of AT [17]. IOS consists of 15 individual sessions with an art therapist who has been intensively trained to apply the program. Characteristics of the treatment and the relevant actions of the art therapist are described in a manual [18]. The starting point of the treatment is attunement to the needs and art expressions of the child.

The IOS program offers a frame that allows adjustments to individual needs, because every child with autism has different interests, skills and varied reasons for being referred to art therapy. For instance, an 11-year-old girl and her environment suffered from her emotional outbursts. An important step during her IOS treatment was to make a colorful felt blanket that she wanted to use to comfort herself. During the creation of this blanket, she moved the soft wool with soap and water until it turned into felt. She enjoyed the creation of the blanket. During this process, she talked with the art therapist and became more aware of what gives her (emotional) stress and what brings relaxation. The girl became aware that sensory experiences helped her to relax. She also made a small plastic bag with smooth glue in it, for keeping in her pocket. Whenever she became aware that her tension grew, it helped her to relax by touching the smooth bag.

The IOS program yielded promising results in a multiple case study among 12 children diagnosed with ASD, aged 6–12 years, with normal/high intelligence profiles [19]. Children were referred to IOS because of difficulties with their 'sense of self' (difficulties with reflecting on their own feelings and behaviors), 'self-esteem' (strongly negative senses about 'being different' but not understanding why), 'emotion regulation problems' (being very depressed; emotional outbursts), 'flexibility problems' (being upset when something unexpected happens) and/or 'social problems' (difficulties in expressing themselves and troubles with understanding others). Nearly all participating children (n = 11) started the program with severe problems in these areas according to the norms of the Child Social Behavior Questionnaire (CSBQ) [20].

During the program, the children were monitored on the outcomes 'sense of self', 'emotion regulation', 'flexibility', and 'social behavior' by therapists, but also by their parents and teachers [18]. The outcome 'sense of self' is a concept that includes a continuum regarding self-development: self-perception, self-image, self-concept, and self-esteem [21].

Seven of the 12 children significantly improved in 'flexibility' and 'social behavior', both during treatment and also 15 weeks after termination of the treatment [19]. These results can be interpreted as positive, because in general, the reduction rate of problems by psychosocial interventions in children and youth lies between 35 and 62 percent a year after the start of a treatment [22,23]. According to the qualitative analysis of the evaluation of IOS, all children were reported by their parents, teachers, and therapists to be happier and more stable, and better able to give words to their experiences. Additionally, improvements in 'emotion regulation' (n = 8) and 'flexibility' (n = 4) were reported.

In our evaluation study, the focus was primarily on the outcomes: do the children improve or not? However, AT is characterized by a triangular relationship between client, art, and therapist [24,25]. In this relationship, it is supposed that communication of the children with the art therapist will be easier and feel safer for the child, because of the component of art making. This especially applies to children with communication challenges such as children diagnosed with ASD [17]. In this paper, we explore the process of therapeutic change, thereby directing the attention to the development of children's and therapists' behavior in relation to each other. The research question in the current study is: *To what extent are changes in the behaviors of the children and the art therapists' activities concerning (supporting) 'sense of self', 'emotion regulation', 'flexibility' related?*

2. Methods

2.1. Participants

The repeated case study design makes it possible to monitor individual patterns of results in different contexts. In our design, we included children, their parents, teachers and their art therapists. The multiple perspectives and the pre-test/post-test provide insight in changes in AT as well as in the contexts of home and school. Twelve children and seven therapists participated in this study. Children aged 6–12 years with an ASD diagnosis and an IQ $\geq$ 80 were included in the sample [19] (Table A1 in Appendix A). Children were excluded if they were evaluated by their art therapists as showing amounts of resistance that were too high or fear of art making. All therapists had a Bachelor's degree in art therapy, which is the required professional qualification in the Netherlands for working as an art therapist. They also had at least two years of work experience in AT with the target group. Parents and teachers of the participating children completed questionnaires, observed daily behavior, and reported possible behavior changes of the child in a form. Parents participated by discussing and evaluating video recordings of selected IOS sessions with the art therapist. All participants signed informed consent forms.

2.2. Measurement Instruments

In this study, two instruments were used to monitor and describe the children's and the therapists' behaviors during the IOS program [26]. (In the evaluative multiple case study three other instruments were also applied: the Behavior Rating Inventory of Executive Functioning (BRIEF; [27,28]), the Children's Social Behavior Questionnaire (CSBQ) [20,29], and the Self-Perception Profile for Children (SPPC) [21,30]. With the first two instruments, parents' and teachers' findings were measured, and with the third instrument, the child's findings were mapped). The first instrument in the recent study is the so-called 'Observation in Art Therapy with a child diagnosed with ASD' (abbreviated as OAT. (In our former studies, the names of the instruments were OAT-A and EAT-A, with '-A' referring to ASD. However, the titles without the suffix '-A' are more compact). The OAT is an instrument that is intended to observe and measure the behavior of the child during art making in the sessions on four subscales: 'sense of self', 'emotion regulation', 'flexibility', and 'social behavior'.

'Sense of self' refers to a theory-based continuum of concepts that represents a development of 'self skills': self-perception, self-image, self-concept, and self-esteem [21,31,32]. Improvement of 'sense of self' is one of the main aims of AT for children diagnosed with ASD [15,18,33]. In studies about AT for children with ASD the importance of development of the lowest level in the continuum, 'sense of self' is often mentioned as a treatment goal [10–12]. An example of an item in the OAT subscale 'sense of self' is: "*The child is connected with his/her experiences during art making*".

'Emotion regulation' is a complex concept that concerns perception of internal and external stimuli within a complexity of mechanisms: physiological arousal, motivation, and cognitive evaluation. The ability of regulating emotions is based on recognition of inner sensations, feelings, and behavior, relating these to their causes [34]. Initiating, maintaining, inhibiting, or moderating emotional reactions may lead to 'emotion regulation' in

association with processes that influence experience and the expression of emotions [35–37]. 'Emotion regulation' refers to the downregulation of negative affects or the upregulation of positive affects [37]. For children with ASD, it is often hard to recognize their own emotions. In art work, inner feelings can be expressed by, for example, drawing cruel fights or monsters. Difficulties with 'emotion regulation' can behaviorally be expressed, for instance, by becoming angry when something disappointing happens during art making, or by lack of emotion expression when it is expected. An example of an OAT item of this subscale is: "*The child is expressing emotions/experiences in art making/symbols*".

'Flexibility' is about adaptation to unexpected situations. Cognitive 'flexibility' (the ability to find new solutions to a problem) is distinguished from flexible behavior (adaptative skills to unexpected situations) [38]. An example of an OAT item of this subscale is: "*The child uses varied art materials and/or techniques*".

'Social behavior' is one of the main difficulties for children diagnosed with ASD [4]. These children are often hardly or not skilled in reciprocity, to adapt to others, to adapt to play, and in working together [6,29]. In art therapy, some social skills can be developed, for instance task-oriented collaboration, asking for help, and connecting words to experiences [24]. The child may enjoy working together, and joint attention skills may also be developed during art making [39–41]. An example of an item in the OAT subscale 'social behavior' is: *"The child shows enjoyment during art making with the art therapist"*.

The second instrument is the so-called 'Evaluation of the Art Therapist's behavior working with a child diagnosed with ASD' (abbreviated as EAT); an instrument that is intended to observe and measure art therapeutic behavior in IOS sessions. This instrument has subscales corresponding with those in the OAT: 'supporting the development of sense of self', 'stimulating emotion regulation', 'supporting the improvement of flexibility', and 'supporting social behavior'. A (corresponding) example of the EAT subscale 'supporting social behavior' is: "*The art therapist supports the child to follow directions of the therapist*".

Items of both instruments have a 5-point Likert scale with values 1 = not observable, 2 = a bit observable, 3 = to some extent observable, 4 = well observable, 5 = strongly observable. Both instruments are filled out by the therapists (see further below). The reliability of the OAT and EAT is 'moderate' to 'substantial' [26]. Inter-rater reliability of both instruments were determined with pairs of raters (trained art therapists and Bachelor students) who scored selected video fragments of AT sessions collected during a pilot study. Interrater reliability has been computed per item and per subscale of the instruments. Because of the ordinal level of the scores (5-point Likert scale) the degree of agreement was computed per item using quadratic weighted Kappas (K_w). K_w may be influenced by a restriction of the range of scores, resulting in an inflated high or low value. For that reason also Gower indices (G) were computed to interpret values of K_w for items with very low or high absolute agreement [42]. In addition: $0.40 \leq K_w < 0.60$ means 'moderate' agreement; $0.60 \leq K_w \leq 0.80$ means 'substantial' agreement.) Training of raters was still proved to enhance the inter-rater agreement regarding the instrument's scales [26].

2.3. Procedure

To include art therapists, a *convenience sample* [41] was drawn using newsletters from the national professional organization of art therapists, calls on Facebook, and word of mouth advertisement. Participating children followed the usual referral procedure from the seven collaborating institutions. Based on the professional judgements of the art therapists, children were excluded if they were assessed as having levels of resistance that were too high or fear of art making.

Both instruments, OAT and EAT, were scored by the art therapist at all of the measurement moments. The use of both instruments was intensively trained and supervised by the PI during the IOS program.

Details regarding the monitoring of treatment were described in our previous publication about IOS evaluation [17].

2.4. Analysis

The data were analyzed in two steps. In the first step, the behaviors of each child during the session at the measurement moments T1, T2 and T3 were visually compared with the acts of the corresponding therapists (EAT). The aim was to explore whether changes in the child's behaviors corresponded to the therapist's actions. Excel (version 2016 for Windows) was used to analyze the data. As a decision rule, we considered differences between two measurement moments equal to or larger than −1 or +1 as substantial. Differences between −1 and −0.5 or +0.5 and +1 were seen as minor or moderate. Differences smaller than −0.5 or +0.5 were defined as negligible.

In the second step, for each subscale, a nonparametric Friedman test was performed on the four measurement moments for the group of 12 children. The aim of this test was to explore whether there was a consistent pattern of change over time. This enabled comparison of the scores at different measurement moments and visual exploration of the development in children's and therapists' behaviors.

3. Results

3.1. Individual Analyses

Detailed information about changes in child behaviors is shown in Figures 1, 3, and 5; in Figures 2, 4, and 6, the corresponding information is depicted regarding therapist behaviors.

Figure 1 shows the development of the individual children at session 8, halfway through the treatment (T2), compared to T1. Substantial positive developments (≥+1) are identified in one or more subscales for eight children (cases 1, 2, 3, 5, 6, 7, 8, 9), and substantial negative developments (≤−1) in one or more subscales for two children (cases 4, 7). Four children (cases 2, 5, 6, 9) developed on at least two subscales substantially in a positive direction.

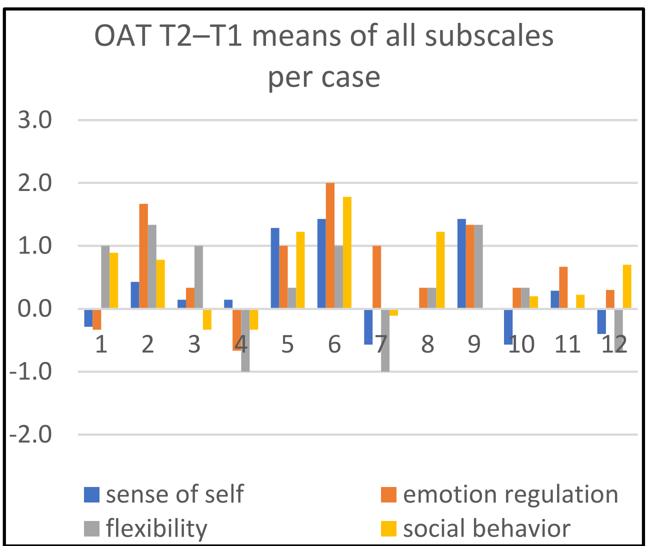

Figure 1. Means of all subscales per case, T2–T1.

In Figure 2, we see four therapists (cases 1, 5, 7, 11) being most active during the time period T1–T2 on the dimension 'emotion regulation'. Two therapists were substantially active on 'flexibility' (cases 5, 12), and one on 'social behavior' (case 9).

Figure 3 compares the OAT subscales' means between the end (T3) and the start (T1) of treatment. Inspecting all four subscales, we see substantial positive change in one or more subscales for ten children (cases 2, 3, 4, 5, 6, 7, 8, 9, 11, and 12) and substantial negative developments in one or more subscales for one child (case 7). Five children (cases 2, 5, 6, 8, and 9) developed substantially on at least two subscales in a positive direction.

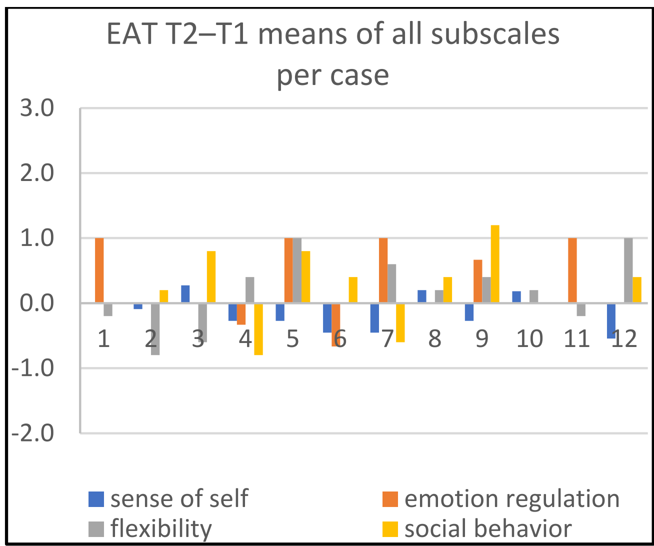

Figure 2. Means of all subscales per case, T2–T1.

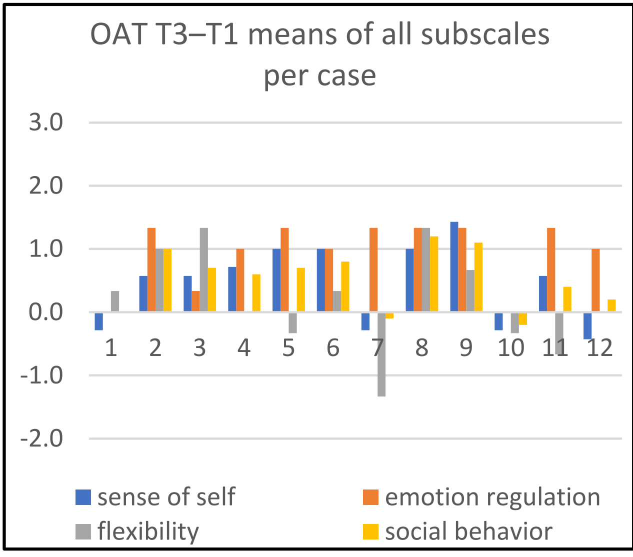

Figure 3. Means of all subscales per case, T3–T1.

The most substantial positive change can be observed on the dimension 'emotion regulation' (cases 2, 4, 5, 6, 7, 8, 9, 11, and 12). For the other three subscales, we ascertain substantial positive change in 'sense of self', 'social behavior' and 'flexibility' in four (cases 5, 6, 8, and 9), three (cases 2, 8, and 9), and again three children (cases 2, 3, and 8), respectively. For two children (cases 1 and 10), we hardly observe change, while also observing some negative tendencies.

Figures 4 and 5 show that the art therapists are most actively supportive on 'social behavior'. For the time period T1–T3, this concerns cases 8 and 9. For T1–T4, this concerns cases 1, 5, 8, 9 and 11. Additionally, for the same time period T1–T4, the art therapist was substantially active in two cases (cases 11 and 12) with respect to 'stimulating emotion regulation'.

The IOS results 15 weeks after termination of the treatment (T4) compared to T1 are graphically displayed in Figure 6. For ten children (cases 1, 2, 5, 6, 7, 8, 9, 10, 11, and 12), substantial or minor positive change is shown in one or more subscales. Substantial positive change in one or more subscales is shown for six children (cases 1, 2, 5, 7, 8, and 9); substantial negative change in one or more subscales is shown for two children (cases 4 and 7). Looking at all subscales, we ascertain substantial positive change in 'emotion regulation'

at T4 compared to T1 in five children (cases 1, 2, 5, 7, and 9). For 'sense of self', we see substantial positive change in three children (cases 5, 8, 9). Regarding 'social behavior' and 'flexibility', substantial positive development can be identified in two children (cases 1 and 8). Child 4 showed a substantial negative development in 'emotion regulation' and 'flexibility'. In addition, one child (case 7) developed substantially positive results in 'emotion regulation', and substantially negative results in 'flexibility'.

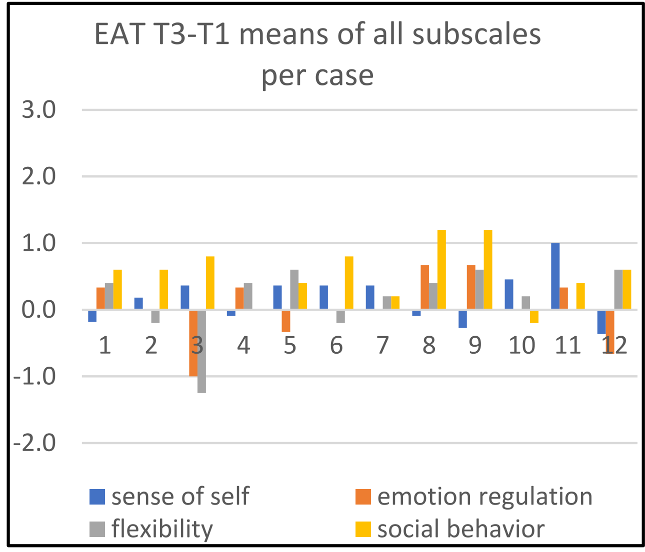

Figure 4. Means of all subscales per case, T3–T1.

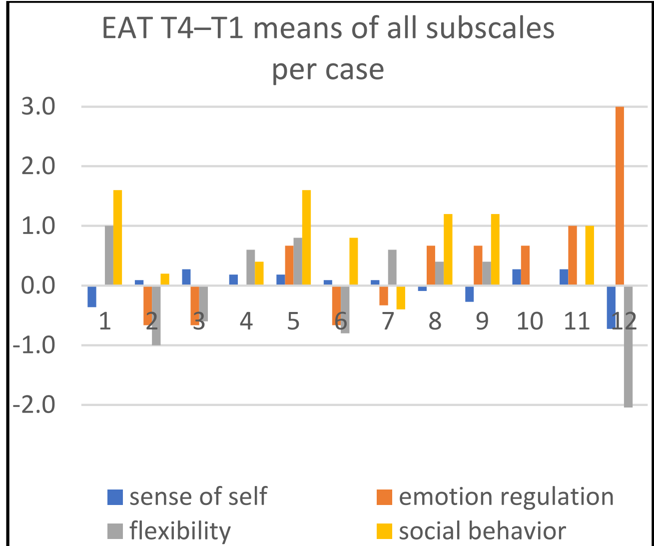

Figure 5. Means of all subscales per case, T4–T1.

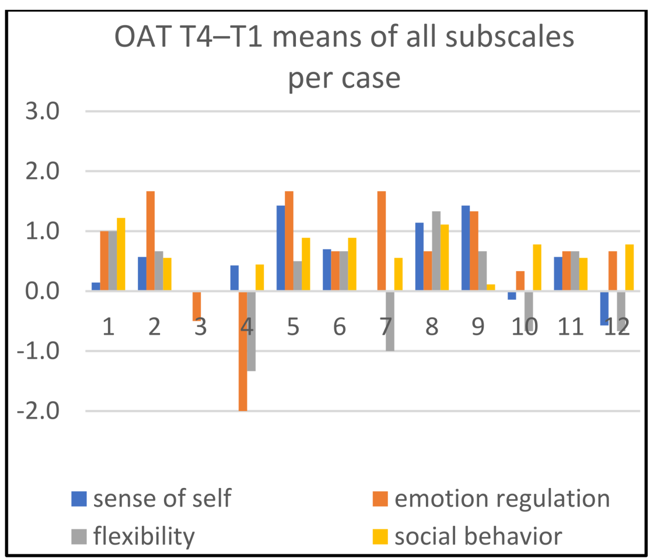

Figure 6. Means of all subscales per case, T4–T1.

3.2. Change in Children's Behavior with Respect to Therapists' Behavior

One purpose of our analysis was to explore whether childrens' behavior changed during the IOS program, and if and how this was related to the behavior of the therapist. We take a look at this question, thereby focusing on three groups of children: children who seemed to take the most (four cases) or least (one case) advantage of the treatment, and a group that did not exhibit much change (three cases).

Most profit. Substantial enduring positive change in more than one subscale is shown in Figure 5 (time period T1–T4) for four children (cases 1, 5, 8, 9). These changes appeared in varied (combinations of) behavior areas. Related to therapist's behavior mean scores, we saw in these cases that the therapist showed most actions in the 'supporting social behavior' area and hardly offered support on developing a 'sense of self'. Additionally, *during* the therapy sessions (T1–T3), most support from the therapists was directed at the 'social behavior' of these children.

Least profit. Child 4 showed relatively flat and substantial negative scores for both the time period T1–T2 (Figure 1) and the time period T1–T4 (Figure 5). The profiles (Figures 2, 4 and 6) also show a therapist who is relatively inactive in supporting the child.

Not much change. For one dyad (case 10), the profile is quite flat in all compared measurement moments; both the child's and therapist's behaviors hardly show any change. Another child (case 3) shows some change on one dimension, 'flexibility', during therapy (Figures 1 and 3), but the change is not persistent (Figure 5). In this case, the support of the therapist is at a low level of activity (Figure 2), or even substantially diminished (Figure 4). Child 12 shows some change during the time period T1–T3 in 'emotion regulation' (Figure 3); but, looking at the other comparisons of time moments, it is difficult to observe change. The art therapist is surprisingly active in supporting 'emotion regulation' at T4 compared to T1 (Figure 6), but this is not associated with positive scores for the child with respect to this behavior (Figure 5).

3.3. Group Analyses

The mean ranks of the OAT and EAT of the four measurement moments are shown in Figures 7 and 8. These two figures also make it possible to perform a visual inspection of the change in child behaviors with reference to therapist behaviors as a group.

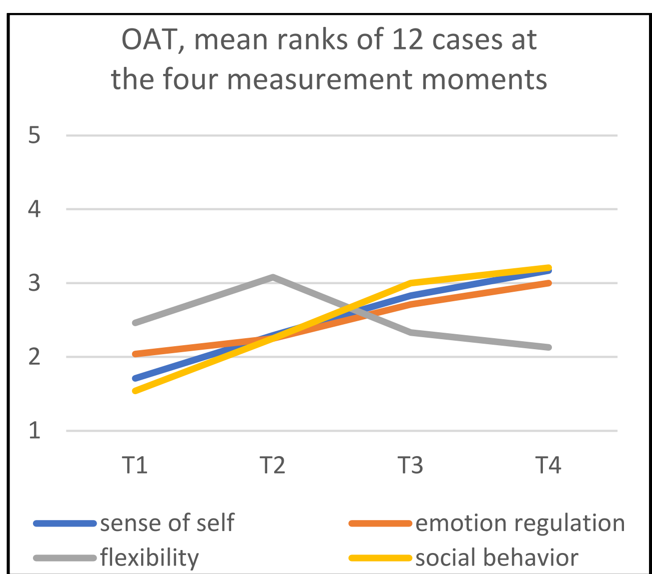

Figure 7. Mean ranks of OAT.

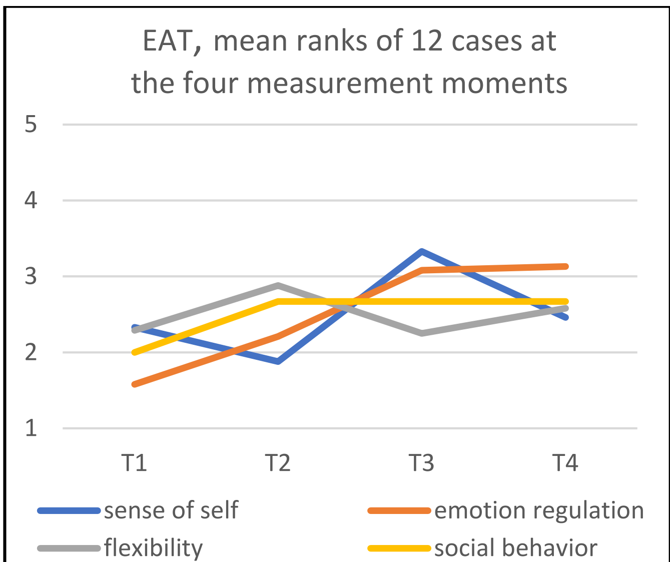

Figure 8. Mean ranks of EAT.

With respect to the development of the children, in Figure 7, it can be observed that the subscales 'sense of self', 'emotion regulation' and 'social behavior' seem to have a linear development. 'Sense of self' ($\chi^2(3) = 9.72$; $p = 0.02$) and 'social behavior' ($\chi^2(3) = 13.72$; $p = 0.004$) increase significantly, while the linear development in 'emotion regulation' is visually apparent, but statistically not significant ($\chi^2(3) = 4.70$; $p = 0.20$). 'Flexibility' shows a constant line ($\chi^2(3) = 4.32$; $p = 0.23$).

As to the behavior of the therapists, in Figure 8, it can be observed that the subscale 'stimulating emotion regulation' seems to have a linear development ($\chi^2(3) = 13.50$; $p = 0.004$). 'Supporting sense of self' also has a significant different pattern from the situation that all measurements moments are the same ($\chi^2(3) = 8.52$; $p = 0.04$). In this pattern, we observe that after a dip at T2, the subscale increased substantially at T3, but decreased again somewhat at T4. However, the mean rank at T4 is still higher than at T1. The development of 'stimulating social behavior' is partly linear; from T1 to T2, this behavior among therapists received more emphasis, which remained at T3 and T4 ($\chi^2(3) = 2.64$; $p = 0.45$). However, this pattern was not significant. 'Supporting flexibility' also shows a constant line in this figure ($\chi^2(3) = 2.21$; $p = 0.53$).

3.4. Patterns in Mean Ranks

The gradients for all four subscales—'sense of self', 'emotion regulation', 'flexibility', and 'social behavior'—show an upward development between T1 and T2 for the children as well as the therapists, except for one of the therapists' dimensions: 'supporting sense of self' (Figure 8). This indicates that halfway through the treatment, it may be expected that an 'average child' would show improvement in all subscales.

Improvement of the children's behaviors continued at T3 (end of treatment) and even at T4 (15 weeks after ending treatment), with the exception of the dimension 'flexibility'.

The gradients of the EAT scores for 'supporting sense of self' show a decrease at T2, an upward development at T3, and again a decrease at T4. Therefore, especially during the first half of the treatment sessions, the art therapists do not seem to be very active with respect to the 'sense of self' dimension.

When comparing the OAT and EAT scores at T2, a comparable pattern can be observed: an increase in mean scores for (supporting) 'sense of self', 'emotion regulation', 'flexibility', and 'social behavior'. In particular, the heightened EAT scores at T2 are remarkable; the therapists clearly seem to increase their support efforts halfway treatment on 'emotion regulation', 'flexibility', and 'social behavior'.

After treatment, only the EAT scores for 'supporting sense of self' decreased.

Regarding 'emotion regulation', the art therapists' supportive behavior appeared to be more strongly represented compared to the other three dimensions.

At the end of the treatment, the therapists' scores seemed to be higher than at the start for the subscales 'stimulating emotion regulation' and 'supporting social behavior'.

4. Discussion

In this study, the changes in behavior of children during the IOS program were explored in four dimensions, i.e., 'sense of self', 'emotion regulation', 'flexibility', and 'social behavior'. Art therapists evaluated the behavior of their young clients and their own behavior by repeatedly completing the OAT and EAT, respectively. Besides descriptive results using each instrument, we also visually explored whether and how changes in the behavior of children were associated with the behavior of therapists.

Looking at the individual children, the change in behavior represented by the subscales 'sense of self', 'emotion regulation', 'flexibility', and 'social behavior' was highly varied. It is plausible to firstly explain this variation on the basis of the diversity of problems in children diagnosed with ASD [7,43]. Despite this variation, we see that ten of the twelve children showed moderate to substantial positive behavior changes during art making considering all OAT subscales—at the end of the program and fifteen weeks after treatment termination. This confirms our expectation that the 'art therapy triangle' may offer an important contribution; the triangular relationship between the child, the art making, and the therapist seems to give opportunities to improve verbal and nonverbal communication skills [10]. In general, it has been shown that AT is a promising treatment for patients/clients who have difficulties in identifying and expressing their emotions verbally [44]. Interactions with a therapist via artistic means are indicated as being supportive for children with autism-related problems in order to improve their social communication skills [5,27].

Qualitative comments by art therapists can be helpful in better understanding cases with negative changes and those with quite a flat profile (cases 4 and 10, respectively). The art therapists reported that both children improved on most outcomes, but at the same time, they were young persons who remained dependent on a supportive environment. This is a realistic prospect for children diagnosed with ASD [45]. With respect to the child with the flat profile (case 10), the art therapist reported that she observed a development in the art making. Nevertheless, the child kept on saying: "Please explain to me what is the point about this art making?". This result may indicate that not every child with ASD may develop skills and positive behaviors during art making.

Additionally, some other patterns emerged. For the OAT subscales, the highest amount of substantial and moderate positive change in behavior was established for 'emotion

regulation': between T1 and T3 for nine children, and between T1 and T4 also for nine children, with an overlap of seven children. This result corresponds with improvement of 'emotion regulation' in 50–55% of AT treatment cases, which is in line with a recently published review [5].

In the mean ranks of scores, it is possible to observe an improvement in children's behaviors, even 15 weeks after treatment, albeit with the exception of the 'flexibility' subscale. We notice here that the results regarding children's behavior during art making differ in some respects from the observations supplied by parents and teachers at home and in the classroom; see also [19]. It may be assumed that the art therapy triangle offers other opportunities for the children's behavior and expressions during art making and for interacting with the art therapist via the art making [24,46]. Another explanation may be found in the different perspectives and situations of observation of therapists compared to teachers and parents [47].

For the 'social behavior' subscale, the moderate or substantial development of eight cases, 15 weeks after treatment, was compared to that of seven cases directly after treatment. The improvement 15 weeks after treatment may indicate an 'after effect'. Improvement of 'social behavior' in 75% of AT treatment cases is in line with a recently published review [5]. For children with ASD, improvement of 'social behavior' is often described as one of the most important AT aims [11,12,48].

The EAT 'supporting sense of self' scores showed a decrease at T2 compared to T1, an increase at T3, and again a decrease at T4. This may mean that the therapists—in line with the literature—adhere at different moments to varying intensities of actions while offering the child opportunities to learn from tactile experiences. In the literature, it has been found that art therapists presume sensory experiences to be the most supportive element for the child in developing a 'sense of self' [10–12,15,16]. Improvement of self-esteem, which is part of the 'sense of self' continuum, seems to be observed in 50–55% of the AT treatments to be observed [5].

Comparison of mean ranks of observed children's behaviors with mean ranks of therapists' behaviors hardly shows a clear relationship between the two behaviors. For instance, we saw little change in efforts in 'supporting sense of self' by therapists. An explanation might be that, according to the therapist's view, the handling and touching of art materials is the main source contributing to improvement of 'sense of self' for these children. In other words, and considering the 'art therapy triangle' and the communication difficulties of children with ASD, it might be assumed that psychological processes involved in the 'sense of self' are not directly influenced by the therapist's behavior.

The mapping of the first and second IOS phases showed a remarkable positive change in children's behaviors halfway through treatment. This might indicate that during the first eight sessions, one could already expect positive developments in some or all behavioral dimensions. Additionally, we found an increased activity of the therapists' halfway treatment on the dimensions of stimulation or supporting 'emotion regulation', 'flexibility', and 'social behavior'. It seems plausible that the therapist does not start with full effort, because at the start, it takes time to get acquainted, build a safe situation, etc. When the therapeutic relationship is more or less set, the therapist may increase efforts at T2 and invite the child to share new experiences. At T3, the therapists become again a bit less active in their support, thereby anticipating the moment at which the child needs to further develop without being supported by a therapist and should integrate his/her new experiences, skills and behaviors into daily life. This pattern reminds us of a model of promoting change in people's behavior, already conceptualized in 1947 by the psychologist Dr. Kurt Lewin in a three-step frame with the phases 'unfreezing', 'moving', and 'freezing'. The steps refer to helping someone to orient him/herself to new behavior, to (tentatively) practice it, and to stabilize it with diminishing external support, respectively [49]. Therapists might apply the model even without being professionally aware of its existence.

In their qualitative reported comments, art therapists mentioned that the clearly designed treatment program was helpful. Feedback informed treatment is supportive

for therapist's working in a child psychiatric setting [50]. This contributes to improved quality of life in children with ASD and also supports parents' expectations. Participating therapists mentioned being surprised that they did not see further change after 15 sessions, because most of them were used to applying art therapy for a period of around a year.

Evaluation moments combined with the use of videos is understood to be supportive for helpers working with ASD patients/clients [51]. Additionally, parents and others who have to communicate with ASD children (teachers) feel supported by the opportunities that video-recordings offers [52].

Our study confirms that working in the 'art therapy triangle' allows children with communication problems to develop their sense of self, emotion regulation skills and communication skills, and sometimes also flexibility.

4.1. Strengths and Limitations

This study provides new insights into the treatment process by monitoring children's and therapists' behavior with respect to the 12 cases that were part of the research. The 'Images of Self' program is—as far as we know—the first empirically studied art therapy program, specifically for children diagnosed with ASD. The intervention, with its 'built-in' monitoring system, creates opportunities to explore characteristics of the processes of change in the 'art therapeutic triangle' of child, art (making), and therapist. The program provides a manual that allows attunement to the client's needs during art making, in order to build a strong therapeutic alliance via art making.

The combination of the IOS program with the measurement instruments OAT and EAT provided a focus in the treatment for the participating art therapists. The instruments that were applied for observing the children's and therapists' behavior were intensively tested on aspects of validity and reliability [26]. The design of the study—a multiple case study with repeated measurements, with a combination of quantitative and qualitative data—allowed us to profile the child's as well as the therapist's developments in behavior, and to compare both—case by case and on the level of the whole sample—in our search for associations and patterns.

We also notice some limitations. Although we have confidence in the observation scales OAT and EAT, it cannot be denied that the study mostly leans on the perspective of professionals, i.e., the art therapists. Missing is especially the perspective of the child. While spontaneous utterances of the participating children were mapped, a child-oriented method including 'their voices' (like, for instance, by interviewing them) was lacking. This holds less true for the parents and teachers, because they were asked to report their observations at home and at school, respectively.

In addition, there are indications that therapists in some situations might overestimate their competences in therapeutic settings [53]. Contrary to this kind of 'bias', we found that participating therapists did not always report their behavior to be as active as might be expected in a therapeutic context. Especially regarding the dimension 'supporting sense of self', the level of input by the therapists was relatively low. This did not seem to be evaluated by them as a 'failure' of engagement and might argue against bias. Nevertheless, it would be profitable in further research to include neutral, trained observers in order to fill out the OAT and EAT forms—in addition to the observations by the therapists.

The design prohibits the possibility of making causal inferences. If we would like to deepen our insights regarding the question as to what in the therapeutic processes 'causes' progress with children, another type of design, i.e., a (quasi-)experimental one, would be needed [54]. This means that a sample of children receiving AT according to the IOS program would be compared to a sample that does were receiving AT, or that were receiving another treatment. Considering the necessary 'power' to make valid inferences, a bigger sample than the current one is required.

As indicated up here we found some differences between the results of this study compared to our former study [18]. This may indicate that the observed behaviors of the children during art making are different from the behaviors at home and in the classroom.

For that reason we suggest to include all relevant contexts (therapy, home, school, leisure time) in future research.

4.2. Recommendations

We recommend continuing the research on art therapy by applying the IOS program on a larger scale and carefully monitoring the results. Above, we already argued in favor of a (quasi-)experimental design to gain further insight into the effectiveness of IOS. More detailed insights into children's and therapists' behavior during AT and how these relate to each other can be gained from a larger pool of n = 1 studies with repeated measurements. In these studies, the 'voice of the child' should be included—more than was the case in the current research.

Special attention should be paid to the working mechanisms of art making as an instrument to improve specific behaviors: what exactly is the role of making art and expressing oneself in an artistic way for the child's development and behavior? A combination of narrative methods (interview, diary, focus group) and content analysis of 'art products' might be helpful in further clarifying the dynamics during AT.

In a more practical sense, we propose to improve the IOS program by gathering feedback from experienced therapists and trainees, as well as from parents or other network members like teachers. As was already indicated, the use of video-recordings, together with analyzing and discussing these afterwards, has proven to be very valuable. For that reason, we consider the instruments OAT and EAT that have been used in this study to systematically observe children's and therapists' behavior, as an integral part of the IOS program. The implication is that AT therapists using IOS should be thoroughly trained in the implementation of these instruments.

Until now, the IOS program has only been applied and studied in the context of mental health care services for children with ASD. Recently, a pilot study started to broaden the field in which IOS could be applied. An empirical study to investigate the possibilities and opportunities to apply the program in a school context, thereby studying the preventive qualities of AT for children with ASD and other psychosocial problems: is participation of vulnerable children in IOS during school hours helpful in preventing their referral to more 'heavy' psychosocial services or treatments? In addition, in what way does IOS, applied in an educational environment for teachers, support expanded possibilities for accompanying children with ASD [9].

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Appendix A

Table A1. Overview of participating children, art therapists, treatment settings, reasons for referral, use of medication, and context information [19] Reprinted/adapted with permission from Elsevier Rights and Permissions, http://s100.copyright.com/mycount/viewrightslinkorders; accessed on 6 July 2022).

Child.	Gender	Age	Art Therapist	Experience of Art Therapist (years)	Treatment Setting	Reason for Referral	Medication	Context Information
1	F	6	1	13	Ambulant mental health care organization	Not going to school at start AT. Heavy emotion regulation problems and inflexible behavior in classroom.	Vitamin B injections	After eight weeks she is part-time visiting school. Mother tells that the teacher does not understand her child.
2	F	9	2	40	(Semi)residential psychiatric center for children and youth	Social communication problems: isolated; what is she thinking/feeling?	No	Philippine background with Asian values about behavior and education. Mother has a burn-out and is in a divorce.
3	F	12	3	8	School for special education	Emotion regulation problems in classroom (crying); negative self-image; oversensitivity.	Methyl phenidate for oversensitivity	Extra psycho- education for child, to improve her understanding of ASD.
4	M	10	4	13	(Semi)residential psychiatric center for children and youth	Child shows severe depressed feelings at home. Negative self-image. Emotion regulation problems in classroom (anxiety problems and anger outbursts).	Methyl phenidate	Parent training to improve understanding of ASD.
5	F	11	5	40	School for special education	Negative self-image. Severe depressed feelings at home. Emotion regulation problems in classroom (anxiety problems). Social communication problems at home and in school (hardly talks).	No	At the end of AT she went to a lower class grade.

Table A1. *Cont.*

Child.	Gender	Age	Art Therapist	Experience of Art Therapist (years)	Treatment Setting	Reason for Referral	Medication	Context Information
6	M	9	5	40	School for special education	Negative self-image. Emotion regulation problems at home and in classroom (anxiety problems and anger outbursts).	Yes, for the anxiety and emotion regulation, but no specific information what it is.	After 10 weeks, mother severely ill. Child has problems with teacher.
7	M	10	5	40	School for special education	Negative self-image. Flexibility problems at home.	No	
8	M	12	6	20	(Semi)residential psychiatric center for children and youth	Negative self-image. Flexibility problems. Social communication problems (what is she thinking/feeling?). Anxiety problems.	No	Parent training to improve understanding of ASD.
9	M	12	6	20	(Semi)residential psychiatric center for children and youth	Negative self-image. Emotion regulation problems at home and in classroom (anger outbursts).	No	Parent training to improve understanding of ASD. Stop-think-do method is used in school.
10	M	11	1	13	Ambulant mental health care organization	Negative self-image. Emotion regulation problems at home (anger outbursts). Social communication problems (what is he thinking/feeling?).	No	Parent training to improve understanding of ASD.
11	F	11	7	9	Ambulant mental health care organization	Negative self-image. Social communication problems.	Methyl phenidate for ADHD	
12	M	12	1	13	Ambulant mental health care organization	Negative self-image. Very depressed feelings. Social communication problems (what is he thinking/feeling?).	No	Parent training to improve understanding of ASD. Divorce of parents during treatment.

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Article

Clinicians' Perceptions of Parent-Child Arts Therapy with Children with Autism Spectrum Disorders: The Milman Center Experience

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Abstract: Different types of arts offer a wide variety of modes of nonverbal communication and expressive tools for children with Autism Spectrum Disorders (ASD). The present study was designed to characterize therapists' perspectives on the implementation of a parent-child arts therapy model for children with ASD. Semi-structured interviews were conducted with 13 arts therapists who participated in the study. The thematic analysis (qualitative analysis) approach yielded seven themes: (1) Therapeutic goals. (2) Adjusting the therapeutic intervention. (3) The advantages of parent-child arts therapy. (4) Difficulties in parent-child arts therapy. (5) The unique contribution of the participants to parent-child arts therapy. (6) The different types of arts in the therapy room. (7) The arts therapists' assessment of the progress of therapy. The discussion focuses on the four central components of parent-child arts therapy room: the child in therapy, the parent, the arts therapist, and the creative arts.

Keywords: parent-child arts therapy; children; Autism Spectrum Disorders; the creative arts

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1. Introduction

Parent-child arts therapy associates the therapeutic models of parent-child psychotherapy and the creative arts therapies (which include visual art therapy, bibliotherapy, music therapy, drama therapy, psychodrama and dance and movement therapy. Each of these modalities implements its own specific art for therapeutic purposes) [1–4]. The present study describes creative arts therapies with children with Autism Spectrum Disorders (ASD) according to the parent-child psychotherapy model and is based on therapists' perspectives and clinical experience.

1.1. Parent-Child Arts Therapy

Parent-child arts therapy is becoming more prevalent, and several qualitative studies have been conducted to conceptualize the use of this type of therapy. The findings suggest that in parent-child arts therapy, spontaneous art-making allows the parent and child to express feelings, unconscious fears, desires, fantasies, and memories, thus reinforcing the bond between the parent and the child. The use of art materials expands the parents' understanding of their child and enables them to develop a more reflective awareness of life experiences [3–6].

For example, Hassid conducted a quantitative study that examined the efficiency of parent-child art therapy in a group format (composed of several dyads) as a form of nonverbal communication in 5–8-year-olds who were referred to therapy. Twenty-two children were randomly divided into two groups: 10 children and their mothers received group parent-child art therapy and 12 children received group art therapy without the presence of the mothers. The findings pointed to a trend in the children in the experimental group toward improvement in social behavior and a significant improvement in certain

measures of self-perception. There was also significant improvement in the mothers' perceptions of their relationships with their children in the experimental group, as compared to the control group that only consisted of children involved in group art therapy [7]. In a preliminary study of parent-child dance and movement therapy, Weston [8] showed that the 10 participating mothers and children showed an improvement in their relationships and in terms of their communication. The mothers improved their parenting skills, and the children improved in terms of their behavioral measures. A recent study included a qualitative examination of the subjective perceptions of mothers in group mother-child dance and movement therapy [9]. In the quantitative part of the study the participants were randomly divided into two groups: 40 children in group mother-child dance and movement therapy and 40 children in group dance and movement therapy without their mothers. The findings showed that the mother-child group made significant improvement on some of the measures in comparison to the group of children without their mothers [10]. In a group parent-child music and dance and movement therapy [11], the participants (20 dyads) noted that they felt considerable improvement in their mutual understanding in terms of their general relationship and as a result of the intervention, and that they felt less tense and calmer. Moore [12] described parent-child drama therapy with parents and their adopted children (21 dyads) and noted that at the end of the intervention, the parents reported that they experienced greater mutual understanding as well as improved communication.

1.2. Parent-Child Arts Therapy with Children with ASD

Psychotherapists who use the parent-child model when working with children with ASD have described improvement in communication and in the relationship between children and parents [13]. They also observed improvement in the children's ability to engage in symbolic play [14,15], the way the children felt that they had been understood, and in terms of support for the parents [16]. A recent study examined the comparative effectiveness of parent-child psychotherapy (Parent–Child Interaction Therapy) for teens with ASD (14 dyads) and without ASD (14 dyads). The results indicated that parent-child psychotherapy significantly improved parent-reported disruptive behavior in children with ASD at levels comparable to children without ASD. Improvements in ASD-related symptoms were also noted for teens with ASD [17].

The different types of arts offer a wide variety of modes of nonverbal communication and expressive tools for children with ASD. Clinical papers indicate that arts therapy enables children with ASD to engage in a nonverbal form of self-expression that can convey their experiences in a non-threatening way because it does not require the use of words, which is often complex for children with ASD [18]. Art-based interventions activate the senses of sight, hearing, touch and smell. In addition, art therapists use different materials with different colors and textures. These can be used as a means of sensory regulation for the child. The activities can be adapted to individual clients in a way that gives them a sense of security [19–23]. In the field of music therapy, preliminary quantitative studies have examined the significance of making music together for children with ASD. For example, a study examining the dyadic work of 10 children with ASD with their music therapist used exploratory factor analysis to show that dyadic drum playing was related to social skills [24]. Another quantitative study in music therapy examined the shared interactions between parents and their child with disabilities or developmental delays. Twenty-six parent-child dyads participated in this pretest-posttest within-subject single-group study. The parent-child dyads participated in a home-based music therapy program. The results showed that the parents' positive physical and verbal responses, as well as the children's positive verbal initiations, increased significantly pre- to post-intervention; however, the children's positive physical initiations did not increase significantly. Parent-child synchrony also improved significantly pre- to post-intervention [25].

There is scant literature on parent-child arts therapy and most publications are based on case studies or clinical presentations that suggest approaches to working with this population. This underscores the need for research in this new field.

Parent-child arts therapy with children with ASD at the Milman Center in Israel ("One of the unique features of the Milman Center is its intensive parent-child therapy program with a psycho-developmental approach, placing the parents in the center of the therapeutic process, which in turn aims to widen the range of the child's development. The therapists co-work with the parents to develop the child's motor, sensory and language skills, as well as social communication and emotional development skills. The parents are an essential element of the therapy process and receive continual supervision and emotional support from the Milman team throughout the program." Retrieved 19.11.21 from: https://www.milman-center.org.il/the-milman-center) treats children with ADS from the time of diagnosis (at approximately 18 months) until the children start school. The children go to the center twice a week for parent-child sessions with a multidisciplinary team. During each session, the children are accompanied by either their mother or their father who are seen by different professional teams. Specifically, each child receives two parent-child arts therapy sessions per week—one with father and one with mother—usually with different arts therapists. In these parent-child arts-therapy sessions, parent and child are invited to engage in various types of arts depending on the therapist's specialization. They also engage in different kinds of arts, play or verbal exchanges according to the needs of each dyad. The present study was designed to characterize the parent-child arts therapy model at the Milman Center from the perspective of the therapists and their clinical experience. It examined the therapeutic goals, the working methods and interventions, the impact and value of using different types of arts, the difficulties and challenges experienced by the clients, and the therapists' assessment of the effectiveness of this type of therapy as well as the needs of parents and children in therapy. These topics are explored below to contribute to developing an effective working model that can lead to the design of an applicable intervention method for children with ASD elsewhere.

2. Materials and Methods

2.1. Study Design

The study design was qualitative. This method draws on a phenomenological philosophical conception that aims to better understand the participants' inner experiences without making prior assumptions. Qualitative research asks interviewees to describe their experiences in an authentic way and is oriented towards maximum expression to the interviewees' views to gain a sense of their life experiences, in the context of the researched experience [26]. Specifically, this qualitative study was conducted according to the principles of the thematic analysis [27]. Thematic analysis is a method for identifying, analyzing and interpreting patterns of meanings or 'themes' in qualitative data. It is characterized by theoretical flexibility and organic processes of coding and theme development.

2.2. Participants

Thirteen arts therapists (M.A.) participated in the study (12 women and 1 man) including nine art therapists, three dance and movement therapists and one music therapist. An invitation to participate in the study was sent to all 28 arts therapists who were and are still working at the Milman Center in Haifa and Carmiel. All are trained to work according to the parent-child arts therapy model with children with ASD at the Center. When the interviews were conducted, the therapists ranged in age from 28 to 50 (M = 38.92; SD = 6.57). The therapists had work experience ranging from one year to thirteen years (M = 5.54; SD = 4.07). Specifically, at the Milman Center, this ranged from one year to thirteen years (M = 4.62; SD = 3.57). The children in therapy ranged in age from two and a half to seven years. Each arts therapist treats between three and twelve clients a year.

2.3. Data Collection

The researchers contacted the Milman Center to inquire whether the management was interested in taking part in this study. The Director of all the creatives arts therapists then informed all the arts therapists of the request, explained the goals of the study, and asked

whether they would be willing to be interviewed. All 28 arts therapists working at the Milman Center were contacted. Thirteen agreed to take part in the study. The researchers decided to interview all the arts therapists who were interested to enable as wide a range of voices as possible. The therapists who were interested in participating responded to the Director who transmitted their names and contact details to the first author. The first author then contacted these arts therapists and again explained the goals of the study. The interviews were conducted between June 2020 and December 2020 individually in-person, at locations requested by the therapists.

The interviews were based on an interview guide (See Appendix A) that allowed the therapists to express their subjective opinions based on their practical experience [28]. The arts therapists talked about their working methods, the involvement of each participant in therapy, the success or lack of success they had experienced and the reasons in their opinion for them. They expressed their viewpoints on parent-child arts therapy including the goals they wanted to achieve, the importance for the client of including arts in the intervention, the difficulties and challenges they faced, the advantages of incorporating the arts, the advantages and disadvantages of including parents in the process, and finally their perceptions of the effectiveness of this therapeutic model.

2.4. Data Analysis

The data processing and analysis of the interviews was carried out according to the six stages of thematic analysis [27]. In the first stage, the interviews were transcribed and reviewed. In the second stage, primary themes and concepts that repeatedly appeared in the data were encoded. In the third stage, central themes were generated from the codes that emerged in the data, and in the fourth stage, links were defined according to the themes. In the fifth stage, central topics were defined and labeled that allowed for a generalization of each topic. The sixth stage consisted of writing a report that succinctly described the insights drawn from the data. Table 1 illustrates the work process on the first theme.

Table 1. Analyzing the first theme according to the thematic analysis.

Theme	Sub-Theme	Sub-Sub-Theme	Examples of Quotes from the Interviews
Therapeutic goals	Mapping the need and setting the goals		"We prepare a sort of diagnostic map of capabilities and difficulties." "How the child and parent communicate, what their relationship is like, how the parent experiences and understands the child, how the parent understands what the child means . . . To understand their relationship." "They have the space to talk, and they say what they feel their child needs."
	The primary goals	Working on the relationship	"This is obvious: creating a relationship, in ASD it's always the relationship." "Working on the ability to play in a trio, not just as a pair."
		Expanding and developing the element of play	"I want to expand the element of play, because play is very, very, limited."
		Working on separation between parent and child	"We noticed that the relationship became very symbiotic. As part of the process, we tried to enable the mother to work on her own surface next to her daughter." "I go through a process of choosing colors with them . . . "

Table 1. *Cont.*

Theme	Sub-Theme	Sub-Sub-Theme	Examples of Quotes from the Interviews
		Working on sensory regulation	"I tell them . . . You can apply some paint but try not to squeeze out too much. Then they get to a stage where they know to squeeze out a little bit of paint, and not squeeze out all the paint."
		Emotional expression	"There was one client we wanted to expose to a large range of emotions. We wanted him to understand and internalize and maybe even share with us what he was feeling, so we prepared a kind of circle of emotions."

In the descriptions below, the phrase 'absolute majority' refers to 10–13 interviewees, the term 'most' refers to 8–9 interviewees and the phrase 'about half ' refers to 6–7 interviewees. When a number of interviewees is mentioned, this is done to emphasize a certain point [29].

2.5. Rigor

At the end of the data processing and analysis process, the findings were presented to the professional team at the Milman Center. At the end of the presentation, the team was asked to comment and provide their opinions, a method proposed by Hill and colleagues [29]. Their opinions were integrated into the final section of the findings.

2.6. Ethical Considerations

The interviews began after a review of the ethical considerations of the study and the signing of an informed consent form. In addition, the researcher asked for permission to mention the arts therapists in future publications. Eleven therapists agreed. The interviews lasted between 56 and 95 minutes. The interviews were recorded and transcribed for the purpose of processing and analyzing the data. They were then sent to each therapist for approval. This study was approved by the ethics committee of the Faculty of Welfare and Health at the University of Haifa (107/20).

3. Results

3.1. Therapeutic Goals

3.1.1. Mapping the Need and Setting the Goals

Most arts therapists stated that the goals of therapy are defined after mapping the personal needs of the individual clients according to their abilities and level of functioning: "We prepare a sort of diagnostic map of capabilities and difficulties." Two arts therapists emphasized the children's connection to their parents: "How the child and parent communicate, what their relationship is like, how the parent experiences and understands the child, how the parent understands what the child means . . . To understand their relationship." They also noted that this was achieved through dialogue with the parents: "They have the space to talk, and they say what they feel their child needs."

3.1.2. The Primary Goals

Working on the Relationship

The absolute majority of arts therapists stated that the main goal of therapy is working on relationships: "This is obvious: creating a relationship, in ASD it's always the relationship." Two therapists mentioned the goal of opening the relationship to a triad: "Working on the ability to play in a trio, not just as a pair."

Expanding and Developing the Element of Play

About half of the arts therapists mentioned the expansion of play: “I want to expand the element of play, because play is very, very, limited,” and developing mutual play: “Usually the main goal is to achieve mutual play, the ability to contain the other, to realize the presence of the other as a subject, not as an object.”

Working on Separateness between Parent and Child

Four arts therapists noted that alongside working on the relationship, there is also the work on separateness: “We noticed that the relationship became very symbiotic. As part of the process, we tried to enable the mother to work on her own surface next to her daughter.” Four arts therapists related to the importance of initiative and self-expression as a means of self-definition: “I go through a process of choosing colors with them ... ”

Working on Sensory Regulation

Four arts therapists related to the difficulties these children have in terms of regulation and the need to relate to these difficulties during therapy: “I tell them ... You can apply some paint but try not to squeeze out too much. Then they get to a stage where they know to squeeze out a little bit of paint, and not squeeze out all the paint.”

Emotional Expression

Three arts therapists related to the possibility of developing emotional expression during the therapeutic session: “There was one client we wanted to expose to a large range of emotions. We wanted him to understand and internalize and maybe even share with us what he was feeling, so we prepared a kind of circle of emotions.”

3.2. Adjusting the Therapeutic Intervention

3.2.1. Adjusting the Room and Setting

Most arts therapists stated that they prepare basic and accessible materials, games or musical instruments: “Usually there are a few materials that I prepare ahead of time: markers, sometimes watercolors. There are also games or musical instruments present.” About half the arts therapists noted that they devote the first sessions to observing the children and learning what interests them: “In the first sessions my goal, and I share this with the parents, is to observe the child, watch where s/he goes, what s/he looks for, what s/he likes and what elicits his/her curiosity.” The absolute majority of arts therapists remarked that after they became familiar with the dyad, they offered materials or interventions according to the goals of therapy: “I think that later it depends entirely on the therapeutic theme that I implement with this child.” Four arts therapists mentioned that they use augmentative and alternative communication symbols to illustrate an activity, the materials or the emotions: “Near the table there is a board with basic pictures, first of emotions ... There is a folder with pictures of all the activities in the room ... ”

3.2.2. Structure of the Session

Most arts therapists reported that the beginning and the end of the sessions are structured: “This framework is important, it has a relatively standard start, and a kind of closure”, but the main part of the session is more open, and the child is free to choose the activities and the materials: “In my room there is a closet that is left ajar so you can see what’s inside ... Then they can actually take things out or ask for them.” Five arts therapists indicated explicitly that they let the children orient the course of the session. The arts therapist and the parent are there with them, based on the premise that where they feel good is where they will feel motivated: “To see where the children go and try to be there with them, understanding that when these children are motivated there is a much better chance for communication.”

3.2.3. Intensive Intervention of the Arts Therapist

All the arts therapists remarked that they were active participants in the parent-child arts therapy process for children with ASD: "In parent-child arts therapy with these children I am definitely a very active participant." They do so mostly to encourage the parents to be active in the therapeutic sessions and especially when the parent is experiencing difficulties: "Often when the parent . . . lacks energy or sits in the corner or doesn't know what to do, I take the role of the parent and demonstrate how it should work," or in order to connect with the children's experience: "I try to personally experience their movements. I often invite the parent to try too."

3.2.4. Understanding and Mirroring the Meaningful Content That Emerges in Parent-Child Arts Therapy

All the arts therapists remarked that they help in mirroring and conceptualizing the emotions of the members of the dyad: "I try to mirror things that everyone does or things that I believe they are thinking or feeling" even if this involves mirroring the child's emotions for him/herself: "One day a child suddenly realized that his mother was not there, that she had left and he was astonished, and I tried to mirror to him what he was feeling, that he might be a little apprehensive that his mother had left, that she was not here in the room," or mirroring the parent's behavior to the child: "When the father doesn't want to do something, I can say: 'Well it seems that daddy is not so interested in playing this game, he is bored.'" About half of the arts therapists noted that one of their responsibilities is to understand the content expressed when the child plays: "In a memory game a lot of things surface where you can learn about the child, the parent and the relationships," or from the child's repetitive speech: "When I discovered it and the parents saw it with me . . . He is not just repeating what he had just heard like a formula; he really wants to say something about himself, there is a deeper and more interesting thought process there . . . "

3.2.5. When Parent-Child Arts Therapy Is Not Appropriate

Five arts therapists addressed the issue of situations in which parent-child arts therapy may not be appropriate. They described cases where the relationship is very complex and does not allow for growth: "There are cases where the dyad . . . itself is so complex and has all sorts of problematic aspects, that it does not leave room for growth." They mentioned cases where the parent did not attend sessions regularly or behaved in ways that were counterproductive for the child: "Sometimes there is unsuitable language, inappropriate attitudes, taking control of the therapy, sometimes actually sabotaging therapy."

3.3. The Advantages of Parent-Child Arts Therapy

3.3.1. The Benefits of Parent-Child Arts Therapy Specifically for Children with ASD and Their Parents

Most arts therapists related directly to the relationship between parent-child arts therapy and children with ASD: "I believe that for young children, it's parent-child psychotherapy, so definitely for children with ASD." They argued that for children with ASD, attending therapy with their parents can pave the way to including other people later on in life: "For lower functioning children . . . I feel that the parents are sometimes really the key. They are definitely the most significant figures in the child's life and at this time these children cannot include another figure."

3.3.2. Understanding the Child through the Mutual Learning of the Parent and the Therapist

Most arts therapists indicated that they learn about the children by watching their interactions with the parent: "There was something much richer . . . in my ability to understand the child when I see him through his interaction with his parent." They described how the parents help them by interpreting and explaining what the child is doing, which makes it easier for them to understand the child better: "When the parent is there, s/he

helps you understand the child, explains things . . . and it makes it easier for me to get to know the child."

3.3.3. Strengthening the Connection between the Dyad Members and Broadening the Support Circle

All the arts therapists mentioned the importance of working together with the parents due to the dependence of the young child on the relationship with them: "Parental presence . . . because the parent is naturally, especially in the early years, such a central figure." The arts therapists noted that since the parents participate fully in the therapeutic process, they feel they make a significant contribution: "I give them space to express their opinions and to feel significant in the thinking process." The parents learn to accept the children with their difficulties: "It can help parents feel closer to their children, love them more, accept them more." Most arts therapists remarked that in parent-child arts therapy, where the parent plays an active role in the process, the effect of therapy is broadened beyond the session itself: "They can take away many tips from what we did in the room and continue to use them in their daily lives at home, in kindergarten," and the parent helps the child make the connection between therapy and daily life: "When parents become part of the therapy . . . the children suddenly grasp that there is a connection between the world when they are in kindergarten and the world when they are at home." Arts therapy also helps the parent find solutions to difficult situations: "For my part, I encourage thinking—why is he doing this . . . to understand that maybe, if you understand why, you can help."

3.4. Difficulties in Parent-Child Arts Therapy

3.4.1. The Difficulty in Adapting the Model to This Population

Five arts therapists described the difficulties involved in applying parent-child arts therapy to children with ASD: "The issue of a parent of a child with ASD, the way you work with them, that is the focus. The parent-child arts therapy changes drastically." Most of the difficulties described occurred in the first year of therapy in terms of level of knowledge: "I laugh because after being there for a whole year I am only now beginning to understand a little bit . . . ", and from the feeling of being overwhelmed: "You know, it was just going in that was so overwhelming, it was like a new world, both the ASD and the parent-child arts therapy."

3.4.2. The Feeling of Failure and Self-Criticism

All the arts therapists described their experiences of failure when they felt that therapy did not progress: "If you just play, I feel . . . well, I don't know, well . . . you know . . . a little redundant. Wait a moment, what am I? A therapist or just there?" Most arts therapists used the word "boredom" and sometimes even harsher words to describe their difficulties in therapy: "It is really this huge emptiness and the boredom . . . and sort of death, of . . . there is nothing here." These hard feelings were connected to repetitiveness, which raised many questions: "Children with ASD often engage in play that is repetitive and empty . . . what does it mean for the child? And what is therapeutic here?" Four arts therapists described specific dyads where they felt redundant and even a burden: "I felt I was incapable, that I don't know how to be a therapist, that I am not interesting, I am not funny . . . I felt I was ineffectual in this dyad." Five arts therapists indicated their difficulties especially during their early years, when the presence of another adult in the room caused their levels of self-criticism to soar: "I think that first of all there is another adult who watches you work in the room, and it takes you right away to a place . . . of kind of self-criticism. How did I do, how was my work, how does s/he see me?"

3.4.3. Frustration and Difficulties in Instances of Lack of Cooperation and Connection between Members of the Dyad and the Therapist

Most arts therapists addressed their feelings of frustration when they fail to motivate the parent to take an active part in the therapy: "There are also families who are more challenging... Their engagement requires us to invest much more energy in therapy and it

also often frustrates us." Five arts therapists mentioned their difficulties and feelings that they had not been able to connect with the child: "Especially in communication disabilities... You feel the difficulty of therapy or the relationship... You have been treating the child for so long and you do not feel that there is a therapeutic alliance."

3.4.4. Anger and Frustration at Difficulties in Child-Parent Communication

Most arts therapists noted a feeling of frustration when difficulties arise in the quality of communication between the parent and the child: "The mother ... read a story to her child and she ... didn't really read ... my heart was torn a little ... It seemed to me that the communication between them was flawed, and it was difficult for me." In these cases, the therapists were torn between the parent and the child and felt anger: "A lot of times I feel torn between the two of them, I see the distress of the daughter, and I want the mother to see it too ... Sometimes I feel that I get a little angry at the mother ... " Three arts therapists remarked that in spite of their difficulties, they tried to understand the parents: "I have to always remember to see both the child and the parent and understand their very sensitive and difficult place, in order to be there with it."

3.4.5. Difficulties with Parents' Criticism

About half of the arts therapists described their difficulties with criticism from the parents on a personal level or in relation to the arts therapy profession: "The principal asked me something about the therapy ... she said: 'Because the mother said that she doesn't quite understand what goes on in your room,' something like that." Four arts therapists mentioned insulting comments they received from parents during therapy: "And then he comes out and tells me 'What was that ... Today was really boring' ... I felt like it was a kind of a slap in the face." On the other hand, two therapists related to this issue and thought that it was possibly caused by arts therapists' difficulties explaining the basis of their therapy: "Most of us find it really difficult to explain ... To conceptualize our therapy. It works, but it is difficult for us to make it clear and put the parents' minds at ease."

3.4.6. Difficulty in Accepting That There Is Not Much Use of the Arts in the Therapy

About half of the arts therapists described the disappointment they felt when they realized that the arts are not always used during the intervention in parent-child arts therapy: "It was a real crisis for me in the beginning, I thought that, look, I am an arts therapist and therapy should be with materials only ... But you see that some children and sometimes even parents don't relate to it ... "

3.5. The Unique Contribution of The Participants to Parent-Child Arts Therapy

3.5.1. The Children's Role in Therapy

Most arts therapists remarked that the participation of these children depends on their level of functioning: "I worked with very low functioning children and it was very difficult to get a reaction from them. I also worked with high functioning children who would come into the room and immediately initiate play together." Most of them noted that in order to feel secure, children will often turn first to a familiar activity: "The children go to a game they know, something they are used to doing." Most arts therapists noted that in parent-child arts therapy, the children express their needs to the parent: "Children's play is often their way to tell the parent what preoccupies them, what they would like to change, what they want from the parent." The arts therapists stated that during parent-child arts therapy sessions the child and the parent share an experience, even though sometimes it can be less than pleasant: "Her communication with him was through very basic games ... At first, he would indicate that it was a little too much for him ... but little by little, this was their way to communicate." This is how the child learns to adapt to the parent. The therapists remarked that the children benefit from the parents' presence as they continue to live their lives with the parent outside the arts therapy room: "This is the most important thing because in the end, they go home with the child and their interactions with the child

continue throughout the day." Most arts therapists mentioned that the bond between parent and child becomes stronger and more secure through the process of learning, and through the child's ability to express him/herself: "The bond between parent and child becomes much stronger and more secure."

3.5.2. The Parents' Role in Therapy

Most arts therapists noted the parents' difficulties coping with their child's disability: "For a parent it is unbearable, the parent comes into the room and sees the autism and sees this repetitiveness, the rigidity and the fact that nothing changes." Most arts therapists described how during the encounter with the parents, the need for professional mediation becomes clear: "Parenting a child with special needs, especially with ASD, does not come naturally, it requires a learning process, and it often needs this professional mediation." Most arts therapists said they understood the parents' difficulties in attending therapy at the Milman Center in terms of scheduling: "It's once a week and she comes for four hours. It's a lot", and in terms of coping: "You need to go on taking care of the child and watch him/her with the other children, and cope with the behavior patterns that may be unanticipated and not easy", and from an emotional standpoint: "It's so easy to feel criticized, so easy to feel I am not doing the right thing as a parent who comes to parent-child arts therapy." Most arts therapists were able to relate to the parents' difficulties in taking part in therapy: "For some of the parents it is hard to be in a room with another adult who can see their relationship very closely; they feel exposed and it's not simple." Some of them prefer to sit on the side and watch or detach themselves by using their phone: "There is one mother who often says: 'No, I will sit on the side, I will watch and learn as an observer' when asked to play" Sometimes parents struggle to deal with the mess in the arts therapy room: "I gave him gouache and told her that . . . I prepared her of course, that it will be messy and to be ready for it," and coping with the boredom of the repetitive play of the child: "The father sometimes tries to encourage the child to play different games." Four therapists remarked that with time, most parents learn to become more playful: "Little by little, they understand what we do here and how you do it and they can become more playful."

All the arts therapists said that in parent-child arts therapy, the parents discovered new aspects of the child's character and the child's new abilities: "The mother said: 'Wow this is new, this is the first time he has shared his drawing with me.'" The parent learns to understand and accept the child: "Because the parent goes through a process and participates in so many therapy sessions and learns to accept the child more and to understand him/her better . . . everybody benefits," and simply to love him/her: "It's very significant for parents to be able to connect and to love their child the way they are . . . Because it is not self-evident, especially when children have difficulties communicating."

3.5.3. The Arts Therapists' Role in Therapy

All the arts therapists related to their need to understand the dyad and how to approach it in a way that can provide an appropriate response: "One moment, I see something good is happening between them so I back off, or one moment I have something good going with the child so I tell the mother go in this direction, you try it." About half the therapists talked about how important it is to find their most beneficial place in relation to the child: "I now try to find how I can be with him, so that I feel him and he feels me and we play together and relate to each other even when he turns his back to me . . . so it will have meaning," but in a way that the parent will not feel threatened: "With some parents I feel the need . . . to keep my distance more, that they might feel threatened maybe . . . if I get too close . . . and there are parents who I feel allow me from the very beginning to be very actively involved."

Most arts therapists mentioned that they focus on forming a better connection between members of the dyad. They use modeling to do so: "I actually tried to show her how I play with him, how I am with him in terms of what he wants." Four arts therapists noted that at

the beginning of the relationship, they concentrated on forming an initial connection with the children: "In the initial stages I . . . would focus more on the child than on the parent, to form an initial acquaintance . . . " whereas two other therapists thought that the first bond should be with the parent: "I think that the initial bond with the parent is even more important than connecting first with the child." Most arts therapists remarked that their role is to support the parents: "The process that happened there . . . to help her understand that it is not because she is not good, but rather take a moment to look at the strengths." Four arts therapists stressed that the parents must be respected and parental authority acknowledged while maintaining parental competency: "This issue of recognizing parental authority . . . they are the experts when it comes to their child and I try to understand what they know and understand . . . " Three arts therapists indicated that they encourage the parents to share their difficulties: "Talk about it, about the difficulty . . . Encourage the mother to express interest . . . To contain the difficulty, to validate what emerges in this dyad."

3.6. The Different Types of Arts in the Therapy Room

3.6.1. Methods of Integrating the Arts into Therapy

Most arts therapists mentioned that they would like to find ways to integrate the arts into the therapeutic sessions. Dance and movement therapists noted it was easy for them to integrate their modality because movement is always present: "The advantage is that it is really there all the time . . . It can happen the minute you start throwing a ball or lying on a mattress." These therapists attempt to explore these children's movements and learn about their emotional state: "To try to understand his movements, what his body is telling me about the emotional experience." The art therapists described how they get acquainted with these children by exposing them to the art materials. In the beginning, they only use a few materials to avoid overwhelming the child: "Naturally, in the beginning, a little bit, just to see if the child is not overwhelmed with what s/he sees." They suggested that contact with art materials is part of self-understanding: "A possibility to investigate the body interacting and touching various things. It is another opportunity for the children to get to know themselves." In music therapy, special effort was needed to integrate music into therapy: "With music . . . I felt that they were less open to it, that I was the one who introduced it and it was less their initiative," and the different ways to include it: "Sometimes I would play something during a session and then I can attach a soundtrack to their dynamics. If, say, they start to fight, then suddenly the music is noisier and angrier." Here too movement is integrated into the session: "Sometimes I strike a gong and then everyone freezes into some sort of sculpture."

Arts therapists in all modalities remarked that not all the children like the arts: "You can see that there are children who don't relate to it." Some recoil from contact with the art materials: "Some children recoil when they come into contact with gouache and with certain textures of art materials". Three arts therapists described children who engage in artmaking, but only for brief intervals: "But it is . . . you know, it's three minutes . . . that's it". One of them believes that it generates anxiety: "I felt that it creates anxiety. There is an expectation for an outcome." The therapists described how engaging in play can sometimes create an opportunity to work with the arts: "He played with animals and dipped them in paint and made a footprint . . . After a long period of not using art materials . . . Afterwards he continued creating with gouache, finger paints and glitter." Six arts therapists noted that they do not always work in their modality but rather a different modality that the child relates to more.

3.6.2. The Strengths of the Arts

All arts therapists described arts as an alternative language: "It's a way to discover the rich world around us, that sometimes children with ASD kind of avoid touching," that enables the creation of a playful space: "It involves creating something that is very playful, with art materials." It also encourages closeness between the child and the therapist: "I feel

that I can be part of these movements and it will connect us." The arts therapists specified that arts make it possible to work on the issue of control: "It's possible to play with themes of control through music . . . 'now you play loudly and now softly'," by regulating and channeling violence: "We can channel the violence to other materials rather than to the mother." The arts therapists noted that working with the arts helps the parent share and connect to the experience of the child: "I see great importance in inviting the parent to draw near the child . . . This way the parents can relate to their children's feelings when they draw."

3.7. The Arts Therapists' Assessment of the Progress of Therapy

3.7.1. Progress in the Child's Expressive Ability

Three arts therapists noted specific improvement in language abilities as a result of the therapeutic process: "It is really a long process . . . Suddenly there were words in the room." Five arts therapists described an improvement in the verbal expression of emotions: " . . . There are still outbursts sometimes but little by little they subsided, little by little he would say I need a moment in the corner to calm down. He was able to verbalize it." The same was true for expressing a desire: "This is something new that I didn't see before . . . This ability to express wanting to play with only one person."

3.7.2. Progress in Terms of the Parents' Acceptance of and Adaptation to the Child

Five arts therapists highlighted the importance of the changes experienced by the parents: "The ability of the parent to change, the willingness to attend and to deal with all this complex content, I think that is the most significant part." They also mentioned its influence on the child's acceptance and progress: "A very big change when he could make space for the violence and participate in the game . . . the child experiences that the father accepts him and wants to be with him . . . The child felt that he had legitimacy and that he is much more accepted."

3.7.3. Progress in the Ability to Be in a Relationship

All the arts therapists related to the change and progress in the relationship among the members of the dyad as observed through the changes in the children's behavior: "It's a process of a full year . . . to show this initiative, to spread the fabric and create some space for himself . . . and then little by little he invited the father and, in the end, invited me too," and in the parents: "A very significant component was that the father simply joined in the game and allowed himself to let go of something that was very suppressed or to experience something new for himself." Most arts therapists related to changes in the structure of play that develops into broadening the communication circles until finally the desire to play with other children develops: "Now when I see him during recess, he says: 'Would you like to play with me? Would you like to ride with me in the car? Let's drive, I can push you in the car.'"

4. Discussion

The present study described parent-child arts therapy from the point of view of experienced arts therapists who work according to this model at the Milman Center. The discussion focuses on the four central components present in the parent-child arts therapy room: the child in therapy, the parent, the arts therapist, and the creative arts.

The arts therapists described the child with ASD as the focus of parent-child arts therapy. The goal of therapy was determined by the therapists by assessing these children's levels of functioning and their ability to be in a relationship. The arts therapists described the primary goals that first and foremost included working on the relationship between the child and the parent, in addition to other facets aimed at improving the quality of life of the child, such as expanding play and its development, working on separateness between parent and child, sensory regulation and emotional expression. Contact and communication emerged as the core of this parent-child arts therapy model. In other studies, as well and

with other populations [4], arts therapists who used this model reported that they focused on the relationship between the child and the parent as a source and a starting point for creating change. This approach is even more pertinent with children with ASD whose major difficulty is related to relationships and communication [30]. Similar to articles that have described clinical work in the field of arts therapy with children with ASD [22,31], here too the arts therapists described how the children learn to express themselves and learn more ways to relate to the outside world. The presence of the parent allows for a broader understanding of the child and working together expands the child's circles of communication for dyadic work and occasionally for triadic therapeutic work.

Most arts therapists related to the parents' difficulties in coping with the child's disability and vulnerability. These difficulties can manifest in different ways when the parents feel guilty and criticized or overwhelmed with emotional issues including depression. Some parents find it hard to cooperate and some find it difficult to establish contact with the child. Note that many parents contact the Milman Center shortly after the primary diagnosis when they are still processing it [21,32]. Regev and Snir [3] indicated that when a child is in distress, parents may feel that their parental competency is being tested. On the one hand, the parents are worried about the child, and on the other, the parents may feel overwhelmed with feelings of guilt and failure. In addition, most interviewees noted the parents' difficulty, as they saw it, in taking an active part in therapy and sometimes in understanding its meaning. These findings correspond to results from other studies where parents described their initial difficulties in dealing with the artistic medium, which is less familiar and accessible to them. This caused them to feel awkward when using the art materials and engage in self-criticism, which required a change in thinking patterns on the part of the parent [9,33]. Nevertheless, some arts therapists related to the parents' needs for intensive professional guidance and reported a shift that occurred in terms of parental participation as therapy progressed. This change relates to different aspects of parenting, but also to opportunities to become more playful and involved. Studies with a longitudinal design on parent-child psychotherapy with mothers and their children with ASD clearly point to the development of positive mutual emotions between the mother and the child that lead to improvement in self-regulation [34] and reduced disruptive behavior, while enhancing communication skills over the course of several sessions. Researchers have noted that the progress persisted even after a longer period of time [35,36].

All the arts therapists related to their need to find the best position for them within the dyad. This can be determined by understanding the needs of the dyad. The arts therapists discussed the changes they needed to make as a function of the interactions in the arts therapy room and their efforts to find the best way to involve parents in therapy. Kaplan and colleagues [37] emphasized the importance of finding the most beneficial position for the therapist in relationship to the dyad at all points in time. This underscores the need for therapists to understand the parental experience and adapt their position and interventions to the members of the dyad at all times [6,33,38]. The arts therapists noted that their relationships with the parents help them gain a fuller understanding of the child in therapy. Together with the parents, they can try to understand the cause and meaning of a particular behavior. In addition, all the interviewees noted that their role also involves mirroring and conceptualizing the emotions that emerge during therapy. Most arts therapists noted that they engage in the process of modeling they think is the most suitable for each child. This, according to them, can help the child be more completely understood, contained, and secure. The findings showed that most arts therapists believe that providing support to the parents and recognizing their authority is part of their role, as well as including the parents in the process, and encouraging them to find solutions. Similarly, several authors in the field of parent-child arts therapy have stated that the therapist should suspend judgmental attitudes and make an effort to understand the difficulties the parents face [3,21] by serving as a "good grandmother" [39]. The arts therapists noted their own complex feelings of failure, boredom, emptiness, and anger that arise during therapy along with feelings of

self-criticism, which are often engendered by the presence of another adult in the arts therapy room.

Most arts therapists stated that they would like to find a way to integrate the arts into the therapy session, but about half noted that some children do not always want to engage in arts modalities. Most arts therapists indicated that in order to feel secure, children will usually turn to a familiar activity, and many prefer to play rather than do artmaking. Some arts therapists mentioned that it is important to understand the sensory profile of each child and that some children recoil from touching or handling the art materials. A few arts therapists discussed these children's difficulty regulating their emotions, and one therapist suggested that even the thought of artmaking might cause a child to feel anxious. However, a few arts therapists described the act of playing as a way for these children to become familiar with the world of arts. Malchiodi [40] and Martin [21] related to the wealth and abundance of art materials and instruments that impact all the senses, but that can also be an emotional overwhelming experience for children with ASD. Dunn [41], an occupational therapist, found that children with ASD have different patterns of sensory processing. They may absorb sensual stimuli at an extremely slow pace, perhaps not even notice the stimulus, or alternatively, they may react very intensely and be unregulated. In this situation, some children will develop a strategy of avoiding engaging with their senses to facilitate their self-regulation. This has led several authors [21,40,41] to note the importance of planning the therapeutic space and finding the right balance between the different stimuli so that the child can remain in the arts therapy room and benefit from the session.

Limitations and Suggestions for Further Research

This study has several limitations. It was based on the perception of arts therapists who work at the Milman Center using the parent-child arts therapy approach. It was therefore written from their point of view without exploring the points of view of the parents or children with respect to the content that emerged in therapy or its effects on them. In addition, due to the limited number of arts therapists working at the Milman Center, all types of modalities were examined together as a whole, which presents a problem when attempting to characterize a specific type of arts therapy. Future research could develop this topic by investigating the parents' experiences during the process or exploring each modality in more detail. Finally, a longitudinal study could examine the effectiveness of parent-child arts therapy with this population post-therapy.

5. Conclusions

The field of parent-child psychotherapy has made considerable progress in recent decades. Arts therapists have also begun to adopt this therapeutic approach, which combines work with children and their parents as illustrated at the Milman Center, where arts therapists work with children with ASD and their parents. The present study was designed to map this process. The findings suggest that according to the arts therapists, integration of the arts can contribute to the parent-child relationship but needs to take the sensory profile and individual characteristics of each client into account.

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Conflicts of Interest: The authors declare no conflict of interest.

Appendix A. Interview Guide

Age
Gender
General experience as an art therapist
Seniority as an arts therapist at "Milman"
Modality
On average, how many children do you work with in "Milman" each year?
What is the age range of the children you work with?
1. Describe the course of one therapy session with a child and his/her parent in your modality. How does the child take part? The parent? How would you define your role?
2. What was the goal of this session? What goals do you set for parent-child arts therapy with children with ASD?
3. Is there a standard way of conducting a therapy session? What interventions typically characterize your work in parent-child arts therapy with children with ASD?
4. In your opinion, which interventions are more successful and which are less successful? What causes failures?
5. Describe how you incorporate your art during the session. Is your modality suitable for all children with ASD? Is it more suitable for some than others?
6. Give examples of a process of change or overcoming a difficulty with clients.
7. What are the challenges of working with this population in parent-child arts therapy? Give an example.
8. How does the parent's participation affect the therapeutic process?
9. What are the advantages and disadvantages of incorporating the arts in parent-child arts therapy?
10. What do you think helps the child the most in parent-child arts therapy? And what helps parents?
11. In conclusion, based on your experience, would you recommend parent-child arts therapy for children with ASD? Why?

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Brief Report

Parents' Views with Music Therapy in the Pediatric Intensive Care Unit: A Retrospective Cohort Study

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Abstract: Purpose: Music therapy intervention (MT) could be used as an adjunctive therapy in PICU for anxiety and pain management. The aim of the study was to examine the perception of MT by children's parents in a PICU of a tertiary care teaching hospital. Methods: This is a retrospective cohort study summarizing the results of an institutional quality improvement initiative. Questionnaires were distributed to parents whose children were exposed to MT. Results: From April 2019 to July 2021, 263 patients received a total of 603 h of MT. Twenty-five questionnaires were distributed to parents over a 4-month period (February–June 2021). A total of 19 (76%) parents completed the questionnaire. The majority of parents thought that MT helped their child to communicate (89%), feel less isolated (100%) and cope with stress during hospitalization (100%). The majority of parents also thought that MT contributed to physical recovery (90%) and alleviated feelings of anxiety (90%). Parents also believed that MT should be offered as an out-patient service. Conclusions: Our study agrees with other studies on the positive potentials of MT in PICU. Music therapy intervention could be used to promote children's and parents' psychological well-being. Further studies are warranted to evaluate the impact of MT on long-term post-ICU outcomes.

Keywords: music; PICU; anxiety; quality improvement; questionnaires

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1. Introduction

The main goal of the use of music in intensive care units (ICU) is to reduce anxiety and pain [1]. Music in ICU has been shown to reduce respiratory rate, blood pressure and heart rate [2]. Music interventions are also associated with decreased pain, sedation and post-traumatic stress disorder in children operated on for congenital heart disease [3].

According to the American Music Therapy Association, music therapy intervention (MT) is "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who completed and approved music therapy program" (available online: https://www.musictherapy.org/about/musictherapy/ (accessed on 14 June 2022)). Music therapy intervention has the potential to alleviate pain, promote physical rehabilitation and help manage stress. Its use is recommended by the Society of Critical Care Medicine in both pediatric and adult ICU [4,5]. The use of MT in neonatal ICUs also suggests that MT is feasible and might have a positive impact on premature children. Little has been reported about the effect of MT in the pediatric ICU (PICU) setting and especially how parents respond to MT [6–9]. Therefore, the aim of this study was to describe the perception of MT by parents of children who were exposed to MT in PICU.

2. Methods

This quality improvement initiative was supported by the Foundation Alta Mane. It was implemented in April 2019 in a tertiary 12-bed PICU at the Geneva Children's Hospital, Switzerland, and is still running as of today. As a retrospective study on a quality improvement project, and in agreement with institutional policy, this study was exempt from ethics committee review. Nonetheless, parents' oral consent was required for participation in the study.

We aimed to evaluate the perception of such an initiative by the parents of a sample of children admitted to our unit. An evaluation of the program was performed by means of two five-point Likert scale questionnaires. The questionnaires were designed and created by the authors to collect views from parents whose children received music intervention in the PICU. This questionnaire was adapted from Moss et al. [10,11], but without previous validation. It was addressed to parents whose children were exposed to MT throughout a five-month survey period (February–June 2021, Supplementary Material). Only patients who were fully responsive and not receiving sedation were exposed to MT. A personalized approach to MT was used whenever possible. In order to avoid possible MT side effects (e.g., anxiety, overstimulation and unwanted memory triggering), MT was tailored to the patients' needs and constantly adapted to the child's responses to music and sound. Two versions of the questionnaire (French and English translation) were given to parents. Participants were encouraged to add comments and suggestions at the end of each questionnaire.

Hospitalized patients participated in personalized MT with a certified music therapist (HC). The therapist was present 4 days per week, for a total of 15 h per week. Music therapy interventions were provided at the bedside in each patient's room. The duration of sessions varied between 25 and 60 min based on the patient's needs, preferences and clinical conditions. Parent's and child's direct participation are considered key components of MT in our PICU, and were encouraged whenever possible. No psychotherapy was offered during MT. Several different instruments were used during MT sessions (kalimba, rain stick, guitar, ukulele, metallophone, small djembe and other percussions).

Descriptive analyses were performed by VLC and AP, using Microsoft Excel 2013 (Microsoft Corporation, Redmond, WA, USA). As our study is solely descriptive, no statistical comparisons were performed.

3. Results

During the study period, 263 patients received a total of 603 h of interventions. The main primary diagnoses were represented by congenital heart diseases (155 patients, 59%), respiratory diseases (42 patients, 16%), central nervous system diseases (24 patients, 9%), post-surgical interventions (16 patients, 6%) and solid organ transplantations (8 patients, 3%).

Parents' views on MT were studied over a 4-month period (February–June 2021); a total of 25 questionnaires were handed over to the parents of PICU patients whose mean age was 7 years (SD+/ −6). The number of sessions per patient was 1 to 2, 2 to 4 or ≥5 in 50%, 39% and 11% of patients, respectively.

One parent per patient answered the questionnaire, with a response rate of 76% (19/25). The results from the parents' questionnaires are summarized in Figure 1. The main reasons for PICU admissions of children whose parents responded to the questionnaire were congenital heart diseases (3/19), central nervous system diseases (3/19), liver insufficiency (3/19) and respiratory insufficiency (3/19). All parents thought that MT was beneficial for their child. Specific benefits of MT, as stated by parents, included helping to communicate (89%), feel less isolated (100%) and cope with being in hospital (100%). Overall, 100% parents felt that their child was respected and supported in MT. The majority of parents also thought that MT contributed to physical recovery (90%) and alleviated feelings of anxiety (90%). Of the parents surveyed, 63% thought that MT facilitated communication with the PICU team. The majority of parents (93%) also believed that MT should be offered as an out-patient service. A few examples of open-ended responses are shown in Figure 1.

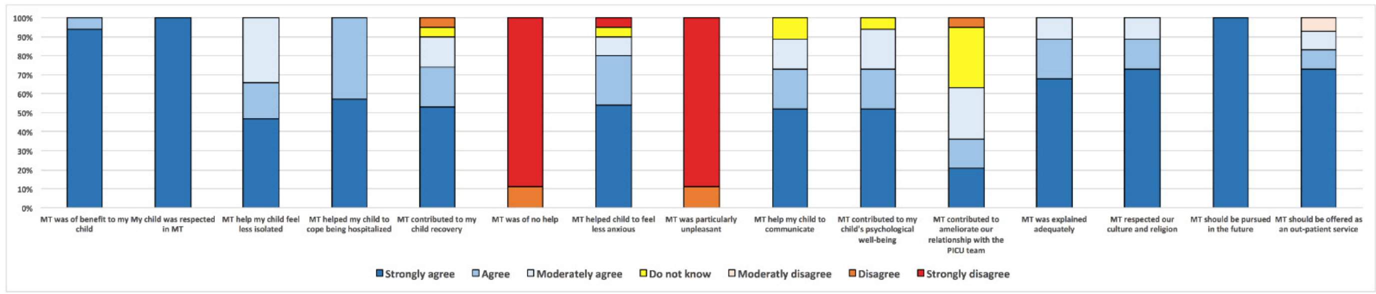

Figure 1. Parents' answers to questionnaire. *Y* axis: proportion in %. MT: music therapy.

4. Discussion

In this single-center study, we showed that MT could introduce alternative ways of supporting children's and parents' psychological and possibly physical well-being. We also found that MT might promote constructive communication between families and the PICU team.

Our results are in accordance with recent literature showing that MT is feasible and is accompanied by a high level of appreciation from staff and families in the PICU setting [12,13]. Music therapy interventions might also reduce anxiety and pain in critically ill children [14–16]. Our results underlined the complex role of MT with a potential impact on multiple aspects of patients' and parents' perceptions during their stay in the PICU. Actually, the Society of Critical Care Medicine strongly recommended MT as part of a multi-component intervention aimed at reducing analgesic use and improving pain management in pediatric patients in ICU [5].

Our report has several limitations. Our results are based on a small sample size. Although it is based on an already published questionnaire, the survey used in this study was created by the authors for the sake of this analysis and has never been validated. We chose the survey approach as our experience with the qualitative interview approach is limited. We believed that, although less informative, the use of an already published survey might have helped us to overcome the lack of familiarity with the qualitative interview approach. However, similarly to humanities in general, MT is a complex phenomenon and is more than just listening to music [17]. As such, the real impact of MT on patients and parents might be only partially captured by objective measurable components [18]. We were able to confirm the usefulness and feasibility of MT in the PICU in terms of patient-centered outcomes and the team's acceptance. Further research looking at patients' and their parents' experiences is warranted to accurately adapt MT interventions to patients' needs and help promote children's autonomy.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/children9070958/s1, Figure S1: parents' questionnaires.

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Abbreviations

MT	music therapy
PICU	pediatric intensive care unit

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Case Report

Butterflies, Dwarves, and Plastic Lollypops: A Case Report on Medical Clowning in a Children's Rehabilitation Hospital

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Abstract: Medical clowning has been evolving in the past three decades and now plays a significant role in the rehabilitation processes of children who have suffered injuries and undergone complex medical procedures. The current paper focuses on this topic by presenting a case study of a young girl who lost most of her functional abilities due to brain damage. During the child's physiotherapy sessions at the rehabilitation hospital, a medical clown was brought in to work together with the physiotherapist in providing the treatment. The case study brings an in-depth perspective on the therapeutic process, as it is based on documentation of the sessions while addressing key stages in the child's rehabilitation, alongside core concepts in drama therapy. The qualitative analysis shows how the playful space in the rehabilitation process enhanced the child's inner motivation, provided a space for role expansion, and promoted the connection between the child and the environment. This paper demonstrates how the involvement of medical clowns can promote the rehabilitation processes of children who have suffered traumatic injuries and help them cope with functional losses.

Keywords: rehabilitation; medical clowning; drama therapy; physiotherapy; role theory

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1. Introduction

1.1. The Role of the Medical Clown in the Hospital

The character of the clown has accompanied humankind since the dawn of civilization, as a spiritual leader, shaman, and healer, and has played a counter role to key roles in society such as the ruler and the priest [1]. The clowns' humor stems from their ability to embody the gap between the spiritual and corporeal, as well as between the tragic and the comic, thus providing a broad and positive perspective on human existence [2].

The clowns' most prominent feature is their paradoxical nature. "Whatever predicate we use to describe them, the opposite can also be said, and with equal right" [3] (p. 307). The constant inner contradiction embodied in the character of the clowns constitutes their inner logic and allows them to be flexible in in-between situations, constantly shifting between dichotomies. The clown can serve as a mediator between contradictions, examine the relationship between them, and deliver an unconventional perspective on reality [4]. This quality is particularly meaningful and important in a hospital environment, where people often need to cope with stressful and even life-threatening situations.

The medical clown's role in a hospital is to contribute to the psychological wellbeing of patients, their families, and the attending staff [5–7]. Medical clowns operate within the hospital's reality and connect with patients by interacting with each in a unique way that is tailored to their specific needs and nature [6]. They rely on their ability to improvise and do so out of a sense of empathy, with an aim to build patients' resources and empower them [8,9].

Clowns invite patients into an imaginary realm, helping them to momentarily escape the harsh reality of hospitalization. This allows patients to delve into a world in which emotions and situations can be taken to extremes for the purpose of transformation, ultimately providing a fresh perspective on the situation. Studies show how the clown's working techniques can be conceptualized using drama therapeutic models and theory [2,10].

1.2. Key Concepts in Drama Therapy

Drama therapy is a health profession that uses dramatic and theater-based methods with the intention of promoting psychological growth within a therapeutic relationship [11,12]. This section describes how each of the drama therapy core concepts finds expression in the work of medical clowns.

Dramatic reality is a key concept in drama therapy. It is a safe space that integrates reality and fantasy and allows the individual to explore subjective experiences in the present [13]. "It is an *as if* made real, an island of imagination that becomes apparent in the midst of actual life" [13] (p. 272). Its therapeutic power stems from its ability to contain imaginary subjective content, some of which may be unacceptable under normal circumstances, thereby creating a legitimate space for such content within the "real" world [14,15]. Once personal content is projected and explored in the dramatic reality, it undergoes a transformation. This transformation seems to be supported by the fact that something real and concrete has been done with the subjective content. Thus, the dramatic reality is a type of lab in which people can explore emotions and situations and experience potential worlds [13,14].

Medical clowns' appearance, clothing, red nose, and accessories, create a dramatic reality that surrounds them like a type of aura [2,10]. As a medical clown walks down the hospital hallways, Winnicott's potential space is with them wherever they go. This is the space in between behavior and contemplation, as well as in between "me" and "not me"—the natural zone where play and creativity thrive [16]. The medical clown embodies this space, inviting patients to play and act in it together with her so they can experience change.

Aesthetic distancing is another key concept in drama therapy and is based in the world of theater [17,18]. The aesthetic experience of theater presents fictional characters and narratives that appear to be removed from the viewers' personal experience. However, paradoxically, this distancing, along with other aesthetic elements of the experience, allows viewers to draw emotionally closer to the events unfolding on stage, thereby drawing closer to themselves [19]. This is known as aesthetic distancing, and it serves a similar function in drama therapy [17,19]. It holds the balance between the emotional component, which fosters closeness and identification with the dramatic material, and the cognitive component, which allows the individual to reflectively observe what is taking place. Thus, aesthetic distancing makes it possible for individuals to distance themselves from personal content that is too close and painful, as well as reduce its emotional charge, creating a safe space for them to observe and explore their experiences [19,20]. Puppets and masks, for example, are well-known theatrical techniques used in drama therapy to facilitate projective expression and create a distance between the self and the characters presented in the process [21]. Similarly, the clown's red nose can be seen as a small mask of sorts, signaling the existence of a space of play and highlighting and creating an aesthetic distance for the patients [22].

Medical clowns reflect the emotions and situations that accompany patients' hospitalization experiences. These include fear, alienation, lack of understanding, helplessness, and pain [8,9]. They do so in an exaggerated and absurd way, so that patients can look at the clown from a safe distance, without the need to associate themselves with these emotions. When a patient identifies with an exaggerated experience that the clown portrays, they will often laugh or smile. For example, when encountering a frightened child, the clown will look for a way to be afraid, perhaps of a small dragon doll, a printed lion on a shirt, the honk of a toy, or anything else they find in the space. The child will laugh at the clown's reaction and will likely want to frighten the clown over and over again. This allows the child to play with the fear and befriend it from a position of power and a sense of security,

as the medical clown copes with the fear projected onto her, which they then perform and process. Therefore, maintaining an aesthetic distance is a significant element of the medical clown's work. It requires a great deal of sensitivity and the ability to adapt from one moment to the next.

Dramatic role is the third key concept we address in this paper. According to role theory in drama therapy and psychodrama, a role is the actual and tangible form of the self, comprising a set of qualities representing the various facets of the individual [23,24]. Each role has counter roles that often represent denied aspects of the self that the individual or society seeks to avoid. These counter roles contain unexpressed emotions, thoughts, beliefs, and experiences [20]. As the therapeutic process progresses, the role of "the guide" emerges to help integrate conflicting roles. At its core, drama therapy focuses on developing a balanced, flexible, and healthy system of roles, expanding the repertoire of roles available to us, and increasing our flexibility in shifting between them [24].

In the hospitalization process, a person steps into the role of "patient". They are removed from their daily life, stripped of their identity features, lose their privacy, and become defined by their illness [25]. In terms of role theory, the hospitalization process pushes the patient's role system out of balance, as the person shrinks into the role of "patient", which is destabilizing and stress-provoking. By playing in the dramatic reality, the medical clown helps patients shift out of this passive and painful role into more active and pleasurable roles that provide them with a sense of control and connect them to their strengths [2]. The role that clowns play in this regard is vital, especially when coping with traumatic events.

1.3. Rehabilitation Following a Traumatic Event

Some children who arrive at a rehabilitation hospital are coping with life-changing traumatic events that have significantly impaired their functioning and put their life in danger [26]. Such events change the life of the child's entire family and necessitate lengthy rehabilitation and adaptation processes, which at times involve reshaping their personal identity [27]. In some situations, the hospitalization itself, which includes the stages of diagnosis and medical intervention, is accompanied by fear, uncertainty, helplessness, pain, and life-threatening situations that could lead to post-traumatic stress disorder (PTSD) [28].

According to Ben Ari et al. (2018), PTSD in response to hospitalization is highly common among children; however, most of them recover from it naturally. Approximately 25–30% of all children develop chronic post-traumatic symptoms that affect their physical recovery and functioning. Others suffer from significant psychological stress and impaired functioning that continue long after hospitalization as a result of their illness or ongoing painful and invasive medical interventions. Symptoms include hyperarousal, avoidance, and re-experiencing the traumatic event [28]. During rehabilitation, children process the traumatic event and learn to adapt to the new reality; this also involves grieving the loss of abilities and aspects of identity [27].

Stroebe and Schut's (1999) dual process model of coping with bereavement describes an adaptive process for grief resulting from loss. This process involves coping with two types of stressors, leading to an investment of energy in two opposing coping strategies. The first is **loss-oriented** and involves processing emotions, thoughts, and actions related to loss, such as anger, crying, denial, longing for the past, sadness over lost abilities, and more. The second is **restoration-oriented** and includes coping with the new reality created by the loss. This involves the restructuring of daily life, forming new social relationships, and regrowth. When a grieving individual copes with loss in a healthy way they oscillate between these two strategies, and this creates a healthy adaptation process [29–31]. The current study presents a case study of a child who experienced a traumatic event and grieving processes following the loss of functions resulting from brain damage. This case study was designed to examine treatment processes with medical clowns who work with children within a rehabilitative framework, to determine the ways in which dramatic

therapeutic work can support the processing of traumatic events and grieving processes in situations of functional loss.

2. Materials and Methods

The case study presented here is based on treatments conducted as part of the rehabilitation of a 5 year old girl during physiotherapy sessions. The case study method involves an intensive and focused unit, and it provides access to information that might otherwise be inaccessible via other means of study [32].

Amira was hospitalized in the rehabilitation ward due to brain damage resulting from complications that occurred during a medical procedure (to preserve confidentiality, pseudonyms are used for the girl and physiotherapist). Her treatment at the rehabilitation hospital lasted over 2 years, and, in the current paper, we describe short vignettes from three different periods of the physiotherapy treatment. The physiotherapy sessions were co-conducted by Yael, the physiotherapist, and the medical clown, the first author of this paper, Sigalit Ofer, also known at the rehabilitation hospital by her clown name of Tsumi ("The Attention Seeker"). The analysis is based on treatment records written by the medical clown and an interview with the physiotherapist during which the records for each period were presented to elicit her perspective on the role of the medical clown in the process. The analysis of the records and the interview was designed to better understand the trajectory of the treatment process and the role of the medical clown in its different phases [32]. This study was approved by the Ethics Committee of the University of Haifa (UH approval 403/22).

2.1. The Triadic Relationship in the Physiotherapy: The Clown, Physiotherapist, and Child

Children hospitalized in the rehabilitation hospital enter into a treatment routine designed to meet their specific needs. To promote their rehabilitation process, the children are required to be active and cooperative; however, they are often in pain or emotionally overwhelmed by their medical condition. In such situations, moving a sore limb or shifting from one position to another can seem like an impossible task. The tension and uncertainty the children and their parents experience can leave them emotionally overwhelmed, hypervigilant, suspicious, or avoidant. In this context, physiotherapy treatments can cause many children to be resistant and experience great difficulty.

Medical clowns join physiotherapy treatments when the attending staff identifies situations of significant emotional difficulty that hinder rehabilitation processes. Their role is to support the children, reduce their anxiety, increase their sense of control, assist them in coping with the pain, and turn the physiotherapy session into a playful experience in which the children feel safe. At the same time, the clowns also support the physiotherapists and the therapy goals that they define. A medical clown's involvement in physiotherapy sessions is generally in collaboration and coordination with the physiotherapist.

The role of a medical clown is dual. They stand by the resisting child and support then while simultaneously supporting the goals defined by the physiotherapist. The clown attempts to identify the sources of the child's resistance and helps the child express this resistance, while simultaneously searching for creative ways to transform it. They seek to expose the child's motivation to do the work in order to promote the physiotherapist's goals. This duality is typical of the clown, which as aforementioned, is paradoxical in nature. The medical clown takes on the child's limitations, resistance, and fear, while simultaneously holding the faith and hope that the child can make progress, improve, and devote themself to the process.

2.2. Amira

Five year old Amira underwent a medical procedure during which multisystem failure occurred. As a result of a lack of oxygen to the brain, she suffered irreversible brain damage and went from being a healthy child to one who needed to cope with a severe disability. Amira lost her ability to speak and lost control of her organs. In the first 2 months of her hospitalization, she suffered from restlessness accompanied by a lot of crying, involuntary

limb movements, no control of her head, and hypertonia. Her condition at the time was characterized by drowsiness, and it was unclear whether she was responding to what was being said to her. The transition into this unfamiliar reality, which was accompanied by strange physical sensations, discomfort, and pain, while having no ability to express herself verbally as she once did, created great emotional distress. Amira was accompanied by her parents, who were also experiencing a deep rupture and loss following the traumatic event. The physiotherapy sessions were difficult for her and induced a lot of crying and uncontrollable emotional reactions. In light of this, the decision was made to have a medical clown join the treatments.

2.3. Data Collection and Analysis

The data include the treatment records written by the medical clown during Amira's rehabilitation process and an interview with the physiotherapist who co-conducted the sessions with the medical clown. The analysis was designed to better understand the trajectory of the treatment and the role of the medical clown in its different phases [32]. First, the researchers (the two authors) read through all the treatment records. They then looked for data segments that represented phases in the process and coded them to identify chronological developments corresponding to the research questions [33]. They next reviewed the codes to define main themes in each phase that related to the role of the medical clown during each phase. Then, the first author presented the treatment records to the physiotherapist to obtain another perspective on the role of the medical clown. During the interview, the physiotherapist was asked to reflect on the treatment records in relation to two questions: (a) What was your experience during these sessions? (b) What was the role of the medical clown in Amira's rehabilitation process? The next step was for the researchers to read through the interview transcript to identify data segments that represented themes in the process. The researchers reviewed and combined the themes from both data resources. These themes were defined and labeled, and selected quotes were chosen to illustrate each theme. Lastly, the findings section was structured chronologically to depict development in line with the research aim and questions [33].

3. Findings

The findings are presented as three phases in the process. Each phase captures one theme that relates to the role of the medical clown in the treatment process: (a) a playful space to enhance the inner motivation; (b) role expansion; (c) connection between the child and the environment.

3.1. The "Butterfly" Game: A Playful Space to Enhance the Inner Motivation

This theme relates to the ways the playful space provided by the medical clown enhanced the child's inner motivation during the physiotherapy sessions. At the beginning of her rehabilitation process, Amira was restless and cried a lot during her physiotherapy sessions. Yael, the physiotherapist who was treating her, understood that, in order to conduct the treatments, she would have to create a safe and quite space for Amira. The goal of the physiotherapy at the time was to relax and lower Amira's muscle tone, maintain her range of movement, and try to give her more control over her movements. Tsumi the medical clown began by making short visits to Amira's room in the hospital, to allow them to get to know each other before she joined a physiotherapy session for the first time. When Tsumi entered the physiotherapy hall, Amira showed great interest. The physiotherapist introduced her and invited to her come closer to Amira with a calming voice. Amira looked at the clown directly, with a gaze that was inquisitive, wide awake, and full of vitality, fascinated by the clown's red nose. This signaled to the clown that she could move even closer and advance the interaction. Amira looked at the two butterflies that were stuck in Tsumi's hair and the physiotherapist said: "Do you see what she has on her head?" Amira's mother noticed that the clown's hat was actually a pair of underpants, and this made her laugh. She shared her discovery with Amira, which caused the child to laugh as well. At

this point, it was clear that, despite her impairment, Amira understood humor, that she was intelligent and highly communicative, and that she could use facial expressions to convey interest or dissatisfaction, even if she could not express herself with words.

The clown took one of the butterflies out of her hair and moved it in the air as if it was fluttering. She sang a well-known children's song about a fluttering butterfly in a soft, calming voice, as she let Amira follow it with her gaze. At this stage, Amira's body language became calmer, her muscle tone had decreased, and she appeared fascinated by the song and the butterfly's movement. The physiotherapist rocked her gently in her arms to the rhythm of the song and sang along. They sang the song together several times. The repetition of the pleasant sounds created a sense of safety and calm. After some time, the clown introduced another game. She put the butterfly on her shoulder as if it had landed there to rest, and then turned to it with an annoyed look. Amira was following this, waiting to see what would happen next. A moment later the clown sneezed, chasing the butterfly away, and Amira laughed with a big smile on her face. This game was repeated in several variations. Each time the butterfly landed on a different area (on the clown's head, arm, or nose), it would bother her, and she would get rid of it until the next time it landed, sharing with Amira how annoyed she was with the butterfly. The clown continued to sing the pleasant song; however, as soon as the butterfly disturbed her, she would sing it in a scolding tone. Amira laughed and enjoyed watching the clown getting angrier and angrier each time. In the next stage, the clown put the butterfly on Amira's hand as if it had landed there. The physiotherapist held Amira's hand and helped her chase the butterfly away. In that moment Amira became more active and attempted an intentional movement for the first time since the therapy session had begun.

While reading the records of these sessions, Yael noted:

> *I remember this period with Amira. She was very, very restless and it was very, very difficult to try to do anything, any kind of deliberate movement. I also remember this part with the butterfly . . . suddenly it became something like a game and her attention was elsewhere and it was calming and relaxed . . . it allowed us to see what she could express . . . and (it helps to) start trying to make a deliberate movement—to shoo the butterfly away . . . which we had not been able to do previously . . . This was a very important step, both for her and for those around her, because we could start to see what was there and what was not and that it was not so scary and that it would be fine. We could move forward from there . . .*

Amira was suffering from restlessness and involuntary body movements; thus, the clown chose to sing a slow and calming lullaby. Singing and following the movement of the butterfly that had come to life allowed Amira to enter into a dramatic reality, into a world of the imagination. She managed to relax and focus her attention, and the involuntary movements subsided. This allowed her to transition to the next stage—a game that emerged from the shared imaginary world that had been created in the room. This new game, involving the butterfly that kept landing on the clown, embodied a relationship between two roles: an active and playful one versus a passive and irritated one. Metaphorically, this reflected Amira's physical and emotional state, as it dealt with the theme of wanting to rest versus the need to cope with restlessness and involuntary body movements that cause discomfort and exasperation. The irritating frantic butterfly was actually looking for a moment of peace; however, as soon as it stopped to rest, it made the clown restless. Thus, the butterfly represented the involuntary muscle movements acting on Amira. Amira could observe this dynamic as a bystander, from a safe distance, as the clown experienced the emotions of anger and discomfort while Amira watched and laughed, having a good time. Later on, when Amira chased the butterfly away, she became active. While she did not make the movement on her own, as Yael the physiotherapist made the movement for her, Amira was still able to play as if she were the one controlling the butterfly. This is a very simple game, but it allowed Amira to take on an active role and experience control, which was incredibly vital for her.

Yael commented on the role of the medical clown in enhancing the child's inner motivation:

> *This is the place I am looking for in therapy. When the movement comes from within the child and from her own drive and motivation . . . Clowning plays an important role . . . the clown enters the room and during the interactions with the child, and this helps the child find motivation and place and what interests her and what causes her to be in movement. This is a very important point in treatment. There are children for whom we cannot get to this stage without the help of the clown.*

Later, Yael talked about her own experiences dealing with Amira's resistance to therapy at that time, and how the medical clown supported her in finding a way to stimulate Amira's motivation:

> *I remember there was enormous distress . . . because it was very difficult for me to deal with Amira's current state. And there was a conflict, ok, I'm the physiotherapist and I have to do this and that. It is important to take care of her body, you have to take care of movement. But I quickly realized that there was no way we could work while she was crying and in distress. And you have to find another way. (At this point) I was also distressed and was looking for a way . . . And the clown . . . she was very important, she also helped me. The clown helps the therapist as well. It doesn't only help the child.*

3.2. The Dwarves Game: Role Expansion

This theme relates to the ways the playful activities allowed role expansion and the development of the self. The next encounter took place about 8 months after Amira's rehabilitation had begun. In this session, Amira was practicing a single intentional movement. The physiotherapist had been training her in different ways to move a hand or leg in an isolated, intentional, and controlled manner, and Amira's abilities were improving. She practiced putting hoops on a cone, popping soap bubbles, doing yoga poses, and more. One of the games she played with the clown during treatments was a song-game called "Dwarf Dwarf in the Forest". In this game, the child plays the dwarf, hiding curled up under a blanket or a piece of fabric and stretching out a hand or a leg according to the words of the song, until they come out entirely from under the cover and those present finally recognize who they are.

This structured game set the pace for Amira and gave her time to prepare herself before making each movement. She was met with great enthusiasm each time she managed to send out a hand or a leg from under the blanket. The clown, the physiotherapist, and Amira's mother sang together for her, "Who is this dwarf who's dressed up so beautifully?", with all three of them acting curious to meet the dwarf and admiring his beauty. The dwarf song is a metaphor that deals with the theme of drawing within and hiding as opposed to being discovered and going out into the world. The exposure is gradual, giving the child a sense of control, as she is asked to move a different limb each time and knows what to expect.

Yael explained how the playful space suggested by the clown, such as in the dwarf game, supported the goals of Amira's rehabilitation physiologically, as well as psychologically, by allowing her to re-explore the role of a child who engages in play like other children her age.

> *During this period, we tried to work a little bit more on the control of movement, to achieve some kind of minimal control. So, for example the (dwarf) game really allowed her to . . . practice it over and over again . . . it's impossible with a 5 year old girl to practice something boring. The game allowed her to enjoy practicing and really, really try hard and be intent (on her movements). Because that's the meaning of this game . . . it was compatible with her age, compatible with her life and very suitable for the goals of the physio and she really liked it, and it was fun for her . . . it really brought back the feeling to her and maybe also to her mother that maybe it's still possible to be a girl who does things that children do.*

This quote illustrates how this process allowed for self-continuity, since Amira was able to re-experience the playful activities as she engaged in before the traumatic event. The dwarf game also enabled transitioning from the inside to the outside world, which

represents Amira's way of coping psychologically with the loss she experienced. The moments of hiding reflect the need to go within and make the necessary preparations required for such a difficult physical task, which previously would have been so easy for her to perform. Here, Amira was able to explore emotions such as loneliness, uncertainty, and fear of encountering the world. Coming out from under the blanket can be seen as a metaphor for Amira's growth, a rediscovery of her capabilities, and her ability to improve them, as if saying "I can move and play in my new condition". This is how Tsumi the clown described the game in her treatment diary: "When Amira came out from under the fabric completely, we were full of joy and admiration. I saw the light and excitement in her eyes, and thought to myself how important and meaningful it was that her mother was present there with us, that she had a chance to enjoy and celebrate her love for Amira". The game allowed Amira to experience the fact that she was loved, that she inspired enthusiasm, and that it was fun and enjoyable to be and play with her, all of which allowed her to develop her ability to adapt and accept her new condition.

In a sense, the game echoed Amira's physical and emotional state in the first stages of her hospitalization. It depicts the process of transitioning from the inner to the outer world, from unconsciousness to awakening and connecting with her surroundings. In light of the new disability to which Amira and those around her had to adapt, the game can also evoke the association of rebirth. The words of the song in the dwarf game, "Who is this dwarf?", contain a question pertaining to identity. This question is highly relevant to a child when one of their greatest tasks is becoming reacquainted with herself and allowing those around to become reacquainted with them. There is an expectation and perhaps even concern regarding what will happen when they encounter the outside world—how will they be received? Step by step, Amira is invited to come out into the outer reality in an organized and gradual manner.

Later on, it was Tsumi's turn to hide under the blanket, while Amira told her which body part to send out each time. Now, Amira was controlling the game. She could look at the clown, who, in a sense, was mirroring her own story, as she played the part of the audience and even directed and led the situation. The clown often got tangled up and did silly things, in an aim to heighten Amira's success and sense of competence.

At this stage of the game, Amira was experiencing a process of role reversal. No longer was she in the role of being passive and having no control; now, she was playing the role of a leader who could guide, control, choose, be mischievous and playful, and have fun as she used to before the trauma she had experienced. From this position, she was able to experience a sense of competence and control she so needed, while the shift between roles allowed her to explore various states of self.

Yael added her comments on the dwarf game, and how the interaction with the clown enriched the game and allowed for role expansion:

> *I think that when the clown was there, the game was richer. I could play the dwarf game with her when the clown was not around. But once the clown was there, the focus was on the game . . . there was much more laughter and much more joy and much more movement. And then there is the positioning, which is very important, when they change roles, she tells the clown what to do . . . like the kids in kindergarten take turns, which doesn't usually happen in normal physiotherapy. So, she (Amira) could also be in the leader role not only the follower . . . The game became very complete.*

3.3. The Shop Game: Connections between the Child and the Environment

This theme relates to the role of the clown in creating connections between the child and the environment which was more visible during the last phase of the rehabilitation process. Toward the end of the therapeutic process, about a year and a half since Amira's rehabilitation had begun, she seemed to be experiencing greater acceptance and an ability to cope with her disability, alongside a sense of competence. She liked the familiar routine of treatment activities, she felt loved and protected by the staff and her family, and she was enjoying her ability to move. She could communicate, choose, laugh, and play. She

did not regain the ability to speak; however, she did learn to communicate "yes" and "no" by making a sound and moving her mouth and with facial expressions. She had been practicing walking with different aids and was now using a special walker that enabled assisted mobility for short distances. Each step she made was met with praise and admiration, and she was working hard and getting stronger. This was the final period of her rehabilitation, and she was preparing to go home and back to school. The physiotherapy sessions were devoted to working on strengthening and controlling her body and working on mobility. During the sessions, she would leave the physiotherapy room to practice walking in the hospital hallways.

One of the games Amira played with the physiotherapist and the clown during this period was the "shop" game. At the start of the session, while the physiotherapist was helping Amira stretch on the mattress, Amira and Tsumi played with sticking colorful balls onto sticks. Tsumi attached a ball to a stick and said to Amira, "Look! It's a lollypop! You want one too?" Amira said yes, and they made quite an impressive collection of lollypops, tasting them and sharing them with Amira's mother and the physiotherapist. They all ate the lollypops with delight. Yael the physiotherapist suggested they sell them outside the physiotherapy room, with the intention of training Amira to use the walker. Amira happily embraced the idea, and Tsumi enthusiastically added that they should go to the hospital cafeteria and sell them there. Yael sat Amira on the walker and fastened the straps and Amira began to walk out of the physiotherapy hall. At the entrance to the hallway, Tsumi blew an imaginary trumpet and announced Amira's arrival in a grand voice, as passersby smiled and took interest. "Dear audience, give it up for the one and only, Amira the sweetie-pie and her sweet lollypops! Now on sale! You taste—you pay! You wanna taste? These are very special lollypops that Amira made with her own two hands". They invited everyone who was there to buy a green pickle-flavored lollypop or a purple fried eggplant-flavored lollypop. Staff members, parents, and children showed interest and surprise, responding with a sense of humor when they heard about the bizarre flavors and outrageous prices. Step after step, happy and laughing, Amira progressed toward the cafeteria—the most central place in the hospital, where multiple interactions take place with a variety of people.

Choosing to leave the physiotherapy room and walk toward the cafeteria is indicative of a desire to explore possibilities and experience social belonging. It allowed Amira to play a central and active social role and experience herself as being able to give to others by "selling" the pretend lollypops she had made. Tsumi the medical clown encouraged uninhibited playfulness, connection, and interaction, thereby inviting Amira to playfully explore her environment.

Amira, who had experienced such a devastating loss, played a role that was full of confidence, the role of one who lacked nothing and, on the contrary, had something to give to those around her. She looked at people directly, feeling proud of herself, initiating contact with the world, and inviting others to take part in her goodness and sweetness. Amira, who was once completely helpless, was now regaining the control she had lost. She was learning to accept her disability, playing and enjoying what she did have, and feeling worthwhile as she experienced abundance and belonging.

Yael commented on the ways the medical clown supports the connection between the child and the environment:

> *The clown makes all these connections, you know, connects it to life, to others, to the outside ... Now that I think about it, she couldn't speak, she couldn't say that she was coming ... She could play ... with us, but she couldn't tell people: "come by, I made candy!" So, the clown was her voice. And this is an important role. She suddenly plays with everyone in the hallway, and everyone obeys her, because the clown is walking beside her and saying what she cannot say ... thanks to the clown the environment was more appropriate and enabling.*

Finally, Yael also reflected upon what she learned from the medical clowns she worked with:

> *I learned to be a bit of a clown myself and to use . . . a bit of these qualities . . . to take a step back, to give children their place, the stage, to let the children reveal themselves. I learned to work calmly and not out of need . . . the clowns allow all this, and I learned from them. Because the clowns are not always there. I wish there was always a clown in (physio)therapy.*

4. Discussion

Accidents and serious injuries are defined as life-changing traumatic events, especially when they involve a physical impairment that affects functioning [26]. Amira, once a healthy child, experienced severe trauma following complications that occurred during a medical procedure that almost cost her life and forced her to have to cope with an extreme disability. There is no doubt that Amira and her family experienced a major loss following the event, which required them to restore and restructure every aspect of Amira's life [34,35].

Physiotherapy treatments are a very significant part of the process of restoring functions and restructuring daily life after experiencing loss. These treatments build and enhance patients' physical capabilities and emotional resources [36]. When children are resistant to treatment, involving a medical clown in the process can help motivate them to cooperate. The qualitative analysis shows how the medical clown's ability to establish a playful space in the rehabilitation process enhanced the child's inner motivation, provided a space for role expansion, and promoted the connection between the child and the environment.

When Tsumi the medical clown joined Amira's physiotherapy sessions, she introduced a playful dimension that helped Amira progress toward the physical goals of the treatment. At the same time, this allowed her to deal with psychological content that was relevant to processing the loss she had experienced and helped her adapt to her new condition. The clown's participation made it possible to simultaneously focus on the two coping strategies referred to above [29,30]: the loss-oriented strategy of expressing and processing difficult feelings entailed in the loss, such as sorrow, pain, fear, and loss of control, and the restoration-oriented strategy of helping Amira organize and relearn her abilities, form new relationships, and rebuild her positive identity.

Theories that deal with processing loss and structuring meaning around situations of bereavement highlight the need to build an enveloping, containing environment that allows the individual to feel secure. As Neimeyer and Rynearson (2022) noted, in order to conduct a restorative work of the loss story in therapy, there is a need to establish a trusting and collaborative therapeutic relationship [37]. The various stages of Amira's therapeutic process describe play processes based on well-known rituals and songs as a means for calming her and strengthening her sense of security. The repetitive songs and games in which various situations were repeated allowed her to safely and gradually enter a playful dramatic space and explore various aspects of loss and growth.

The dramatic work in the butterfly and dwarf games enhanced her inner motivation and allowed Amira to shift between roles that had qualities of control and competence and roles that lacked control and were chaotic and passive. The games depict the dynamic between the roles created through aesthetic distancing [17,18]. The passive role played by the clown is in fact a reincarnation of the role of "patient" [25]. This role is characterized by the fact that the hospitalized person's privacy and control of their body is violated as a result of their injury and being hospitalized. It contains unexpressed emotions, thoughts, and experiences such as anger, helplessness in the face of feeling invaded, restlessness, and frustration. The situation played out in the games is a metaphoric reflection of the inner experience. However, in the dramatic reality, the medical clown reflected the situation for Amira in a way that was playful, spontaneous, and full of humor, by using aesthetic distancing: "It's the butterfly that's bothering me"; "It's the clown who got tangled up in the blanket and can't get out". This allowed Amira to encounter and explore the difficult emotions she was experiencing in her life.

Alongside roles that lack control, which represent the losses caused by the impairment, the games allow other roles to be expressed—roles that are active, in control, and competent.

For example, in the butterfly game, when the butterfly bothered Amira, it made her laugh and she was able to use those around her to get rid of it, as the butterfly was the one who was helpless. Thus, the dramatic game allowed Amira to expand her repertoire of roles [20] and express qualities of self that where active and able to experience pleasure, control, and strength. In this way, Amira could explore situations that had previously been inaccessible to her since her injury, while training her body to return to a state in which she was controlling it and not the other way round.

Playing with the opposing roles of passive and active through the various games created an experience of integration. Much like muscle training, the repetitive shifts between the opposing stances helped to practice narrowing the gap between anxiety and calmness, between helplessness and competence, and between the inner and the outer. The clown helps achieve this mission because she herself is a flexible character, full of contradictions, and able to constantly shift between opposites [2,22]. The goal of drama therapy is to develop a balanced, flexible, and healthy role system and expand the range of roles available to us, while helping integrate conflicting roles and accept the ones we deem less legitimate [20,24]. The clown can be viewed as a character that shifts between the conflicting roles, holding and exploring them and, thus, allowing them to become integrated.

In addition, the repetitive shifts between the opposing positions in the various games are similar to the oscillation described in Stroebe and Schut's (1999) adaptive model of coping with bereavement [29,31]. The oscillation between processing the sorrow and difficulty and focusing on restoration and taking action takes place within a game, as the clown sets the pendulum in motion and helps the child shift between the strategies while the physiotherapist holds the process of restoration and regrowth.

Successful rehabilitation processes are based on the individual's perception of self-efficacy, which stems from the way the environment perceives their disability and their own self-image, body-image, and mood [27]. Toward the end of her rehabilitation process, Amira had made peace with her new condition; she could accept it, could cope with it, and was able to communicate with the environment. In the "shop" game, Amira was happy and active as she confidently went out into the hospital space, knowing that she could contribute to the other children and parents at the hospital. She could initiate contact with them and draw them to her out of a sense of joy and self-worth. Amira experienced independence as she walked using her special walker, which supported her physically.

It is possible to see how personal content that was brought into and explored in the dramatic reality was transformed. Content that was difficult and oppressive was brought into a safe and playful space and was embodied in a way that was tangible, concrete, and alive, allowing for new perspectives of the loss story to be discovered [37]. The possibility of entering the reality of a game and acting within it provided the opportunity to be creative and active, as in an act of creation.

While this work discusses a particular case, it is undoubtedly representative of many others. The observation presented here contributes to our understanding of the role that medical clowns play in children's rehabilitation processes. Much like Amira, many children in rehabilitation experience a profound sense of loss and helplessness following traumatic events. These children need to rediscover their strengths, regain a sense of control and self-efficacy, and restore their self-worth. However, one limitation of this case study is that it is based on the medical clown's diary and the physiotherapist's point of view, but it does not include the child's or her parents' perspectives. Future studies should integrate information from diverse sources (such as the child, parents, and medical staff) to gain an in-depth understanding of the phenomenon. In addition, future studies that make use of additional research tools such as quantitative measurements or qualitative interviews would provide a broader perspective of the influence the processes described here have on psychological and physiological health indicators.

5. Conclusions

The primary contribution of the current work is the opportunity it provides to gain an in-depth understanding of the role of medical clowns in children's rehabilitation. It sheds light on the purpose of their red nose, their unique presence, and what they do as part of the rehabilitation process. An acquired disability such as Amira's requires coping with a substantial loss of functioning. Many children in rehabilitation face a similar task of having to adapt to a new reality and find the strength to cope with fear, pain, and emotional stress. Involving medical clowns in rehabilitation processes can help children surmount this essential and complex process.

Medical clowns invite these children into the playful space of a dramatic reality where they can process complex and difficult emotions, as the clowns use aesthetic distancing to approach this content. The current work demonstrates how the playful encounters with a medical clown provide a meaningful psychological exploration of feelings of helplessness and lack of control in the face of major losses, while helping the children access their ability to cope and grow from their new condition. The clown brings with her a flexible spirit, helping the children practice inner flexibility and move between various states of self, thereby allowing them to expand the repertoire of roles available to them. Children can transition from the role of the passive "patient" who has no control to roles that are strong, in order to enhance their sense of security and trust in the treatment and in themselves. This allows them to process the loss, create meaning in their new condition, and significantly promote their rehabilitation processes.

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Article

Visual Expressions of Children's Strengths, Difficulties and Wishes in Person Picking an Apple from a Tree Drawings among Preschoolers Living in Areas of Persistent Political Violence

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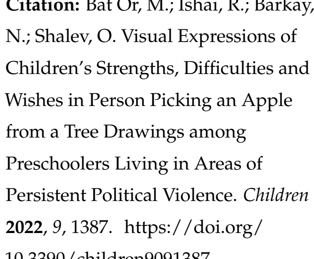
Abstract: The present study sought to inquire into the subjective experience of 156 preschoolers (age 4–6.9 years) living in an area of political violence in Israel (on the border with the Gaza Strip) during a period of massive bombing. Children were invited to draw a Person Picking an Apple from a Tree (PPAT), and were interviewed on their sense of self-potency using the CAMP, a measure of potency. Teachers were asked to report problems in executive functions using a few BRIEF scales; and mothers filled out a questionnaire for maternal distress (BSI), a measure of their child strengths and difficulties (SDQ), and were asked to provide their assessment regarding the extent to which their child was exposed to political violence. Findings reveal associations between mothers' distress, the degree of exposure of their child to trauma, and the child's emotional symptoms. PPAT analysis identified four main factors: Tree Generosity, Person Agency, Vividness, and As-Real-R. Positive associations were found between self-potency and the main factors of the drawings; negative associations were found between the child's difficulties in executive functions and the drawing's four main factors; and two small negative associations were found between the child's emotional symptoms and Tree Generosity and As-Real-R factors. The following associations were found within each gender group: mothers' depression degree was associated with boy's Tree Generosity, and mother's perceptions of their girl's exposure to trauma was related to Person Agency, Tree Generosity, and As-Real-R factors; furthermore, a significant difference was found between the narrative focus of drawings in this sample and the narrative focus of drawings of a sample of the same age group from a non-war zone. In addition, narrative focus was found to be related to children's self-potency. The discussion deals with the study's findings through the prism of developmental psychology, self-agency, object-relations, and art-therapy theories.

Keywords: PPAT; children; self-potency; EF; maternal distress; political violence



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1. Introduction

1.1. Civilians Living in Conditions of Persistent Political Violence

Civilians living in conflict-affected settings, who experience war, terror, military attacks and more, are exposed, as individuals and as a community, to immediate and unforeseen threats and danger. These situations were found to be associated with civilians' reduced sense of safety, heightened anxiety, and post-traumatic stress symptoms—PTSD (e.g., [1–3]). PTSD, according to the DSM-V, appears after an exposure to traumatic event/s, and symptoms include re-experiencing, avoidance, negative mood and cognitions, and hyperarousal [4]. Since ongoing political violence causes an accumulation of stressful events over time, its impact can be explained by the Allostatic Load Framework that shows that the

more people are exposed to stressful or traumatic events, the more they are at risk [5]. Diamond et al. [6] described the phenomenon of Ongoing Traumatic Stress Response (OTSR) as a unique outcome for some people who live for years in conditions of political violence. OTSR is different from PTSD in four aspects: (a) clients describe their anxiety symptoms as the cumulative result of repeated ongoing stressful events, and not as related to a marked traumatic event; (b) fewer re-experiencing symptoms appear; instead, the fear is focused more on daily life routines such as those that require leaving the house (for example-picking up the children); (c) Client's patterns of fear and avoidance are reality-based, and thus can be considered reasonable; and (d) clients report a marked decrease of symptoms when they are away from the war zone.

The present study focused on preschool children who were born into a situation of persistent political violence that began in the area where they reside about 12 years before they were born. It may be thus assumed that their parents, who were about to serve as a protective envelope to their children, experienced their safety as compromised, due to constant uncertainty and alertness. It is well known that young children's development, health, and well-being depend on their caregivers; for example, research showed that the mother's well-being serves as a resilience factor [7–9], while maternal stress was associated with children's internalizing and externalizing disorders [10]. In a systematic review on the effects of political violence on young children [11], parental care was found as a moderator of the associations between exposure to violence and children's outcomes. For this reason, we included in the current study a measure of the degree of maternal stress, as this maternal aspect may have a significant impact on the child. Since the missile attacks occur suddenly in the child's daily life, and are uncontrollable, there is a high risk that these children's development and resiliency will be impacted by the trauma in these living conditions (e.g., [12,13]).

1.2. Children's Emotional-Behavioral Aspects in Political Violence Settings

Since events of political violence mainly function as threats and stressors in the children's daily life, they can elicit fear and anxiety and other overwhelming feelings that arouse a sense of helplessness. These emotional states may be seen as a normal reaction to an abnormal situation [12]. However, prolonged exposure to political violence in childhood may limit children's adaptation [14]. Research shows that children who live in an environment of political violence tend to suffer more from clinical behavioral and emotional distress [15–17]; PTSD; psychosomatic symptoms; sleep disorders; and disturbed play [11]. Wessells and Kostelny [18] recently coined the term Violence In Childhood (VIC), that also refers to how children who witness violence are impacted [19]. VIC may occur in home, school, community, social and cultural settings.

The impact of prolonged political violence may be devastating to children's well-being and development; however, its continued appearance may prompt civilians under fire and the community at large to be proactive; develop solutions for coping with the challenges; and provide children, families, and educational institutions suitable preventive resources, therapeutic interventions, and resiliency building routines [20] to support health and recovery, and bolster children's sense of self-agency.

The sense of potency among children living in environments of political violence

Self-agency is the perception that the individual's actions have an impact and influence the physical and relational environment [21]. Research shows that self-agency is shaped by the repeated behavior of the caregiver toward the infant or child (e.g., [22]). Specifically, when the infant experiences sensitive and good-enough parenting, he or she internalizes a sense of self agency, by which non-verbal cues bring positive changes (for example, a cry of hunger, will result in feeding). Two concepts related to self-agency, the first is self-efficacy [23], that describes the belief in one's ability to fulfill tasks and goals, and the second is the concept of self-locus of control [24], which is the assumption that one can change reality. Self-efficacy was found as associated with motivation and cognitive achievements (e.g., [25,26]), as well as with social relationship aspects (e.g., [26,27]); In accordance

with Ben-Sira [28], self-potency includes the dimensions of self-efficacy, and self-locus of control, and, in addition, one's understanding that one's social surroundings can be an important and significant anchor. To summarize, the sense of self-potency indicates the individuals' sense of competency, based on various abilities and potential support from others. Self-potency may thus be regarded as a protective element that can support children's successful adaptation and handling of aversive conditions, such as living in war zones. The concept is important from the aspects of health and self-resourcefulness; nevertheless, very few systematic study of self-potency has been undertaken [29], particularly in the context of war zones. Amongst the challenges of studying children's self-potency is their limited ability to express themselves verbally.

1.3. Children's Drawings as Communicating Their Experiences

Since most of the research-tools for assessing preschoolers' emotional state and subjective experiences are verbal ones, and raters are mainly stakeholders such as parents and teachers, the present body of research in this field lacks the child's perspective and voice [30]. The child's perspective can be included by incorporating children's non-verbal expressions, such as drawings. Drawings are a natural activity for children and engages them in exploration, communication, fun, and learning [31]. From a realistic perspective, children's drawings progress gradually from scribbling to schematic and realistic images [32].

The current research included the drawings of children ages 4–6.9 years, a period of life which incorporates two developmental stages in drawing according to Lowenfeld and Brittain [33]. The first is the Preschematic stage, characterized by a conscious and clearly recognizable creation of form and objects, The child continually searches for new concepts and engages in problem solving, so symbols constantly change. The second developmental stage is the schematic stage, which characterizes the drawings of five- to six-year-old children, who draw schemas of specific objects in a repeated form, add a baseline [34], and emphasis objects by enlarging them. They also consider the space, demonstrated through variations in distance and how objects are organized [31]. Since the present study focuses on self-potency and emotional and cognitive aspects, the drawing task of a "Person Picking an Apple from a Tree" (PPAT: Gantt, [35]) was chosen, as it invites the child to depict a person that is in the process of reaching a goal. This drawing was found in previous studies to be related with children's motivation, and executive functions [36], and with emotional and relational aspects [37]. For example, preschoolers' executive functions problems were found to be related with a drawn person that was less active, while girls' self-potency was associated with a successful apple picking [38]. The PPAT has reliable rating systems for form, content, and narrative aspects, and thus it can be incorporated in quantitative research format. The present study's aim was to broaden our knowledge about children who live in areas of prolonged political violence by examining associations between children's variables (cognitive and emotional) and maternal stress and their PPAT drawings (form, content, and narrative layers). The inclusion of the children's drawings in this study incorporates their voices while enabling a closer inquiry into the explicit and implicit aspects of their subjective experience in relation to other data that was collected from their caregivers. This data triangulation may also strengthen and enrich the study's results, and further deepen our understanding of how preschoolers communicate via their drawings subjective experience, strengths and difficulties that may need to be addressed.

1.4. Research Hypotheses

Hypotheses of background variables:

1. Significant negative correlations were expected to be found between children's self-potency, and emotional symptoms; executive functions (EFs) difficulties; and maternal stress.

2. Significant correlations were expected to be found between mothers' assessments as to degree of exposure of their children to events of political violence, maternal stress, and child's emotional symptoms.

Hypotheses regarding the child's PPAT drawings

Since the child's gender was found to be an intervening variable in previous studies, all the following hypotheses were also examined in relation to gender.

1. Significant positive correlations were expected to be found between child's self-potency and positive content and form aspects in the PPAT.
2. Significant negative correlations were expected to be found between child's EFs difficulties/ emotional symptoms and content and form aspects in the PPAT.
3. Significant correlations were expected to be found between maternal stress and negative aspects in the PPAT.
4. Significant correlations were expected to be found between the mothers' assessments of the children's degree of exposure to events of political and negative aspects in the PPAT.
5. The PPAT drawing's narrative focus was expected to be less on the picking script in comparison to a sample of preschoolers in the same age group who live in a non-war zone [39]. In addition, the aspect of narrative focus was examined in relation to the child's variables.

2. Method

2.1. Participants

156 preschool children (the age range of 122 children was: 4–6.9 years; Mean 5.32; SD = 0.75) who were recruited from randomly selected Israeli kindergartens located in an area affected by chronic political violence. Table 1 presents participants' demographic variables.

Table 1. Demographic Data: Means, SDs (in Parentheses), and Percentages.

Variable, *N* and *N* Missing	Indices and Percentages
Child's age (in years) *N* = 122 (34 missing)	Mean = 5.32 (SD = 0.75) Range 4–6.9 years
Gender of children (%) *N* = 147 (9 missing)	47.8% girls 46.8% boys
Socioeconomic status *N* = 105 (51 missing)	Mean = slightly above average level
Mothers who completed higher education (%) *N* = 107 (49 missing)	80%
Marital status (% married mothers) *N* = 107 (49 missing)	96%
Locality (% rural) *N* = 156	81%

Table 1 about here.

As described in Table 1, 107 mothers (96% married; about 80% with an academic degree and 20% with a high-school education or diploma; 41% reported an average economic status; 34% an average plus economic status, and 19% a high economic status), and 15 kindergarten teachers participated in the study. This sample was recruited from an area near the Gaza strip, affected by political violence, mainly in the form of rocket attacks since the year 2001. Participants were mainly from small villages and kibbutzim (81%), while the minority were from the city of Sderot. The gender distribution of the children was equal.

2.2. Instruments

2.2.1. Mother's Questionnaires

SDQ: Strengths and Difficulties Questionnaire [40]—Parent Version

A brief behavioral screening questionnaire assessing children's (age 3–16 years) mental health, and social functioning. The questionnaire was translated to about 40 languages. The 25 items measure 5 scales: emotional symptoms, e.g., "Many fears, easily scared;" behavioral problems, e.g., "Often lies, and cheats;" hyperactivity/inattention, e.g., "Restless, overactive, cannot stay still for long;" peer relationship problems, e.g., "Rather solitary, tends to play alone;" and prosocial behaviors, e.g., "Considerate of other people's feelings." The items are coded on a three point scale: 0 = Not true, 1—Somewhat true, and 2 = Certainly true. The item's score is calculated according to the online SDQ manual. In an extensive study of the psychometric characteristics of this tool, the measure was validated with DSM-IV diagnoses, and the five subscales were found as having a sufficient internal consistency (of 0.73) [41]. In the present study, only two scales had adequate internal consistency: the hyperactivity scale (Cronbach = 0.82), and the emotional problem scale, after omitting item no. 3 (Cronbach = 0.76). The internal consistency for the 19 items (omitting item no. 3, and the prosocial scale) was sufficient (Cronbach = 0.77). Scores were computed for each of the two scales and a total measure was computed, without the prosocial scale, and item no. 3.

BSI-18: Brief Symptom Inventory-18 [42]

An 18-item self-report questionnaire on psychological distress that was experienced in the previous week. The items are rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). In the present study we used Canetti, et al. [43] in its Hebrew translation. The items covering three dimensions are measured through the subscales: somatization (e.g., "Pains in heart/chest"); depression (e.g., "Lonely"); and anxiety (e.g., "Scared for no reason"). Additionally, a Global Severity Index (GSI) score is also calculated [44]. Prior studies confirm that the BSI-18 has good internal consistency, as reflected in a Cronbach's alpha of 0.89 [44,45]. There is adequate internal consistency for each of the scales: anxiety (0.71–0.79); depression (0.84–0.88); and somatization (0.74–0.80) [44,45]. The scales have adequate convergent and discriminant validity, constructing a three-factor structure (e.g., [44,46,47]). Adequate internal consistency was found in the current study for each scale: anxiety (Cronbach = 0.86); depression (Cronbach = 0.77); and somatization (Cronbach = 0.80). The internal consistency of the 18 items was high (Cronbach = 0.91). Scores were computed to each scale and for the total score.

The Child's Exposure to Trauma [15]

The questionnaire included 7 items (yes/no answers) that refer to missile attacks and exposure to political violence (e.g., the child saw a missile fall, etc.), and two items that refer to nonpolitical trauma (e.g., the child was exposed to other dangerous/traumatic events). The sum of the total scores of political violence categories was used for further analysis.

2.2.2. Teacher's Questionnaires

Five Scales of the BRIEF Questionnaire [48], for Assessing EF Problems.

The children's teachers rated 46 items relating to the child's functioning during a time period of three weeks before and after the PPAT drawing, using a three—point scale (*N* = never, S = Sometimes, O = Often). The five scales that teachers evaluated included: initiating (e.g., "Needs to be told to begin a task even when willing."); planning and organizing (e.g., "Has trouble concentrating on chores, schoolwork, etc."); monitoring (e.g., "Has good ideas but cannot get them on paper."); working memory (e.g., "When given three things to do, remembers only the first or last."); and emotional control (e.g., "Erupts in rage for an insignificant reason"). The scales have high internal consistency (Cronbach = 0.90–0.93) and validity ($p < 0.001$) [48]. In the current study, the scales had high internal consistency (Cronbach = 0.88–0.95), and the global consistency was high

as well (Cronbach = 0.98). A general score of the difficulties in executive functions was calculated as the total sum of these five scales.

2.2.3. Children's Questionnaires

The CAMP: The Child Adaptation and Measure of Potency [49]

An interview-administered questionnaire, involves 19 potency statements which are answered orally by a yes or a no. The instrument's statements were adapted from the adult's Potency Scale [28], and were modified for children, by adding an opening question: "Which child resembles you?". Each statement was formulated as positive and a negative, for instance: "A child who tries and succeeds" versus "A child who does not succeed even if he/she tries." In cases when a child did not understand the statements, the researcher supplied examples for clarification. The measure has high internal consistency (Cronbach = 0.81), and a global score was computed.

PPAT—Person Picking an Apple from a Tree Drawing [35]

Children were provided with white sheets of paper (21 cm × 29.5 cm) and 12 scented Sanford Mr. Sketch colors: red, orange, blue, turquoise, green, dark green, hot pink, magenta, purple, brown, yellow, and black. Each child was asked, separately, to draw a person picking an apple from a tree; no time limitation was set for the assignment. The PPAT drawings were scored based on three rating systems:

PPAT Drawings Analyses

FEATS—Formal Elements Art Therapy Scale [50]. This rating system is designed to measure the drawing's form features. It uses twelve 5-point Likert scales: Prominence of Color; Color Fit; Implied Energy; Space; Integration; Logic; Realism; Problem-Solving; Developmental Stage; Details of Objects and Environment; Line Quality; and Person. A low score (0) on the Space scale represents a non-existent phenomenon, e.g., the absence of any drawing. A high score (5) reflects the prominence of this phenomenon, e.g., 100% of the space was used.

Two art therapy graduate students underwent training in which they learned to rate PPAT drawings based on the FEATS Rating Manual [50]; Each of the students individually rated 40 PPAT drawings (which were not part of this study), and they reached a high inter-rater reliability calculated by ICC scores ranging between 0.72 to 0.95.

SC-PPAT/c—Symbolic Content in PPAT drawings of children [51]. The SC-PPAT/c comprises of 9 Likert scales for ranking the content-related characteristics of the tree, the person, and the relationship between them. The scales measure the quantity of apples on the tree; a tree's strength vs. its weakness; the degree to which the person is active or passive in the apple-picking; the degree of success in picking the apple; amount of contact between the person and the tree; the height ratio between the person and the tree; the position of the tree trunk in relation to the person; the proximity of the branches to the person; and the proximity of the tree's apples to the person. The Likert scales each have five to six points, depending on the scale. A low score (0) reflects a non-existent phenomenon, e.g., one of the objects is missing, while a high score (5 or 6) reflects the strong prominence of this phenomenon, e.g., a person with an apple in hand, which demonstrates success in the picking task. A previous study [38] revealed high inter-rater agreement and Interclass Correlations Coefficients (ICC) ranged from 0.78 to 0.96. In the current study ICC scores ranged between 0.84 to 0.99 (n = 35). After reaching inter-rater agreement, the rest of the drawings were divided between them for scoring.

The Narrative Focus Degree Scale [52]. A 6-point Likert scale measures the narrative focus of PPAT drawings. Narrative focus varies and ranges from drawings focusing only on the picking theme to drawings that contain a competing narrative that steers attention away from the picking theme. Drawings featuring the PPAT as the main theme receives a score of 1 to 4 that reflect an increasing PPAT narrative emphasis and richness. A score of (5) reflects the presence of a competing narrative, and a score of (0) reflects the absence of a

picking narrative. Two art therapy students who were asked to rank 35 drawings reached high inter-rater reliability (ICC = 0.84).

2.3. Procedure

The Israeli Ministry of Education and the ethical committee of the University of Haifa's Faculty of Social Welfare and Health Sciences approved the study. First, kindergarten teachers were invited to take part in this research, and then the children's parents were contacted. Data was collected during 2018 and 2019. PPAT drawings [35], and the CAMP [49], were administered individually in the presence of a researcher. The children's mothers completed the SDQ [40], which measures the child's strengths and difficulties, the BSI-18 [44], which measures maternal stress, and a measure that assesses the degree to which their children were exposed to events of political violence [15]. Finally, the children's teachers responded to five scales of the BRIEF questionnaire [48] that measures children's problems in executive functions.

3. Results

3.1. Preliminary Analyses and Descriptive Statistics—PPAT Drawings

Table 2 about here.

Table 2. Ranges, Means, Standard Deviations of the FEATS scales (*N* = 156).

Scale No.	FEATS Scales	Min	Max	Mean	SD
1	Prominence of Color	1	4	2.28	1.10
2	Color Fit	0	5	4.09	1.09
3	Implied Energy	0	5	2.96	0.94
4	Space	0	5	3.16	1.13
5	Integration	0	4.5	3.02	1.03
6	Logic	0	5	4.12	1.24
7	Realism	0	4	2.64	0.79
8	Problem Solving	0	5	2.07	1.61
9	Developmental Level	0	4	2.52	0.49
10	Details of Objects & Environment	0	5	2.13	1.38
11	Line Quality	2	4.5	3.38	0.56
12	Person	0	5	3.40	1.43

Table 3 about here.

Table 3. Means, Standard Deviations of the SC-PPAT/c: Symbolic Contents in children's PPAT [51] (*N* = 156).

Scale No.	Measure	Points on Likert Scale	Score No. 1	Score No. 5 or 6	Mean	SD
1	Quantity of apples on the tree	6	A tree with no apples	Above ten apples on the tree	3.22	2.10
2	Tree's strength vs. weakness	5	A very weak tree (more than 3 weakness indicators)	A very strong tree (more than 3 strength indicators)	2.29	1.62
3	The degree to which the person is active in apple-picking	5	The person clearly avoids picking (e.g., turned in another direction)	The person is clearly active in the picking process, plus stands on a heightening object	2.35	1.52
4	Degree of success in picking the apple	5	There is no closeness nor touch with the apple, or there are no apples on tree.	The person holds one or more apples, and/or the apple/s is/are in a basket/container	1.98	1.57

Table 3. *Cont.*

Scale No.	Measure	Points on Likert Scale	Score No. 1	Score No. 5 or 6	Mean	SD
5	Contact between the person and the tree	4	There is one point of contact between the person and tree/apple	The person is actually within the contour of the tree	1.21	0.97
6	Height ratio between person and tree	6	The person is significantly shorter than the tree (1:5)	The person is taller than the tree (2:1)	3.25	2.02
7	Position of tree trunk in relation to the person.	5	The tree trunk is inclined away from the person.	The tree trunk is inclined toward the person.	2.22	1.39
8	Branch (or tree top) placement in relation to the person (close vs. far).	5	Branches placed on the side of the tree farther from the person.	Branches stem from the trunk, towards the person (clearly assisting).	2.30	1.60
9	The extent to which apples are scattered on the tree either close or far from the person	5	All apples are placed on the side farther from the person	All apples are placed on the side closer to the person	2.62	1.75

Based on Tables 2 and 3, the average drawing in this sample (see for example Figure 1) demonstrates the use of realistic color, with some of the drawn forms colored in. Children invested moderate energy in their drawings and used approximately 50% of the space. Most of the drawing reflect a development stage approaching the latency period; the items in the drawings were recognizable but simply drawn. The drawings contained only one unrecognizable item. The drawn person is holding an apple, but it is not clear how he/she obtained it. In addition to the person, tree, and apple, a horizon line/ground is perceptible, line quality is good (a controlled line), and there is integration of two to three elements. The drawn person is identifiable.

Figure 1. An average PPAT drawing, in regard to form and content layers.

Observation of the content layer of the PPAT drawings reveals a fairly weak tree with 3 or 4 apples on it. The drawn person seems passive or is avoiding the picking process, and though the apple and person are close, there is no contact between them. The person is shorter than the tree by a ratio of 1:3. The tree truck is slightly inclined away from the person. Tree's branches or treetop are neutral in relation to the person; however, they are high and inaccessible to the picker. The apples are placed on the side farther away from the person or distributed equally.

Confirmatory Factor Analysis (CFA) was conducted using AMOS software version 23 for the FEATS and for the SC-PPAT scoring systems that compares the theoretical model and the empirical model (leaning on previous data, [39]).

Table 4 about here.

Table 4. Confirmatory Factor Analysis of FEATS scales.

Measure		Factor	Estimate
Prominence of Color	<—	Vividness	0.419 ***
Implied Energy	<—	Vividness	0.719 ***
Space	<—	Vividness	0.666 ***
Details of Objects & Environment	<—	Vividness	0.906 ***
Integration	<—	As-Real-R	0.699 ***
Realism	<—	As-Real-R	0.714 ***
Problem Solving	<—	As-Real-R	0.306 ***
Developmental Level	<—	As-Real-R	0.878 ***
Color Fit	<—	As-Real-R	0.553 ***
Person	<—	As-Real-R	0.452 ***
Line Quality	<—	As-Real-R	0.369 ***

χ^2 (36) = 84.10, $p < 0.0001$, CFI = 0.936, RMSEA = 0.093, SRMR = 0.067. Correlations between the two latent variables r = 0.734. *** $p < 0.001$.

Table 5 about here.

Table 5. Confirmatory Factor Analysis of SC-PPAT/c2 scales.

Measure		Factor	Estimate
The degree to which the person is active/passive in apple-picking	<—	Person's Agency	0.985 ***
Degree of success in picking the apple	<—	Person's Agency	0.862 ***
Quantity of apples on the tree	<—	Tree's Generosity	0.543 ***
Strength vs. weakness of tree	<—	Tree's Generosity	0.541 ***
Position of the tree trunk in relation to the person	<—	Tree's Generosity	0.893 ***
Branch/s placement in relation to the person	<—	Tree's Generosity	0.890 ***
The extent to which apples are scattered on the tree either close or far from the person	<—	Tree's Generosity	0.836 ***

χ^2 (13) = 22.85, $p = 0.043$, CFI = 0.98, RMSEA = 0.070, SRMR = 0.046. Correlations between the two latent variables r = 0.746. *** $p < 0.001$.

Regarding the FEATS scores, the CFA yielded acceptable goodness of fit indices. The first factor, Vividness, was identical in scale composition to this factor in previous sample [39], incorporating the following scales: Prominence of Color; Implied Energy; Space; and Details of Objects and Environment (Cronbach's Alpha was 0.80). Vividness accounted for 40% of the common variance. Figures 2 and 3 illustrate high and low levels of this factor respectively.

Figure 2. PPAT drawing with a high Vividness factor.

Figure 3. PPAT drawing with a low Vividness factor.

The second factor was found to incorporate more scales than the previous model; specifically, it included: Color Fit, Integration, Realism, Problem Solving, Developmental Level, Line Quality, and Person, with a good reliability (Cronbach's Alpha was 0.73). This factor was named As-Real-R, because most of its scales serve the purpose of drawing recognizable images through the use of realistic colors, the relationships between the drawn objects, and a controlled line quality. R stands for Revised and different this factor from the original 'As-Real' factor in the study of Roth et al. [39]. Figures 4 and 5 demonstrate high and low levels of this factor respectively.

Figure 4. PPAT drawing with a high As-Real-R factor.

Figure 5. PPAT drawing with a low As-Real-R factor.

Regarding the CFA of the SC-PPAT scores, we found no difference between the two models. As shown in Table 5, two main factors were obtained: 'Person's Agency' describes the degree a person is active/passive in the apple picking process, and the degree of apple-picking success. Figures 6 and 7 demonstrate high and low levels of this factor, respectively.

Figure 6. PPAT drawing with a high Person Agency factor.

Figure 7. PPAT drawing with a low Person Agency factor.

'Tree Generosity' pertains to the tree's strength, its number of apples, and the tree's orientation is relation to the drawn person, including the trunk's inclination, and placement of branches. Figures 8 and 9 demonstrate high and low levels of this factor, respectively.

Figure 8. PPAT drawing with a high Tree Generosity factor.

Figure 9. PPAT drawing with a low Tree Generosity factor.

These factors yield a total of 84% of the explained variance.

Table 6 shows frequency score distribution of the PPAT drawing's narrative focus. As can be seen the PPAT narrative was observed to be the main narrative in only 43.6% of the drawings. In about 28% of the PPAT drawings, the PPAT script was absent due to lack of at least one of the objects (a tree, a person, and/or an apple) (see for example Figure 10); in

about 33% of the drawings, the children depicted narratives that rival the picking script and that became the central narrative (see for example Figure 11). The Mean score in this scale was 2.48 (SD = 2.03), i.e., on average the drawing showed a PPAT script that is limited to the picking script, with some degree of emphasis on one element of the script.

Table 6. Frequencies of Degree of Narrative Focus [52] *N* = 156 in comparison to the prevalence in percentages from a sample of the same age from a non-war zone [39] *N* = 125 in parenthesis. Adapted with permission from [39] 2020 Elsevier Ltd.

Score	Category	Description	Frequency	Valid Percent	Cumulative Percent
0	Absence of PPAT narrative message	Partial or complete absence of picking aspects	37	23.7 (12)	23.7
1	Schematic and balanced PPAT narrative message	The drawing focus solely on the PPAT story, with equal investment in all parts of the drawing	30	19.2 (20)	42.9
2	Emphasized narrative message	The drawer emphasizes certain details about the person/tree/ picking/apples/accessories/environment (in this example the trunk)	20	12.8 (28)	55.8
3	Narrative message supported by the environment	The environment supports the picking process sun, plants, flowers, etc.	9	5.8 (4)	61.5
4	Narrative message of PPAT reflected by other/s	The presence of a live audience watching the picking (e.g., a turtle.)	9	5.8 (12)	67.3
5	Competing/rival narrative message	The presence of elements that distract the attention of the apple picker (e.g., a snake approaching the picker)	51	32.7 (21)	100.0

Figure 10. PPAT drawing with a missing apple-picking narrative.

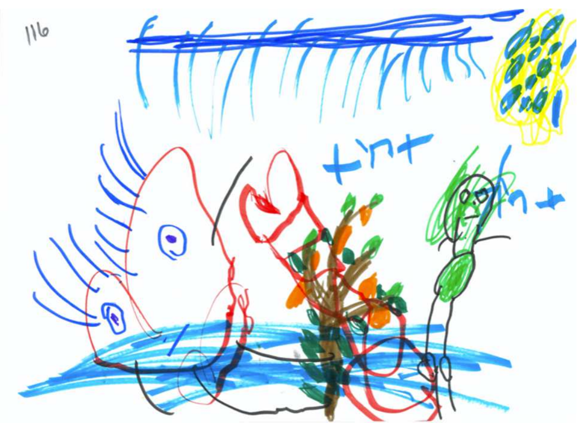

Figure 11. PPAT with a rival narrative.

3.2. Preliminary Analyses and Descriptive Statistics—Independent Variables

Pearson correlations were calculated between the child's variables with the goal of analyzing theoretical validity (Table 7), in specific, between the BSI global score of maternal stress, the SDQ sum of two scales that were found with high reliability (emotional symptoms, and hyperactivity), the BREIF total score summing the five scales, and the CAMP score of child's self-potency. The results in Table 7 show that a significant association was found between the emotional problems of the child reported by the mother and EF problems reported by the child's teacher (r = 0.438, $p < 0.0001$). Additionally, a medium significant association was found between the degree of maternal stress and the child's emotional symptoms reported by the mother (r = 0.273, $p < 0.004$). Non-significant associations were found between the child's self-potency, maternal stress, and child's emotional symptoms. We also calculated these correlations in each gender group and found two additional associations only among girls: a positive association between maternal stress degree and girls' EF problems (r = 0.351, $p < 0.011$), n = 52; and a negative correlation between girls' EF problems and self-potency (r = −0.27, $p < 0.036$), n = 60. These associations partly confirmed the first hypothesis.

Table 7. Associations between global scores of child's problems in EFs, emotional symptoms, self-potency, and maternal stress, for the whole sample and for gender groups.

Correlations					
		Maternal Stress (BSI)	**Emotional Problems (Total of Two SDQ Scales)**	**Difficulties in EFs (Total of BREIF 5 Scales)**	**Self-Potency (CAMP)**
Maternal Stress (BSI)	Pearson Correlation	1	0.273 **	0.128	−0.007
	Sig. (2-tailed)		0.004	0.194	0.945
	N	109	109	105	109
Emotional Problems (Total of two SDQ scales)	Pearson Correlation	0.273 **	1	0.438 **	−0.001
	Sig. (2-tailed)	0.004		0.000	0.995
	N	109	111	107	111
Difficulties in EFs (Total of BREIF 5 scales)	Pearson Correlation	0.128	0.438 **	1	−0.121
	Sig. (2-tailed)	0.194	0.000		0.188
	N	105	107	120	120
Self-Potency (CAMP)	Pearson Correlation	−0.007	−0.001	−0.121	1
	Sig. (2-tailed)	0.945	0.995	0.188	
	N	109	111	120	154

** Correlation is significant at the 0.01 level (2-tailed).

Spearman correlations were calculated between maternal assessments of the amount of political violence events that children witnessed and maternal stress and the child's emotional and cognitive problems. As Table 8 shows, the number of events of political violence to which the child was exposed according to the mother's assessment was positively correlated with the emotional problems she reported about her child (r = 0.362, $p < 0.0001$) and with her level of maternal stress (r = 0.309, $p < 0.002$). The last result confirms the second hypothesis, and indicates that the more the mother assessed that her child was exposed to events of political violence, the more she experienced maternal stress.

Table 8. Associations between the mother's assessment of political violence events, with global scores of maternal stress and child's variables.

Correlations						
			Emotional Problems (Total of Two SDQ Scales)	**Difficulties in EFs (Total of BREIF 5 Scales)**	**Maternal Stress (BSI)**	**Self-Potency (CAMP)**
Spearman's rho	Political violence events—amount assessment	Correlation Coefficient	0.362 **	−0.010	0.309 **	−0.033
		Sig. (2-tailed)	0.000	0.921	0.002	0.740
		N	102	99	100	102

** Correlation is significant at the 0.01 level (2-tailed).

3.3. Hypotheses Analyses Regarding the PPAT Drawings and Independent Variables

To examine hypotheses no. 3–5, we computed Pearson correlations between the child's variables and the main factors of the drawings. Table 9 presents these associations.

Table 9 about here.

Table 9. Associations between the PPAT drawings' main factors, and global scores of maternal stress and child's variables, for the whole sample and for gender groups.

		Tree Generosity		**Person Agency**		**Vividness**		**As-Real-R**	
Self-Potency (CAMP)	Pearson Correlation	0.381 **		0.310 **		0.124		0.360 **	
	Sig. (2-tailed)	0.000		0.000		0.126		0.000	
	N	154		154		154		154	
	By Gender Girls | Boys	0.54 **	0.295 *	0.408 **	0.206	0.249 *	−0.075	0.560 **	0.178
	Sig. (2-tailed)	0.000	0.013	0.000	0.084	0.033	0.535	0.000	0.138
	N	74	71	74	71	74	71	74	71
Emotional Problems (Total of two SDQ scales)	Pearson Correlation	−0.214 *		−0.170		−0.134		−0.222 *	
	Sig. (2-tailed)	0.024		0.075		0.161		0.019	
	N	111		111		111		111	
	By Gender Girls | Boys	−0.081	−0.351 **	0.000	−0.283 **	−0.139	−0.055	−0.090	−0.241
	Sig. (2-tailed)	0.564	0.007	0.998	0.031	0.322	0.683	0.523	0.068
	N	53	58	53	58	53	58	53	58
Difficulties in EFs (Total of BREIF 5 scales)	Pearson Correlation	−0.421 **		−0.301 **		−0.192 *		−0.453 **	
	Sig. (2-tailed)	0.000		0.001		0.035		0.000	
	N	120		120		120		120	
	By Gender Girls | Boys	−0.274 *	−0.561 **	−0.124	−0.424 **	−0.108	−0.174	−0.176	−0.563 **
	Sig. (2-tailed)	0.034	0.000	0.347	0.001	0.413	0.186	0.180	0.000
	N	60	59	60	59	60	59	60	59

Table 9. *Cont.*

		Tree Generosity		Person Agency		Vividness		As-Real-R	
Maternal Stress (BSI)	Pearson Correlation	0.019		0.067		−0.077		−0.064	
	Sig. (2-tailed)	0.841		0.487		0.425		0.510	
	N	109		109		109		109	
	By Gender Girls | Boys	−0.119	0.247	0.054	0.071	−0.098	−0.105	−0.124	−0.044
	Sig. (2-tailed)	0.395	0.067	0.702	0.604	0.484	0.440	0.377	0.746
	N	53	56	53	56	53	56	53	56

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

Hypothesis no. 3: As can be seen from Table 9, positive associations were found between the child's self-report of self-potency, and three of the main aspects of PPAT drawings. In specific, the more the child saw herself/himself as self-potent, the more the PPAT drawing depicted a more generous tree (r = 0.38, $p < 0.0001$), a more active drawn person (r = 0.30, $p < 0.0001$), and the drawing was drawn in a more realistic manner (r = 0.36, $p < 0.0001$). These results confirmed the third hypothesis. Two of the associations were significantly stronger among girls than boys, according to Fisher Z of the difference between the correlation coefficients: specifically, the more a girl reported higher self-potency, the more her drawing was higher in As-Real-R factor (r = 0.56, $p < 0.0001$) z = 2.67 ($p < 0.007$), and higher in Vividness (r = 0.24, $p < 0.033$) z = 1.94 ($p < 0.05$).

Hypothesis no. 4: Regarding children's EF problems, negative associations were found between the child's EF difficulties and the four main aspects of the PPAT drawing for the whole sample (associations range between −0.19 to −0.45). However, after a division according to gender, one significantly stronger association was found among boys (n = 59). Specifically, the more the teacher reported that a boy had EF difficulties, the more the boy's PPAT drawing was lower in As-Real-R factor (r = −0.56, $p < 0.0001$) z = 2.44 ($p < 0.01$).

In relation to the children's emotional problems, small negative associations were found between the total score of emotional problems and two PPAT aspects (tree generosity and the drawing's As-Real-R factor) for the whole sample. The correlations in each gender group were not significantly different according to Fisher Z. These associations (between EF and emotional problems and the PPAT drawings' main factors) partly confirmed the fourth hypothesis.

Hypothesis no. 5: As Table 9 shows, we found non-significant associations between maternal stress and the child's PPAT drawings, for the whole sample and for gender groups. For further examination, we also computed Pearson correlations for each sub-scale of the maternal stress measure, and we found a single positive association between the degree of maternal depression and the generosity of the boy's tree (r = 0.28 *, $p < 0.035$). This means that the more the mother was depressed, the more her son drew a generous tree. This result showed that the fifth hypothesis was not confirmed.

Hypothesis no. 6: To examine the possibility of an association between the assessments of mothers regarding the degree of exposure of their children to events of political violence and PPAT drawings, we calculated Spearman correlations, and found that only among girls (n = 50), the higher the number of events of political violence that the daughter was exposed to according to her mother's assessment, the more the daughter tended to draw an active drawn person in her PPAT drawing (r = 0.49 **, $p < 0.0001$), a generous tree (r = 0.28 *, $p < 0.048$), and a realistic drawing (r = 0.33 *, $p < 0.016$). The sixth hypothesis was disapproved.

Hierarchical linear regressions were carried out to examine the impact of children's gender, self-potency, and EF difficulties on the main factors of the children's PPAT drawings. Gender was entered in the first block; in the second, self-potency and EF difficulties were entered using the stepwise method. Two statistically significant models were found as explaining the drawing's As-Real-R factor, and the Tree Generosity (see Tables 10 and 11).

The results of the hierarchical linear regression analysis revealed that in regard to the Tree Generosity factor, gender was not a statistically significant predictor ($p > 0.05$); however, in regard to the As-Real-R factor, gender was found to be a statistically significant predictor.

Table 10. Multiple Linear Regression Stepwise (Dependent Variable: As-Real-R Factor in PPAT).

Variable	Model 1			Model 2			Model 3		
	B	**SE B**	**β**	**B**	**SE B**	**β**	**B**	**SE B**	**β**
Gender	0.34 **	0.12	0.25 **	0.22	0.14	0.16	0.20	0.11	0.15
Difficulties in EFs (BRIEF) [b]				0.02	0.003	−0.42 ***	−0.01	0.003	−0.39 ***
Self-Potency (CAMP) [c]							0.07	0.018	0.31 ***
F Change		7.68 **			25.71 ***			16.08 ***	
R^2 (Adj. R^2)		0.06 (0.05)			0.23 (0.22)			0.33 (0.31)	
R^2 Change		0.06			0.17			0.09	

Gender 1 = Female. [c] CAMP Questionnaire; [b] BRIEF Questionnaire. ** $p < 0.01$; *** $p < 0.001$.

Table 11. Multiple Linear Regression Stepwise (Dependent Variable: Tree Generosity in PPAT).

Variable	Model 1			Model 2			Model 3		
	B	**SE B**	**β**	**B**	**SE B**	**β**	**B**	**SE B**	**β**
Gender	−0.15	0.25	−0.06	−0.40	0.23	−0.15	−0.45	0.21	**−0.17 ***
Difficulties in EFs (BRIEF) [c]				−0.03	0.006	−0.45 ***	−0.03	0.006	**−0.41 *****
Self-Potency (CAMP) [d]							0.17	0.04	**0.37 *****
F Change		0.36			28.24 ***			**23.56 *****	
R^2 (Adj. R^2)		0.003 (−0.005)			0.20 (0.18)			**0.34 (0.32)**	
R^2 Change		0.003			0.20			**0.14**	

Gender 1 = Female. [d] CAMP Questionnaire; [c] BRIEF Questionnaire. * $p < 0.05$; *** $p < 0.001$.

Tables 10 and 11 show the influence of gender, self-potency and EF difficulties on the degree of the drawing's As-Real-R factor (F(3,115) = 18.55, $p < 0.001$) and the influence of self-potency and EF difficulties on the degree of Tree Generosity (F(3,115) = 19.27, $p < 0.001$).

Specifically, the R2 indicated that 33% of the variance in the drawing's As-Real-R degrees can be explained by variances in the three predictor variables: gender, self-potency and EF problems. For Tree Generosity, the R2 indicated that 34% of the variance in the Tree Generosity degree is explained by the child's self-potency and EF difficulties.

Hypothesis no. 7. As can be seen in Table 6, in drawings of children from the same age group from a non-war zone (n = 125) [39], the main narrative in the majority of the drawings (66%) was that of a person picking an apple from a tree (the percentage-sum of categories number 1 to 4); however, the current study revealed different results. Specifically, only 43.6% of the drawings depicted a central narrative of a person picking an apple. To calculate the difference of comparison of the proportions (of the two categories of missing picking narrative and rival narrative), a significant Chi-Squared of 14,084 was found $p < 0.002$.

The Focus of the Narrative scale was recoded into three main categories: (a) drawings lacking a picking scene (category 0; n = 35); (b) drawings depicting a picking scene as a the main narrative (categories 1–4; n = 68); and (c) drawings that depict a rival narrative as the central narrative (category no. 5; n = 51). We first conducted Spearman correlations between the three narrative categories and the child's variables, including maternal stress, and then conducted further One-Way ANOVA tests (see Table 12), which revealed significant differences between the three narrative focus groups in terms of their self-potency scores F (2,115) = 12.05, $p < 0.0001$, Partial Eta Squared was 0.163. (Scores of self-potency for each narrative groups: Group 1. Missing picking narrative-Mean: 13.67, SD = 3.5; Group 2. A

focused picking narrative-Mean: 16.60, SD = 2.24; Group 3. A rival narrative-Mean: 16.41, SD = 2.74). A post hoc Bonferroni test showed significant differences between Group 1 and the other two groups, i.e., children that drew a PPAT drawing without a picking narrative had the lower self-potency scores in comparison to children who drew a picking scene as the main narrative or a picking scene with a rival narrative.

Table 12 about here.

Table 12. Univariant ANOVA for self-potency differences withing the three narrative categories.

Tests of between-Subjects Effects						
Dependent Variable: Self Potency (CAMP)						
Source	**Type III Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**	**Partial Eta Squared**
Corrected Model	220.677 [a]	2	110.339	14.723	0.000	0.163
Intercept	34,659.932	1	34,659.932	4624.984	0.000	0.968
PPAT Narrative Focus: 3 groups	220.677	2	110.339	14.723	0.000	0.163
Error	1131.604	151	7.494			
Total	40,154.750	154				
Corrected Total	1352.281	153				

[a] R Squared = 0.163 (Adjusted R Squared = 0.152).

4. Discussion

The present study sought to investigate the experiences of preschool children living in areas of prolonged political violence through examination of their PPAT drawings in relation to various child and maternal variables.

Regarding the children's mothers' perspective, significant associations were found between mothers' reports on the degree to which their children were exposed to events of political violence and the degree of maternal stress. According to caregiving theory, one of the parent's roles is to keep the child safe for the purpose of her/his survival [53], as well as to serve as a secure haven, helping the child in times of need to cope with stress and anxiety [54]. However, within the context of political violence, the parent may feel that his/her ability to fulfill the two roles is compromised, and thus experience heightened emotional distress (e.g., [55]). This may trigger a cycle in which the maternal caregiver's functions- for instance maternal responsiveness and sensitivity- are limited due to higher maternal stress, and this in turn may have a negative effect on the child's well-being (e.g., [10,55]). Accordingly, the current study found that the more mothers reported experiencing stress, the more they tended to report that their child suffers from emotional problems. Although parent's reports may be biased by their own distress and symptomatology [56], significant associations were found in the present study between the mother's and teacher's reports about children's difficulties. Thus, the current study confirms the presence of associations between maternal stress and the child's emotional problems. In regard to maternal stress and child's variables, we found that among girls only, the more the mother felt stress, the more EF problems her daughter has, and the more girls had EF problems, the lower their sense of self-potency. Bearing in mind the small sample size of the current study, particularly in the context of the effects of gender, further research is required in order to determine whether girls' executive functioning is vulnerable to the effects of maternal stress or distress.

Regarding children's self-potency, which was assessed from the child's perspective in this study, we found a surprising finding of no association between maternal stress and the child's self-potency. We would like to present three possible explanations for this finding. First, from a developmental perspective, the child's sense of self-agency is formed early in her/his development, and this may show continuity despite contextual liabilities over time (e.g., [57]). Second, the present study did not measure additional

parental aspects that are known to have an impact on the child's variables in the context of conflict, for example parental support and monitoring [58,59]. In addition, the present study did not include paternal variables that have a crucial influence in the context of the triadic relationship, and in particularly during stressful events, when the child might calm down as a result of reaching out to the other parent, or even by watching her/his parents in a calm dialogue or discussion about the situation [60]. The third explanation leans on the ecological perspective which takes into account the potential of the community to mitigate the effects of armed conflict [61,62]. Specifically, in the present study, the children and their families live within mainly small collective communities that have already established social and community initiatives and services designed to help their members cope with the daily events of violence [63]. Thus, we can suppose that the community, which also includes members of the kindergarten staff, functions as a buffer and as a protective factor in regard to the children's sense of self-potency. This speculation is in accordance with one of the dimensions of the self-potency concept- which includes the individual's perception of the social envelope as a source of support in times of need [28].

4.1. The Drawings as a Source of Insight

The current study sought to examine associations between PPAT drawings of normative and functioning children who live in an area of persistent political violence and children's and maternal variables. The study's results illuminate the potential clinical-assessment value of careful observation of positive and negative aspects of children's PPAT drawings in relation to emotional strengths and cognitive difficulties. The drawings were analyzed and coded quantitatively into art formal elements, content aspects and categories of narrative focus.

Although the form and content aspects were similar to those found in a normative sample of the same age group that lives in a non-war zone in Israel [39], when we examined the focus of the drawings' narrative, we found significant differences: the current sample had more drawings lacking a picking scene narrative, and more drawings with a rival narrative diverting the observer's attention away from the apple-picking scene. These differences may be explained by the unique context that may have interfered and reduced the children's focus on the task's requirements. This could happen for example when children felt preoccupied with other issues, and/ or were overwhelmed with feelings of unsafety, or were vigilant or fearful in the context of living in an area of political violence. Bearing in mind that the drawing task was conducted in the kindergarten setting with an unfamiliar adult (the researcher), it could have been experienced by the children as a stressful event (e.g., [64,65]). Although the same procedure was used in the previous study [38], it may be speculated that the children in the conflict zone suffer from the cumulative effects of stress and this affected their performance. Psychoanalytically-speaking, war interferes with the continuous flow of everyday life and impairs one's sense of personal safety; thus, it may impact attention and perception [66].

Sandler [67] has introduced the concept of 'background of safety,' as a feeling generated from our perceptions:

> "the successful act of perception is an act of integration that is accompanied by a definite feeling of safety—a feeling so much a part of us that we take it for granted as a background to our everyday experience". (p. 353)

Gampel [66]), who researches the experiences of traumatized individuals, has identified the opposite experience, the 'background of the uncanny' which emerges from situations of living in contexts of social violence. Overwhelmed by horror and pain, our precepting and symbolization abilities are impaired. Neuroscience has shown that long-term and chronic stress are related to the heightened secretion of cortisol levels, which may negatively affect cognitive functions by changing processes of neurotransmission in the hippocampus and the prefrontal cortex [68]. We can thus speculate the abilities of 56% of the children who took part in the present study and who drew a missing picking scene and a rival narrative were compromised, and they could not respond accurately to the requirements of the task.

Furthermore, it can be speculated that these children communicated authentic subjective experiences in their drawings, such as the experience that something is missing, and thus fragmented, as in the cases of the missing picking narrative; they also communicated the need to process other "burning" issues that they were coping with, such as by drawing PPAT drawings with a rival narrative.

An additional important finding in this study was that children who drew PPAT drawings with a missing picking narrative reported the lowest self-potency in this sample. This could indicate that these children, whose PPAT drawings revealed a deficient triad (absence of a person, or tree, or apple), implicitly communicated the basic experience of being unable to reach a goal, or to be part of an effective triadic alliance. These are the children that might be in a need of therapeutic intervention to strengthen their sense of self-potency.

The present study also showed evidence of associations between PPAT drawings and emotional and cognitive aspects; in some cases, gender was an intervening variable. The child's experience of self-potency was found to be positively associated with positive aspects in the PPAT drawings; specifically, the more the child perceived herself/himself as self-potent, the more the drawn tree was generous, the drawn person was active, and the drawing was realistic. In addition, the PPAT drawings tended to be more vivid among girls with stronger self-potency. The differences in the expressions of positive experiences of potency between the two genders may be related to meta-analysis reviews showing that girls express more positive emotions than boys (e.g., [69,70]). As mentioned above, in a previous study with the same age-group in Israel in a non war-zone [38]. we found associations between self-potency and positive content in the PPAT drawings only among girls.

Children's difficulties, as assessed by teachers and mothers, were inversely associated with the PPAT drawing's main factors; specifically, as much as the child coped with cognitive and emotional problems, the less generous the drawn tree was, and the less realistic the drawing. EF difficulties were also found to be associated with a less active drawn person, and a less vivid drawing. The present study used a regression model for calculating the explained variance of the PPAT drawings by cognitive and emotional child's variables. Findings show that the children's cognitive difficulties and their self-potency experiences explain only about 30% of the variance of the As-Real-R and the Tree Generosity factors. This indicates that there are additional aspects—not measured in the current study—that may explain the variances of these drawing, for example, creativeness; motivation; cognitive abilities; social abilities; and environmental variables, such as art, education, and more.

In summary, these results may be described as a parallel-track visual communication pattern, in which children express their personal strengths through positive form and content aspects of the drawing, and express difficulties through negative form, content and narrative aspects of the drawing.

This pattern was found in many studies that showed that positive visual drawing elements were associated with child's strengths and abilities, and negative visual drawing element were associated with children's emotional difficulties (e.g., [71–73]). Evidence of this parallel-track visual communication was also found in studies of children's PPAT drawings, for example, poor line quality and less color prominence were associated with children with ADHD [74]; a less active drawn person was associated with EF difficulties, while an active drawn person was associated with higher self-potency in preschoolers [38] and with maternal hostility/aggression among school-age children [37].

The present study, however, also identified an inverse pattern, where negative child/maternal variables were associated with positive expressions in the PPAT drawings. These may be understood as hope expressions, correcting or compensating efforts, and/or wish fulfillments representations in the face of experiences of adversity and helplessness. In this pattern, we found gender to be an intervening variable. Specifically, the more the mother reported feeling depressed, the more her son tended to draw a more generous tree, and the higher the exposure of the daughter to events of political violence according to the

mother, the more the daughter drew a more active person, a more generous tree, and a more realistic drawing. Psychoanalytic theory perceives compensating expressions/behaviors—for example, the phenomenon of an imaginary friend that functions as a buffer against loneliness—as non-adaptive; moreover, when the child relates to the imaginary friend in a concrete way, it also prevents him/her from establishing real relationships [75]. In the same vein, artistic products are interpreted as expressing contents of the unconsciousness as wishes and expressions of the forbidden (e.g., [76]). Furthermore, children's drawings may demonstrate children's defense mechanisms [77]. However, drawing could serve as a space in which the child could engage in intellectual play [78], and/or immerse himself or herself in the potential space and move along the bridge that connects reality and phantasy [79]. Accordingly, the child could feel he or she is a problem solver, a creator and one who controls the drawing medium [80]. Symbolic expressions of hope and overcoming may be understood as child's attempts to self-soothe, regulate emotions, have fun and make the shift from helplessness to agency. Thus, further research is recommended to better understand the nature of the positive images and visual elements in the PPAT drawing in the face of negative life contexts; specifically, do they serve as non-adaptive compensations defenses, or expressions of hope and positive thinking that may be part of adaptive efforts.

The present study's findings—that of a parallel-track communication pattern reflecting child's difficulties and strengths through negative and positive aspects in their drawings versus compensating positive expressions despite experiences of deficit and stress—may demonstrate the complex nature of the individual's drawing as it relates to multiple and sometimes contradictory phenomena. These findings may also reinforce McGrath & Carroll's [81] tenet that projective tasks, including projective drawings, may serve as a portal for the broadband implicit representations of the individual, and not as valid personality tests. This implies that extra caution is needed when endeavoring to draw conclusions from children's drawings.

4.2. Study's Limitations, Future Recommendations, and Clinical Implications

The present study's sample size was 156 children, however teachers and mothers' compliance rates were low, so sample size was reduced when calculating some of the associations and regression tests. We thus recommend conducting this research with a larger sample size, and in particularly, to examine the gender differences that were found in the current study. Secondly, we did not measure paternal variables, and this may be a limitation due to the fact that both parents affect the way children function in many areas. Another limitation is that we did not measure child's behavior factors in times of stressful events, for example behavior of comfort-seeking was found as associated with child's better functioning in a war-zone [82]. This article, because of space limitations, does not include a description of the processes of drawings and the accompanying verbal stories of these children that were also documented.

Regarding clinical implications, the present study makes three main contributions. The first is the ability of PPAT drawing to communicate issues of self-potency, particular drawings that lack the picking narrative. The second is the potential to gain insight about children by observing the narrative of their PPAT drawings. In cases of a missing picking narrative or the presence of a rival narrative, the clinician should ask herself/himself: What is going on? Why is the drawing incomplete? What is the meaning of the absence of an element? What is the meaning of the additional predominant narrative? Thus, the narrative focus may serve as a source of questions and associations for the clinician, as part of her/his effort to better understand the child. The third contribution is addressed towards the psychotherapist who works with children's drawings. The findings which reveal the presence of a parallel-track communication pattern, along with compensating and/or hope expression pattern, demonstrate that each drawing may be the individual child's idiosyncratic expression. This means that in our endeavor to understand the messages the child communicates through his/her drawing, we need to carefully observe each nuance in the drawing, whether it is in the form or content layers, and determine if it illustrates a

positive aspect reflecting the child's strengths or a compensating or hope expression in the face of adversity. During the therapeutic process, after the child draws the PPAT drawing, the clinician may ask questions or even invite the child in a playful manner to draw, for example: "What happened next?"; "what happened before?". These questions/invitations may serve as therapeutic interventions in the case of a picking narrative that is lacking, or the depiction of a passive figure, and may thus enliven the narrative and encourage the child's expressions of self-potency.

5. Conclusions

The present study shows that the PPAT drawings of preschool children who live in area of persistent political violence convey the children's strengths and difficulties through layers of form, content, and narrative. The narrative focus's analysis of these drawings revealed that these children express much more either competing narratives and either the absence of a picking script, than children who live in a non-war zone. These specific narratives may be interpreted as a call for further attention to the child's self-potency and unique needs as they may arise in the context of the 'background of the uncanny' [66]. The associations between the PPAT drawings main factors and the child's variables that were found in the present study reveal a complex communication dynamic. Specifically there are parallel patterns pertaining to the child's strengths and difficulties as they were associated with positive and negative visual aspects in the drawings, respectively, as well as the presence of compensating expressions, reflected in the positive visual aspects created despite adverse context's variables. These expressions may be interpreted as resisting responses against helplessness, and/or restoring actions towards safety, at least in the child's creative space. Further research is required to illuminate on these two patterns; for example, what are the characteristics of children who lean more on parallel versus compensation patterns in their PPAT drawings? What is the role of gender in this respect? Is resiliency related to these forms of communication? Finally, if it is, can we use children's drawings to learn more about how they are coping in the face of stressful event? And how can we further foster their coping skills through art-based interventions?

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Article

Relationship Aspects of Mothers and Their Adolescents with Intellectual Disability as Expressed through the Joint Painting Procedure

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Abstract: The quality of the interaction between mothers and their children with an Intellectual Disability (ID) plays a crucial role in their development and in particular during adolescence. This qualitative study was designed to provide a better understanding of aspects of the relationships between mothers and their adolescents with ID through an art-based tool, the Joint Painting Procedure. The qualitative analysis of six dyads of mothers and adolescents with severe, moderate and mild ID was based on the principles of narrative and phenomenological inquiry. The findings yielded three key themes that emerged from the relational dynamics during the JPP: (1) from dependency to autonomy, (2) the joint painting as a way to foster verbal communication, and (3) playfulness and enjoyment. The JPP appeared to serve as a meaningful art-based assessment of the implicit and explicit aspects of the relationships which evolved during the interaction. The findings underscore the potential of the JPP as a non-verbal, art-based tool that allows researchers and clinicians to learn more about the dynamics of relationships between mothers and their adolescents with ID. It also enables a context where the expression of relational issues can be communicated and even transformed.

Keywords: intellectual disability; adolescents; mother–adolescent relationship; joint painting procedure; art therapy

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1. Introduction

Intellectual disability (ID) manifests before the age of 22 and is characterized by significant limitations in intellectual functioning (IQ < 70) and adaptive behavior compared to peers from the same background and community [1,2]. In recent years, there has been growing acknowledgment that the functioning of children and adolescents with ID is affected by interactions between personality traits, genetic factors, family relationships and parental approaches, much like typically developing children [3]. Similarly, the quality of the interaction between mothers and their children with ID plays a crucial role in their development [4,5]. The phase of adolescence presents even more challenges for mothers and their adolescents with ID [6]. The present study focused on better understanding the relationship between mothers and their adolescents with ID using the Joint Painting technique, a non-verbal, art-based tool.

Parenting a child with ID is an immense challenge that can impact parenthood and the mother–child relationship [3,7]. Children with ID have multiple difficulties that can affect their relationships with their parents, since they experience not only cognitive difficulties, but also difficulties in their emotional and social understanding [2]. Children with ID often display little initiative [8] and limited responsiveness [9]. Consequently, parental

interactions with these children is perceived as less rewarding, and is characterized by less synchronization, pleasure, and reciprocity than for parents of typically developing children [10]. More specifically, studies have found that mothers of children with ID tend to present a more didactive parenting style [11,12], and often use controlling and intrusive behavior [13]. In addition, mothers of children with ID report feelings of tension and guilt [14], stress [15] and a need for support [16].

The quality of parent–child interactions is a significant marker of present and future child and adolescent development. In contrast to the considerable research on typically developing children [17], few studies have examined the interaction between parents and their children with ID. Within this literature, most studies have focused on a specific aspect of parenting such as structuring [18] or comforting [19], and have primarily dealt with samples of young children with ID (for example [17,20]).

The phase of adolescence, which includes complex physical, social and emotional changes [21], may present an even greater challenge for the mother–adolescent relationship [22]. Adolescents with ID and their families are predisposed to a variety of behavioral problems and often need to cope with bullying [23,24]. Studies comparing adolescents with and without ID have noted that the former experience a higher rate of psychopathology, a lower level of satisfaction, greater symptoms of depression and increased bullying [6,25]. In addition, mothers of adolescents with an intellectual disability often report higher levels of parenting stress than parents of typically developing adolescents [22].

Although there is extensive research on the influence of the mother–child relationship on the emotional world of typically developing adolescents [21,26], the relationship of mothers–adolescents with ID has not been sufficiently explored [4]. Most research has focused on relations during childhood or adulthood and has dealt with the parental experience and its impact on the characteristics of the child's behavior [27–29]. Studies conducted with mothers and adolescents with ID relate mostly to the motherhood experience of raising an adolescent with ID [30–32]. For example, studies indicate that mothers of adolescents with ID are concerned about their adolescent's future and the need to use specific coping strategies [33].

Assessing the relationships between mothers and their adolescents with ID is complex, since these adolescents have difficulties verbally expressing their perceptions of the relationship [34]. Most studies rely on verbal reports, but human relationships are composed of two channels of communication: an explicit channel which is captured by the verbal account, and the implicit channel that is connected to non-verbal, procedural and nonconscious expression. These two dimensions develop in tandem, suggesting that relationships should be evaluated on both these levels [35]. Researchers who have probed the implicit aspects of relationships indicate that to evaluate implicit aspects, they should ideally be examined during an interaction [35,36]. One way to evaluate these implicit qualities of the relationship between parents and children is through joint creative processes [37,38]. Over the last four decades, extensive clinical literature has pointed to the value of joint painting and drawings as a way to better understand family relationships [39,40]. These instruments contribute to the evaluation of the implicit dimensions of relationships but have rarely been empirically tested [41].

The present study examined aspects of implicit relationships between parents and adolescents with ID using an art-based assessment, which can thus bypass the verbal obstacles characterizing population with ID [34,42]. It implemented the Joint Painting Procedure (JPP) [43], a validated, art-based assessment tool that has been used in research and clinical settings for over a decade with children in middle childhood [37,44,45].

Joint parent–child painting can shed light on the implicit representations of each partner, as well as the shared representation of a specific dyad. A shared relationship representation differs from an individual representation in that it relates to the behavior of each member of the dyad toward the other and can capture mutual emotional responses in the "here and now" of the mother–child interaction. This ongoing interaction can provide a clearer picture of the implicit aspects of the actual relationship [37,45]. Previous

studies using the JPP indicate that it allows for the evaluation of a range of aspects of the implicit relationship conveyed nonverbally through the painting, the artistic process and the behavior [37]. To the best of our knowledge, no studies have examined aspects of the implicit relationship between mothers and their adolescent children with ID. This study was designed to fill this gap by examining the characteristics of mothers and adolescents with ID nonverbally during a "here and now" interaction using the JPP.

2. Method

This study is part of larger mixed-method research that explores the parent-child relationship of mothers and adolescents with ID. It presents the qualitative part of the study that sheds light on their relationship.

2.1. Participants

The participants were on a list of families who took part in a study conducted 11 years ago on families with children with ID, who were originally recruited through child development clinics. For the purposes of this study, the families were approached by letter followed by a phone call to ask whether they would be willing to participate in the study. The aims and procedure were explained and a meeting was scheduled at the family's home.

This article describes six dyads of mothers and adolescents (five girls and one boy) who were representative of the levels of disabilities of the broader study population; namely, two adolescents with severe disability, two adolescents with moderate disability and two adolescents with mild disability. All the participants were diagnosed as having a non-specific ID (with unknown etiology). The IQ of the adolescents ranged from 40 to 78, based on the Stanford–Binet intelligence scales [46] that was administered to all the participants as part of the larger study. The mothers ranged in age from 46 to 58, and the adolescents ranged in age from 16 to 20. All the mothers were Israelis. One mother was Druze. One Jewish mother self-defined as Orthodox whereas the others stated that they were secular. The mothers' years of education ranged from 11 to 15 with a mean of 12.6. One dyad's native language was Arabic, whereas the others were native Hebrew speakers. All names used in the text are pseudonyms to preserve the participants' anonymity.

2.2. Procedure

The JPP administrator (the third author) met with the dyads in their homes for two to three hours. After a short interaction with the dyad and a brief explanation of the procedure, the researcher and the mother found a suitable space for the joint painting process. Then, the mothers and the adolescents engaged in the JPP, using materials that were provided by the administrator. The procedure was videotaped and still photographs of the artwork were taken. The administrator took detailed notes on the implicit and explicit aspects of the interaction (verbal, behavior and affective components) in each phase of the JPP. A self-reflection diary was written by the researcher/administrator after each home visit. The researcher met the second author (the developer of the JPP) after each session to view the video and discuss it.

This study was approved by the Ethics Committee of the University of Haifa (# 18/036).

2.3. Assessment Tool

The Joint Painting Procedure—JPP [43]. The JPP is comprised of a structured five-step process in which both partners paint on the same sheet of paper, first working separately side by side, and then painting together on a shared area. In the first step, the mother and child are asked to use a pencil to mark their own personal space on the shared sheet of paper. Next, each partner paints inside his or her personal space using gouache. This is followed by the instruction to draw a frame around the painted space, and then paint a path from that frame to the frame painted by the partner. In the fifth and final step, parent and child are asked to paint the rest of the paper together. After painting, the parent and

child look at the painting with the therapist, discuss the shared experience, tell a story about the painting and give the painting a title.

The JPP, which is grounded in the principles of parent–child art psychotherapy [47] and art-based assessments [41], is based on the assumption that diagnostic information is embodied in the way in which the artwork is done, beyond the symbolic content in the artwork. The emphasis is on how people paint and not just about what they paint. The JPP analysis assesses the formal elements of the joint painting (i.e., color, forms, shapes), and assumes that these elements provide information about various implicit aspects of the relationship. At the same time, it incorporates symbolic content such as images and metaphors [43]. The JPP has a validated coding manual designed for middle childhood that includes seven scales, with descriptions of the phenomena that characterize each level of every scale, and relate to the painting process and the final product, as well as behavioral phenomena in each stage of the process. During the data collection phase (administering the JPP to the dyads) which took 12 months, the manual was adapted to adolescents with ID by the researchers including the inventor of the JPP (the first author). In this study, the qualitative analysis of the joint painting used the scales as a way to observe phenomenological phenomena for the purposes of structuring the observation and was not intended to code it numerically [45].

2.4. Data Analysis

The qualitative analysis was based on the principles of narrative and phenomenological inquiry [48,49]. The aim was to conduct an in-depth observation of the ways in which the joint painting process evolves as a reflection of the narrative of the dyadic relationship [50,51]. This phenomenological approach served to investigate the nature of the mothers' and adolescents' relationship as revealed in the process and product of the joint painting [48,52]. The researchers analyzed the concrete descriptions (phenomena) produced in the artwork (i.e., shapes, forms, colors, images) [49]. The narrative inquiry situated the dyad within a storyline where the evolving narrative was composed of the dynamics of the dyadic relationship as conveyed through the process and product of art-making [53]. The dyadic interactions were observed in their natural context in the participants' home and examined the way the relationship unfolded and changed during the joint painting [49,54]. The narrative qualitative inquiry in this study focused on the narrative as it unfolds during the interaction through verbal communication, behavior (individual and joint), the evolvement of the painting process and the narrative embedded the painting itself (analyzed from a phenomenological perspective). The analysis sheds light on the complexity of the dyads' experiences throughout all the phases of the process [49].

The analysis took place in three stages: 1. observing the process separately for each dyad; 2. creating and writing an inclusive narrative for each dyad based on the joint painting, the artwork and the dyad's behavior; 3. consolidating the insights for each dyad and integrating the explicit and implicit aspects of the relationships as they were expressed during the painting process and in the artwork into main themes and sub-themes. This was done by comparing cases to identify the central themes, similarities and differences [55]. 4. Then, the researchers examined and discussed each theme in relation to each dyad.

To strengthen reliability, a number of analysis methods were implemented [56]. The authors examined the videotaped interaction as well as the paintings of each dyad, and made considerable use of the written self-reflection and in-depth descriptions of the third author. The third author conducted on-going consultation sessions with the research facilitators (authors A and B) for the purpose of triangulating points of view.

3. Findings

The narrative analysis was based on total of six dyads, four of which are described in depth below. All six dyads are described in the themes section.

Case Study # 1: Rona (17) with severe ID (IQ < 40) and her mother.

Rona looked excited before the joint activity, and she smiled and hugged her mother. Her mother stroked her head and said: "Come on Rona, we have work to do". Rona held her mother's hand and her mother gave her the pencil and said that they both had pencils. Rona's mother outlined the shape of a heart and Rona scribbled across the page and tapped on it with the paintbrush, with excitement. When the mother realized that Rona could not draw the outline of the shape, she held Rona's hand and drew a heart with her and said: "Mom drew a big heart and Rona is drawing a small heart". Rona tapped her mother's shoulder with a broad smile.

When they were asked to draw in their individual spaces, Rona's mother placed a paintbrush in Rona's hand and said: "A paintbrush for you and one for me". Rona was curious about the paintbrush and painted a blue line without any help. Her mother encouraged her, and Rona tapped on the page with the paintbrush. Her mother outlined the heart she had drawn in red and connected it to Rona's border. When her mother encouraged Rona to continue, Rona painted in black inside and outside her mother's heart, and then added yellow inside her mother's heart shape. Rona mixed a large quantity of different color paints until the color turned brown–purple, and then smeared thick layers on the page. Her mother painted the heart that she had drawn beforehand for Rona using the thick paint that Rona had left on the page, and Rona painted over it in various colors (see Figure 1).

Figure 1. Rona and her mother.

Rona became tired, placed the paintbrush to the side and rested her head on her mother's shoulder. Her mother put another paintbrush in Rona's hand and tried to help her find a color, but Rona refused, and painted with her finger on her hand. Her mother put her hand over Rona's hand and helped her paint with her hand on the page, but Rona preferred to continue painting on her hand and not on the page. Her mother painted on the page using her finger and said to Rona: "Now it's your turn", but Rona still refused to join her.

When asked to draw a border around their paintings, Rona's mother again drew Rona's attention to the big heart frame in turquoise. She asked Rona: "Where is your heart?" but Rona did not react and refused to draw a border, while continuing to paint on her hand. Her mother painted a pink heart outline for Rona. Rona was excited, took the paintbrush from her mother's hand, dipped it into her mother's palette and together they reinforced the border of Rona's heart in turquoise. When asked to draw a path, Rona's mother painted a pink line from the inside of her heart to the inside of Rona's heart and continued to thicken the borders of the hearts in the same color. Rona did not want to paint a path and continued to paint on her hand. In the joint space, her mother painted orange

and blue scattered circles and one small heart inside her heart. She tried to paint dots in the style of Rona's tapping and then tried to hold Rona's hand and paint with her, but Rona refused and continued painting on her hand.

In the discussion after the painting process, Rona's mother mentioned that the colors were beautiful and asked Rona what they should call the painting. In response, Rona looked at the painting, hugged her and held her hand. Her mother said that they could call the artwork "Hand in Hand" and she told a story: "Rona and I spend a lot of time together, we walk hand in hand, we take walks together, and this is our story, hand in hand".

To summarize: During the entire painting process, Rona's mother tried to help Rona and be attentive to her needs, while trying to be 'with' her in the painting by painting in a similar way. For example, she imitated Rona's style and choice of colors when finger painting. Rona's mother commented verbally on their joint work and their similarities. While supporting Rona, she was able to express herself in the painting. During the process, Rona sought her mother's touch, and it seemed to help her regulate her emotions. She got attention and reinforcement, and as a result was often able to create without assistance and express herself in various ways (i.e., the way she chose and mixed colors), and seemed to have the choice to withdraw when she was tired. In addition, the painting process and the product seemed to display processes of both autonomy and closeness. This occurred, for example, when her mother repeatedly bolded the outline of both heart shapes, or when Rona and her mother painted freely in each other's shapes (see Figure 1).

Naama appeared timid and embarrassed, and she clung to her mother. Her mother drew an ellipse on the right across the width of the page, and Naama imitated the same shape in a smaller form on the left. When they were asked to paint in their own spaces, Naama said she was falling asleep and hugged her mother. Her voice was weak and bashful. Her mother colored the ellipse turquoise and encouraged Naama to join her, and then Naama colored her ellipse in turquoise using small brushstrokes.

When asked to draw a frame around their spaces, Naama's mother painted a red frame attached to the ellipse, and Naama painted a thick purple frame and described what she was doing. When asked to paint paths, her mother painted a full, thick yellow line that began at Naama's frame, and then turned to Naama and said: "Your turn". Naama drew a green line parallel to her mother's path, starting from mother's frame to hers. The line, however, did not touch either end of their frames.

Case Study #2: Naama (17) with moderate ID (IQ = 44)and her mother.

When asked to paint in the joint space, her mother asked Naama what and how she wanted to paint. Naama suggested filling in the areas with color and asked her mother to paint a yellow heart which she then colored purple. Her mother suggested that this time Naama should draw something, and she would paint inside it, but in response Naama raised her voice slightly, refused, and then drew a small orange shape next to her own space. Her mother reinforced it and filled the shape with light blue. Naama's mother then suggested that each of them could paint a sun and that Naama could paint in other places on the page. She asked Naama to choose what to paint, but Naama admitted that it was hard for her to decide. With considerable mediation by her mother, Naama painted a light blue sky. Her mother asked if she could continue the sky on her side of the page in a different shade of blue, and Naama answered "Only use light blue" and pointed directly at where she could paint. They both painted parallel skies, in each of their own spaces, in the same painting style, and Naama connected them. Naama's mother added white clouds and black birds and explained they were like the birds that fly over their house. Naama painted blue birds, and her mother reassured her and asked what else she could add by pointing to the remaining empty space on the page. She asked, "If there is a sky up above, what can we paint below?" Naama answered "The ground". Her mother suggested they paint the ground on both sides connecting them. Her mother added a turquoise pool and Naama added a blue and black pool. Her mother encouraged her to go on painting and suggested she could add the figure of a child. Naama responded enthusiastically and painted an orange- and grey-colored figure of a boy and asked her mother to draw a girl.

Mother painted a girl with an orange head and asked Naama humorously to give her some positive feedback. In response Naama hugged and kissed her. Naama painted another sun, but this time in the sky and not on the ground. Her mother painted a tree with lemons, a beetle and a snail, and Naama painted grass and a snail (see Figure 2).

Figure 2. Naama and her mother.

When they were asked to give the painting a title, Naama's mother insisted that they should decide together. Naama suggested "Rain" and they both said that the story was about a boy and a girl who go for a walk. Naama asked if she could take the painting to her bedroom.

To summarize, during the painting activity, a process of change was apparent. At first, Naama seemed embarrassed and painted hesitantly with small brushstrokes, slowly, and by focusing on a small shape. Her mother, by contrast, painted with flowing movements and spoke liberally. When connecting their individual spaces with paths, Naama seemed to reach to the dominant path her mother painted along with her comment "Your turn". Her painting style then seemed to change slightly and displayed involvement and confidence. This persisted into the joint painting, during which Naama actively responded to her mother's request to make decisions. She gave instructions, expressed herself from time to time, and even raised her voice somewhat when she was not pleased.

Most of the interaction between Naama and her mother, as expressed in the joined painting, was based on her mother's attempt to mediate the painting process, encourage her to paint, help her make choices, and support her during painting. Her mother tried to be attentive to Naama and her needs, by upholding and providing her with a space to express herself on her own. The joint painting appeared to have provided Naama with a secure space to express herself and allowed both mother and daughter to experience mutual and shared creative expression (see Figure 2).

Case Study #3: Lianne (17) with moderate ID (IQ = 57) and her mother.

Lianne sat down immediately to the right side of her mother, and seemed excited. She wanted to start painting right away and was the first to paint on the page, creating a square frame with a heart shape inside and asking her mother (who had not started to paint yet) "Who paints better?" Her mother appeared tenser and more hesitant, and painted a square frame with a moon shape inside. When they were asked to paint in their individual spaces, Lianne painted a red heart in quick short brushstrokes. While she was painting, Lianne suddenly remarked loudly: "Mom, we never paint together, only when I was little, and that was a long time ago". Her mother agreed and complimented Lianne on her painting. Lianne suggested that her mother paint with turquoise and white, and her mother responded to her suggestion. Lianne's mother painted slowly and did not interact with Lianne

at this stage. Lianne mixed colors on the page and her mother suddenly commented in a relatively loud voice that Lianne's mixture produced a lovely color.

When they were asked to paint a frame, Lianne painted intensively and made red strokes with spaces, and then added white-turquoise strokes until the border turned pink. Her mother painted a pink frame with long slow movements. She commented that Lianne had painted a special frame and Lianne answered with pride: "I was born talented". When asked to paint paths, Lianne said she would choose black, and then burst out laughing. She said: "A black path!" and laughed again, and her mother answered that she could do whatever she wanted. Lihy painted a pink path from her frame towards Lianne's with delicate brushstrokes. Lianne painted a turquoise path from her mother's frame to her own, and then added a parallel purple path but in the opposite direction. Lianne's mother then reinforced her pink path and Lianne imitated her. Then, her mother asked if the paths needed to be joined and immediately Lianne connected them at the point that touched her frame and painted onto a small section of her mother's path (see Figure 3).

Figure 3. Lianne and her mother.

When asked to paint in the joint space, they engaged in a discussion that led to joint artwork: Lianne's mother asked her what she would like to paint and told her that she was creative. Lianne suggested they write their names in English and they both wrote their names in pink. Lianne commented that people tell her she has nice English handwriting, and then she bolded her name. Her mother responded in a soft voice that she writes beautifully. Lianne and her mother decided to paint the shape of a heart around their names together. Lianne said she was excited and they both smiled. Her mother indicated clearly that she was going to paint on her side in red and started painting, while Lianne painted another part of the heart in pink and made it thicker. Lianne said excitedly: "Everything is going well for me today; it's like a miracle". Finally, Lianne added purple stripes inside the heart, and her mother called this addition a "decoration" and complimented her. When they finished painting, Lianne commented that the artwork was very beautiful, hugged her mother and called out "my mom". Her mother suggested they title the painting "Creative Lianne". Lianne said that the painting was about "the way to the moon leads to the heart; you'll always aspire for the moon or to your heart" and decided to call the painting "The Way to the Moon leads to the Heart". She said that she had enjoyed the joint part of the painting experience very much. Her mother said that she particularly liked when they completed the heart together, and that Lianne's idea had helped her.

To summarize, Lianne may have been testing out separateness from her mother, which emerged in her sense of competitiveness and the comparison at the beginning of the

painting process, as well as later on when Lianne said she was going to paint a "black path". Nevertheless, while seeking autonomy, Lianne sought to be close to her mother by using similar colors and saying that she specifically enjoyed the joint painting and the moments when they connected. During the painting process, a change appeared to have occurred in the relationship. Her mother started from a more distant and hesitant stance. When asked to paint a path towards Lianne's frame, she painted a thick, prominent line. Lianne responded to her mother's path by connecting them both. From this stage onward, they both appeared to be enjoyed expressing themselves mutually and individually. The joint heart which was painted during the last stage of the process contained colors from their individual spaces that were associated with their names written inside the shape (see Figure 3). During the creative process, there was a noticeable change in the mother's behavior, from a hesitant presence to active involvement and positive attributions about Lianne. Lianne's story metaphorically described a journey towards closeness.

Case Study # 4: Meital (16) with mild ID (IQ = 70) and her mother.

Meital and her mother looked relaxed and started painting together. Meital painted a square frame and her mother painted a circle. When asked to paint in their individual spaces, Meital's mother said that she did not know what color to choose, and Meital reacted angrily by saying that her mother had never told her what her favorite color was. Meital's mother painted inside the circle in various colors and Meital painted in black. They were both quiet and careful not to color outside of the frame. Meital's mother said: "I have not painted for a long time" and Meital answered furiously: "A long time, never!"

When asked to paint the frame, Meital painted a wavy purple border, and her mother painted a round red frame with black dots. Meital told her it was pretty, and her mother giggled and said: "Thank you, this is fun!"

When they were asked to paint a path, Meital's mother suggested painting two paths that would meet. Meital agreed enthusiastically and started painting in green. Her mother guided her on how to paint and how to hold the paintbrush, although Meital did not appear to have any problems doing so. They painted in green together, towards each other, and met in the middle. Meital's mother made the paths thicker and asked Meital if she wanted to add any extra decorations. Meital decided that they would paint flowers below the path and together they decided to add more paths: her mother painted a brown path underneath the joint path, and Meital painted an orange path above it towards her mother (see Figure 4).

Figure 4. Meital and her mother.

During the joint painting stage, Meital's mother asked her what she would like to paint, and Meital answered: "Whatever you like, mom", and her mother said "So we are

not deciding on something together? What should we paint and where?" Meital suggested they paint butterflies, hearts and trees. Her mother painted two connected hearts in blue and turquoise, and Meital painted two butterflies. Her mother painted two more hearts below Meital's drawing, and then commented twice: "I am invading your drawing space," and added "you are welcome into my space." Meital painted a turquoise heart shape, and her mother painted a colorful butterfly. When her mother commented that there was more empty space on the page, Meital suggested that they each paint a cloud. Meital's mother asked her if she knows how to make grey, and Meital said that did not know. Her mother explained to her and demonstrated how to mix the colors together. They both added rain drops, Meital in blue and her mother in turquoise. Meital's mother then asked what else they could paint, and Meital replied that they could paint a sun. Her mother suggested that Meital paint the sun, and Meital immediately responded that this was a joint painting, and that they could do whatever they liked. Finally, Meital painted a yellow sun on her side of the page (see Figure 4).

When they finished painting, Meital suggested giving the painting a title that related to both of them. They chose the title "Mother's and Meital's painting". They both liked the painting: Meital liked the butterflies and the connecting paths, and her mother liked the clouds and rain.

To summarize, during the creative process, the interaction between Meital and her mother shifted from a relaxed atmosphere to anger when Meital reacted to the fact that her mother had never told her what her favorite color was, and about not painting together. At this stage, Meital only painted in black, and later, when her mother painted a colorful frame, Meital responded positively and used other colors (see Figure 4). At this point the mood changed, and there was laughter in the room and both of their paintings became more colorful. This atmosphere continued during the joint painting stage, when the conversation between Meital and mother was respectful and mutual. This type of communication was also portrayed in the artwork that included pairs of similar figures such as the sun, butterflies, and hearts.

3.1. General Themes: Relationship Dynamics

The analysis of the six case studies yielded three key themes reflecting the dynamics of the relationship during the JPP: (1) from dependency to autonomy, (2) the joint painting as a way to foster verbal communication, and (3) playfulness and enjoyment.

3.1.1. From Dependency to Autonomy

Assistance versus autonomy. The mothers apparently felt the need to help their daughters paint. At the same time, they acknowledged their children's separate space that allowed the adolescents to express themselves as a function of their own abilities and needs. Some of the mothers found it difficult to encourage their daughters to create autonomous artwork. When the mothers enabled autonomy, the adolescents responded by more independent functioning, positive behavioral patterns, and fewer conflicts (as in the case of Meital and her mother # 4). By contrast, with Rona and her mother (case-study #1), the painting process elicited a tension between the need to support Rona and granting her autonomy and separateness.

Nevertheless, the tradeoff between the need to support and granting autonomy was present in all the dyads irrespective of the level of disability. For example, Shirin (IQ = 40) alternated between scribbling on the joint page while playing and enjoying herself, to playing with her mobile phone. Her mother spent most of the time encouraging, helping and re-engaging Shirin in the creative task. Her mother reported that it was difficult for her to cope with Shirin's low functioning and her inability to follow instructions. However, at times, her mother failed to observe Shirin's desire for autonomy; for example, when Shirin asked to paint in a specific color and her mother ignored her and handed her a different color. At a specific point during the painting process, her mother moved away from the page and Shirin began painting a few strokes on her own. It looked like they were playing

a game of "tag" where every time her mother encouraged Shirin to paint, she avoided her, and when her mother moved away, Shirin began painting.

The issue of separateness emerged verbally during the painting process in a dyad composed of Ben (with mild ID) and his mother. Ben's mother delineated a large space for herself that covered half the page and physically approached Ben's side of the page. Ben complained that she was occupying a larger part of their page, and turned his back to her, painted in his space that was detached from the mother's space, and commented that he was demarcating an area for himself. When asked to paint a frame, Ben painted a very thick one. During the entire painting process, Ben refused to paint together and furiously rejected his mother's suggestions. Anger and a lack of willingness to cooperate may have represented his need for separation and autonomy from his mother.

Enabling adolescents' expression of different roles within the dyad. During the joint painting, the adolescents were able to express themselves within the relationships verbally and implicitly and transition from a passive to a more active role. For example, at the beginning of the joint painting process, Meital's mother (case-study #4) was dominant and tried to guide Meital by telling her what to do and how to do it, but as the process continued, her mother suggested that Meital make her own decisions about the painting and invited her to occupy a space on the page both verbally and through art. Meital reacted positively to her mother's encouragement and started to be more active and involved in the painting process. She then was able to decide on the content and its place in their joint painting. Similarly, in Lianne and her mother's joint painting (case-study # 3), the creative process became mutual and they could both express themselves. Lianne manifested her sense of success and satisfaction when she said that everything was working out like a miracle.

A space for mutual recognition. The joint painting appeared to provide an opportunity for these adolescents to express their inner world while remaining in the shared dyadic experience of joint and playful artwork with their mothers. For example, during Naama and her mother's painting process (case-study #2), Naama's mother tried to support Naama and at the same time encourage her independent expression. This allowed them to form a joint mutual space where they both painted the sky and the ground in their own spaces at their own pace and brush strokes until they met. Her mother expressed her desire for connection through her conspicuous path and by asking Naama to paint closer to her, while at the same time encouraging Naama to paint whatever she wanted. In the final painting, there were representations of two figures that were similar, but each has its own unique characteristics. At the beginning of Lianne and her mother's painting process (case-study # 3), there was tension between Lianne's dominance and her mother's hesitancy. When the mother implicitly expressed her wish for a connection via her thick pink path, Lianne immediately responded, and a mutual creative dialogue was initiated while they painted the joint heart in which each contributed an individual expression.

3.1.2. Painting as a Way to Foster Verbal Communication

Conversations emerged during the painting and afterwards, when the mothers and adolescents observed the final artwork together. For example, during Meital and her mother's painting process (case-study # 4), Meital was able to express her anger and frustration. In the end, Meital's title expressed their sense of togetherness. Naama (case-study # 2) was able to verbally express her difficulty deciding on the theme of the painting, but as the creative process unfolded, she was able to clearly express her ideas verbally. The discussion at the end allowed some of the dyads to reflect on the interaction while engaging in conversation where they could share their thoughts, feelings, and experiences about the process and the product. For example, Lianne and her mother (case-study # 3) told the story of a girl on a journey toward closeness that actually took place during the painting process.

3.1.3. Playfulness and Enjoyment

For most of the dyads, the joint interaction had a didactic element that consisted of guided questions, instructions and teaching on the part of the mother, regardless of the level of disability of the child. However, during the creative process, the mothers and adolescents started to communicate with each other through painting, which enabled some of the dyads to create an atmosphere of playfulness and enjoyment. This playfulness was expressed through gestures, speech, and specifically, in the paintings themselves. For example, in the case of Shirin and her mother, in spite of the mother's need to direct and help Shirin, and her concern about her daughter not following the instructions, Shirin expressed positive affect throughout the entire process by laughing, making ecstatic sounds, clapping her hands, forming eye contact and touch. Even though Shirin was often distracted and used her phone as a means of self-regulation, she managed to express herself in the painting in a rich way: it was full of thick colorful lines. Enjoyment was also evident in the creative interaction and exchange of humor between Naama and her mother (case-study #2). Similarly, Rona and her mother (case-study # 1) seemed to experience moments of enjoyment with spontaneous gestures. This was particularly evident when her mother playfully joined Rona in painting with her finger.

4. Discussion

The present study examined aspects of implicit relationships in mothers and adolescents with ID through a non-verbal art-based tool. The findings help reveal and facilitate a better understanding of the relationship dynamics that develop between mothers and adolescents with ID. The JPP was shown to provide a meaningful art-based assessment of the implicit and explicit aspects of the relationships that evolved during the interaction.

One of the central themes that emerged in all the dyads was the negotiation between dependency and autonomy. Autonomy is a central relational issue between parents and typically developing adolescents [57], but is also present in the relationships between parents and adolescents with ID [6]. This may be explained by the specific tension between dependency and autonomy in children with ID, where the dependence experienced by adolescents with ID may lead to compliance but also to difficulty in expressing anger and separateness, which in turn may lead to difficulty in becoming autonomous [32].

A previous study that examined processes of separateness and autonomy through the JPP in dyads of mothers and typically developing children found that autonomy is a crucial facet in the relationships of typically developing children [45]. In the present study, adolescents with ID allowed themselves to express their anger and separateness within the context of making art together. As the findings suggest, the JPP allowed for the expression of both dependency and autonomy. The joint painting allowed the adolescents to find their own separate voice. They could make decisions and occasionally control the situation, which is often impossible for adolescents with ID because of their disabilities [58,59]. Hence, the JPP acted as an assessment tool and as an intervention process that enabled transformative processes.

The joint painting process allowed the dyads to move between mutual experiences of "togetherness" to an individual, autonomous space. The process of mutual recognition was expressed through personal images or the painting styles of each partner that involved certain shared elements such as connected figures or a joint pictorial story. The painting process that developed from the individual work towards a joint work facilitated a rich relational process [37,43]. Mutual recognition within the relationship involves the ability to recognize the self and the other as having separate inner worlds, who at the same time can have a close mutual relationship [60,61]. Mutual recognition does not typically characterize interactions with children with ID [10]; however, in four dyads the painting process encouraged and enabled this recognition. In Rona's and Shirin's dyads with their mothers, the process of mutual recognition did not evolve. This could be related to their level of disability, their difficulties perceiving the point of view of the other, and their need for more assistance in comparison to the higher-functioning dyads [32].

Some of the parents presented a parenting style characterized in the literature as didactive or directive, which often characterizes parents of children with ID [11,12]. This parental behavior makes sense in view of the difficulties faced by children with ID and the support they need [62]. However, throughout the painting process, along with more guided assistance, the possibility for playful and creative mutual interactions emerged. Other studies that have examined the process of joint artwork of children and parents showed that creative work elicited feelings of enjoyment and playfulness and supported the relationship between the parent and the child [45].

As noted by Patton and colleagues (2018) [22], parenting children with ID leads to parental stress, which in turn can prompt negative parenting behaviors that lead to further difficulties in the relationship [63]. The joint painting process offers parents and adolescents a rare opportunity to engage in a creative, playful joint space, with no targeted end point and where they are encouraged to express their emotions and playfulness. As Lianne (case-study # 3) told her mother: "Mom, we never paint together, only when we were little, and that was a long time ago." In a different study on the role of playfulness and joyful interaction in preschool children with ID [64], playful interactions with medical clowns had a significant effect on children's development, whereas the parents of these children reported that they rarely managed to create a playful and enjoyable interaction with their children. The joint painting allows for a mutual experience and sense of enjoyment that seldom occurs in the daily lives of mother and an adolescent with ID.

5. Limitations

One notable strength of this study is the use of art-based assessment that served not only to learn more about the implicit relationships of mothers and adolescents with ID, but also to enable playful and creative communication, which is often rare. However, this study is not without limitations. This study used the JPP, a validated tool for parents and children in middle childhood. Although the manual was adapted for parents and adolescents with ID, further validation of the JPP for this population is needed. The present study examined the interaction between mothers and adolescents, but there are other meaningful relationships in the family, such as the relationship with the father, which was found to be essential for child development no less than the relationship with the mother [65]. Further research could examine the interaction between adolescents with ID and their fathers to explore implicit aspects of their relationship within the framework of joint painting. In addition, this study examined a very small number of participants with relatively diverse levels of disability. Future studies could utilize the JPP with a larger number of dyads that would shed more light on specific levels of disability. Research could also examine gender and cultural features that could impact the specific findings reported here.

6. Conclusions

Two main conclusions emerged from this study. The first relates to the importance of joint painting as a non-verbal art-based technique that allows researchers to learn more about the dynamics of relationships between mothers and adolescents with ID. The findings suggest that the joint painting process allowed for a deep and rich emotional expression on the part of each member of the dyad that yielded a representation of their dyadic relationship. The joint creative process and the shared observation of the product helped manifest a space of expression and communication that does not exist verbally because of these adolescents' disabilities and the difficulties in parenting this population. Some of the joint paintings allowed for a process of change during the interaction where there was a shift towards a mutual space that afforded both mother and adolescent self-expression and enjoyment. From this perspective, the joint painting process provided an opportunity for a unique experience for these adolescents and their mothers.

The second conclusion is connected to the importance of the tradeoff between dependency and autonomy that emerged from the implicit expressions during the painting process. The inevitable tension that exists between the two is common in parent–adolescent

relationships and in particular with mothers and adolescents with ID [59]. The JPP provided a context where the expression of these relational issues could be communicated non-verbally.

Learning about the inner world of adolescents with ID in general and their experience of their relationship with their mothers is challenging due to the verbal barrier. The present study employed an art- based method to learn more about the relationship between these adolescents and their mothers. The engagement and accessibility of the art activity for this population is a significant strength of the JPP, as was found in other art-based studies with adolescents, as well as with young people with ID (see for example, [66,67]. It enables direct access to the lived experience of these adolescents in the context of a relationship dynamic with their mothers.

The results point to the existence of a range of emotional features in the relationships of adolescents with ID and their mothers, much like in typically developing adolescents. It also shows that these implicit qualities can be changed and transformed through the painting process. As such, the present study provides valuable information that can be used by researchers and therapists who work with populations with ID and their parents. This study can inform therapists who work with this population on the potential of using an art-based dyadic intervention that is accessible, informative, engaging and possibly transformative for adolescents and their parents.

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Article

Use of Self-Figure Drawing as an Assessment Tool for Child Abuse: Differentiating between Sexual, Physical, and Emotional Abuse

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Abstract: Child abuse is a worldwide phenomenon with adverse short- and long-term mental and physical negative consequences, with a huge gap between the prevalence of child abuse and disclosure rates. The study aimed to examine and validate the self-figure drawing as an assessment tool to differentiate between three forms of child abuse, i.e., child sexual abuse (CSA), child physical abuse (CPA), and child emotional abuse (CEA). Following the ethical approval, 1707 Thai children (13–18 years old) from the general population (schools) were asked to complete a self-report anonymous questionnaire consisting of four measures (Demographics, Childhood Trauma Questionnaire (CTQ), The Medical Somatic Dissociation Questionnaire (MSDQ), and The Disclosure of Trauma Questionnaire (DTQ)). After completion, they were asked to draw themselves. There was a significantly positive link between the reluctance to disclose and the experience of abuse, indicating that the more severe the abuse the higher the reluctance to disclose. The findings broaden the knowledge of movement and symbols as representations of inner personal conflictual material. Additionally, it substantiates self-figure drawing as an assessment tool and assists practitioners in early child abuse detection.

Keywords: child abuse; sexual abuse; physical abuse; emotional abuse; self-figure drawing

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1. Introduction

Child abuse is a worldwide epidemic, resulting in actual or potential harm to the child's health, development, and dignity [1], that has a devastating variety of short- and long-term physical and mental negative consequences [2]. The long-term consequences contain impaired capacities for trust, intimacy, and sexuality, including a variety of chronic mental and physical health problems [3].

Although child abuse has been classified into four different forms— sexual abuse, physical abuse, psychological abuse, and neglect—the overlapping and the inter-relationships between them bring such difficulty in evaluating the impact of each form towards mental consequences and disclosure [4]. Several studies reveal that multi-types of child abuse often co-occur [5], with neglect accompanied by physical and emotional abuse found to be the most common occurrence [6]. Emotional abuse has been proposed as the core of multi-type abuse, resulting in negative consequences of most cases of abuse [7].

Even though disclosure can bring an end to the child abuse, a great number of survivors keep silence for reasons such as feelings of fear and shame, difficulty to articulate the experience, or are silenced by the perpetrator or his or her supporters [8,9]. Moreover, the impact of abusive experiences on the brain area often leads to dissociation and an inability to recount the traumatic experiences [10].

Under the above circumstances, these proved to be a great challenge for investigators and practitioners to develop techniques to aid victims' willingness to disclose. The self-figure drawing was developed by Lev-Wiesel [11] from the draw-a-person test [12] to identify significant drawing indicators in human figure drawings of individuals with traumatic experiences as it can be used to assess specific psychological and emotional characteristics.

Thus, by differentiating and categorizing indicators presented within drawings into each type of abuse, the self-drawing figure can become a valuable tool to identify the different types of abuse and to evaluate the mental health of individuals.

1.1. Childhood Sexual Abuse (CSA)

This term describes the condition where the child is being subjected to any behavior of sexual intent or content by an adult or another child that is older than them. Therefore, CSA may range from fondling to rape, non-contact abuse, e.g., voyeurism, exhibitionism or unwanted sexual comments, sexual exploitation, or any other sexual assault form [13].

Survivors of CSA are at high risk of developing subsequent physical health symptoms, i.e., general health, gynecological pain, cardiopulmonary symptoms, and obesity [14]. CSA was found to be strongly associated with clinical levels of psychological distress, low self-esteem, PTSD, anxiety, depression [15], eating disorders [16], borderline personality disorder, alcohol and drug abuse, and delinquency [17].

1.2. Child Physical Abuse (CPA)

According to Al-Shail et al. [18], the term is stated as the intentional use of physical force that caused harm, or high risk of harm, to the child. This definition generally includes a large variety of types and degrees of physical force, e.g., shoving, hitting, slapping, shaking, throwing, punching, biting, burning, or kicking.

There is a high prevalence of head and orofacial injuries in CPA, with bruising as a common injury among children [19]. CPA is a risk factor for a range of long-term consequences, i.e., depression, anxiety, low self-esteem, PTSD, borderline personality disorder, suicidal behavior, and aggression [20]. Suffering from CPA also results in eating disorders, insecure or disorganized attachments, and the tendency to become a victim of intimate partner violence [21].

1.3. Child Emotional Abuse (CEA)

The term comprises verbal and nonverbal degrading, terrorizing, exploiting, corrupting, ignoring, and isolating, as well as hostility, rejection, and the prevention of needed stimuli and/or the denial of emotional responsiveness [22]. The interactions, as well as inappropriate emotional responses from a parent, are in repeated patterns and perceived as typical in the parent–child relationship.

A large array of evidence indicates that childhood emotional abuse has adverse detrimental short- and long-term negative consequences [23] that involve a wide range of physical and psychological issues, e.g., PTSD, anxiety, depression [24,25], low self-esteem, substance abuse, obesity, fatigue, poor general health, chronic pain conditions [26], sexual difficulties, and a higher risk of committing suicide or having suicidal thoughts [21].

1.4. Multi-Type Abuse

In many cases, the child is subjected to multi-type abuse, especially CEA with either CPA or CSA [27]. It has been indicated that exposure to multi-type childhood abuse is associated to higher levels of mental and physical negative consequences severity [21,28]. In young children and adolescents, exposure to multi-type childhood abuse is likely to result in low self-esteem [29], eating disorders [30], antisocial behaviors, and aggressive behavior [31].

1.5. Child Abuse and Brain

Several research found anatomical, functional, and neurohormonal changes in the brain as a result of child abuse. However, it seems that different types of abuse produce their own changes to the brain. Exposure to CPA and CSA led to hyperactivation, decrement of the amygdala volume, reduction of the hippocampus thickness, and low connectivity at the medial prefrontal cortex. These areas were associated with the reduction of IQ, high aggressiveness and impulsiveness, and difficulty in differentiation threatening situations [32]. An alteration in the myelination of the corpus callosum and the decreasing of gray matter at the fusiform gyrus and the medial occipital gyrus were induced by CEA. These changes produced cognitive alterations in learning and memory, elevation of anxiety and depression, interruption of emotional regulation, and alteration of emotional perception of situations and faces [33]. Furthermore, it was believed that suffering from child abuse might cause pain reduction as the developing sensory system and pathways that transmitted disgust and traumatic experiences decreased.

Previous studies discovered the link between CSA and the structural and functional changes in limbic and prefrontal brain regions such as the amygdala, the prefrontal cortex, the orbital frontal cortex, and the subgenual area. The reduced activity in the orbital frontal cortex linked to damaged emotional inhibition, social behavioral problems, and violations, whereas the disruption in the subgenual area induced mood disorders such as depression [34,35].

Thus, experiencing different types of child abuse, particularly CSA, acted as a moderator between MSDQ and CTQ. A high severity of abuse predicted high detrimental impacts on an individual [36], in relation to MSDQ and its subscales: somatization, depression symptoms, and dissociation [37].

The brain is responsible for high-level cognitive functions such as planning and organizational abilities, body language, hand movements, and eye-hand coordination, which is required for daily activities [38]. As vision could not be separated from motion, drawing was one of the effective tools used in order to express an individual's perception of the world by employing the coordination of visual perception and fine motor control. [39]. The right and left hemispheres were both engaged in the process of visualizing and drawing in different areas [40]. The left hemisphere is involved in verbal and rational knowledge, information processing, and analyzing. Therefore, in the context of drawing, the left hemisphere played the key role in the understanding of rules and systems, resulting in a quality drawing through several drawing practices. On the other hand, the right hemisphere entailed relationships, patterns, and intuition, which resulted in creativity [41]. The unconsciousness and internal world appeared through micro movements; the process was uncontrollable and mostly went unnoticed [42]. For that reason, the use of self-figure drawings could be one of the excellent paths for an individual to identify the unconscious signals and to explore and successfully bridge the gap between the consciousness and the unconsciousness.

1.6. Disclosure of Child Abuse

According to Ullman [43], disclosure is referred to the telling anyone of the abuse, including formal or informal support sources, with voluntary victim and non-victim initiations. It is a unique process of each victimized individual that is likely to be influenced by the aspects of culture, religion, gender, and the abuse itself [44]. In addition, Foynes et al. [45] propose that children's age, gender, relationship to the offender, fear of negative consequences, perceived responsibility for the abuse, and characteristics of the abusive event are all part of the disclosure process as well. Not only does reluctance to disclose expose the child to the risk of further victimization it also prevents him or her in receiving the appropriate treatment. In the cases of CSA and CEA, it is difficult to identify the abuse due to the lack of visible physical injury, although apparent symptoms of distress are presented [46].

Several studies found that the most common self-reported reason for non-disclosure is that many children considered their experiences of violence not to be serious enough to report. They do not recognize their experiences as abusive or view some of the abusive acts as a normal part of everyday life [47,48].

1.7. Self-Figure Drawing as an Assessment Tool

Self-figure drawing is one form of a well-known and frequently used projective drawing technique for assessment in a clinical setting. Machover [12] developed the Machover Draw-A-Person (DAP) test with the assumption that, within the drawing, the human figure is the subject and the paper is the representation of the environment surrounding the subject. Lev-Wiesel [11] has developed a version of the draw-a-person test called the self-figure drawing that forces the drawer to relate directly to oneself. As such, drawing has been broadly regarded as an additional assessment tool for assessing different personality traits and adverse experiences.

So far, concerning research on drawings of CSA, CPA, and CEA survivors, although there are no studies that compared these three abuses, the effects and consequences were studied. CPA children often exhibit tendencies of aggressiveness, which were found in indicators, e.g., the presence of straight lines, clawed fingers, long arms, and pressed lines [49]; shaded, crossed, hollowed, or omitted eyes; emphasized eyebrows; thick mustaches and beards; large pointed clawed fingers; broad shoulders and strong posture [50]; teeth, emphasized nostrils [51].

The study by Lev-Wiesel [52] presented four indicators of experiencing CSA, i.e., face line (double, hollow, or shaded), eyes (dots, omitted, shaded, hollow), hands and arms (clinging, cut off, detached, omitted), and genitals (shaded, blocked, disconnected from the rest of the body). Research by McInnes [53] found that within self-figure drawings, despite the absence of important facial details, the mouth is prominent. In the depiction of oral sex, the exaggerated mouths and teeth are often featured in drawings, while an emphasis on genitals frequently occurs in the drawings with missing arms or legs. The floating position of a figure, unconnected to the ground, is associated with a dissociation experience, implemented as a coping strategy during the abuse experience.

Indications of CEA in self-figure drawings are often depicted as small, faintly drawn, or positioned at the paper corners, indicating low self-esteem or low self-concept [54]. The lack of facial details in a figure represents the lack of voice and identity, while the lack of arms represents the feeling of helplessness [53]. Anxiety is one of the symptoms of distress indicating signs of emotional abuse [24]. The indicators include face shading, broken/varying line, and off-balance figures reflecting insecurity (implying a state of anxiety) [55].

1.8. Thai Culture

Hierarchy is essential for Thai families, i.e., a child must obey their parents. This belief leads to the acceptance of the parent's right to discipline their children and to the positive perception of physical punishment as a way for parents to express love to their children and not as abusive behaviors [56].

Many Thai parents do not perceive the importance and need to communicate with children about sex. They may lack the knowledge and skills about sex, are embarrassed to discuss sex within a family or are reluctant to discuss sex as it might encourage children to try sexual intercourse [57].

A study by Binson and Kinear [58] found that in self-figure drawings, Thai people tend to omit the legs. This may be due to their perception of feet as the dirtiest part of the body. Moreover, smiling faces are frequently presented to show the eagerness to be genuinely nice, friendly, and polite in order to preserve a harmonious relationship with others.

Based on the above review indicating that (a) there is a huge gap between the prevalence of child abuse and disclosure rates, (b) there is a lack of assessment tools that indicate child abuse, (c) self-figure drawing enables children to express aversive experiences in a

non-verbal way, the following hypotheses are made: (a) there are drawing indicator differences to specify each type of abuse; (b) for each type of abuse, drawing indicators follow the findings of previous studies; and (c) the result of DTQ is able to be used in explanation in case of the negative correlation between drawing indicators and the CTQ and MSDQ scores. Thus, the results of the study can support the indication that the self-figure drawing is a reliable assessment tool for predicting child abuse of each specific type.

2. Materials and Methods

2.1. Participants and Procedure

Following receiving the certificate of approval no. 001.1/64 with the exemption of informed consent from the Research Ethics Review Committee for Research Involving Human Research Participants, Group 1, Chulalongkorn University, Thailand, 1707 Thai children between the ages of 13 and 18 were recruited from schools with different socio-economic status through a convenience sampling method. The exemption was granted to maintain the participants' anonymity and confidentiality and to prevent the concealment of any disclosure to the extent feasible.

A convenience sampling method was applied in the proposed study. The schools located around Samutprakarn, Bangkok, and Nakhon Pathom were approached through letters asking for permission. Upon receiving the approval from the schools, another letter was sent to all the students aged between 13 and 18, detailing the study's aims and procedure. Those who were interested would participate in the study. Participants were anonymously asked to indicate which events they experienced before filling out the questionnaires. Confidentiality was ensured and participants had the right to withdraw from the study at any time and for any reason. Participants who felt stressed by the procedure were free to contact the researcher through the given email. In addition, free professional counseling information, such as helpline1323 and samaritansthai, was provided. Due to the study's anonymous design, no tracking could be made on participants' access to the mentioned counseling resource.

Participants were asked to complete an anonymous questionnaire that consisted of three measures: the Childhood Trauma Questionnaire (CTQ), the Medical Somatic Dissociation Questionnaire (MSDQ), and the Disclosure of Trauma Questionnaire (DTQ), in addition to self-figure drawing (Draw Yourself). All the measures were adapted to Thai culture through translation and back translation. For meaning accuracy, the measures were first translated to Thai by two Thai researchers and were translated back to English by the other two researchers. The study offered both paper and online questionnaires; therefore, the participants might or might not have had access to the internet. The authors have no relevant financial or non-financial interests to disclose.

2.2. Measures

2.2.1. Demographic Questionnaire

The questionnaire contains three questions focusing on demographic data, i.e., age, gender, and ethnicity, used in order to collect background information.

2.2.2. Childhood Trauma Questionnaire (CTQ)

The CTQ short-form [59] comprising 25 items plus the three validity items, producing a 28-item short form. The 25 items of the CTQ refer to lifelong abusive experiences and cover five types of abuse, i.e., CEA, CPA, CSA, emotional neglect, and physical neglect; in a five Likert scale format, ranging from 1 (never true) to 5 (very often true). The Cronbach Alpha reliability scores of the five scales were 0.84–0.89 for CEA, 0.81–0.86 for CPA, 0.92–0.95 for CSA, 0.85–0.91 for emotional neglect, and 0.61–0.78 for physical neglect.

2.2.3. The Medical Somatic Dissociation Questionnaire (MSDQ)

The questionnaire was developed by four experts in child abuse and dissociative disorders [37]. The questionnaire includes 30 items, all of which were written in behavioral

terms with no reference to the terms 'somatic' or 'dissociation'. The items of the MSDQ covered three factors of somatization, depression symptoms, and dissociation. The questionnaire employs a 5-point Likert-type scale, ranging from 0 (nothing) to 4 (extremely). The Cronbach's alpha for the full MSDQ was 0.93, and the Cronbach's alpha of the three factors were 0.76 for somatization, 0.89 for depression symptoms, and 0.85 for dissociation. The MSDQ can differentiate between CSA survivors and the general population.

2.2.4. The Disclosure of Trauma Questionnaire (DTQ)

The questionnaire [60] focuses on aspects of an individual's intention to disclose traumatic events. It employs a Likert scale ranging from 0 (not at all) to 5 (completely) for each of the questionnaire's 34 items. The questionnaire comprises three subscales: reluctance to talk (13 items), assessing reported resistance to tell others about the trauma; urge to talk (11 items), assessing participants' need to disclose traumatic experiences; and emotional reactions to disclosure (10 items), assessing affective states and experiences that may occur during disclosure. The Cronbach's alpha reliability scores of the three DTQ scales were 0.82 for reluctance to talk, 0.88 for urge to talk, and 0.87 for emotional reactions.

2.2.5. The Draw Yourself Test

Draw your self-figure, is a version of the draw-a-person test [12] developed by Lev-Wiesel [11]. Participants were asked to draw themselves on A4 paper with a pencil. No further instructions were given. Any question regarding the drawing was responded to with "as you wish". The drawings had been given blindly to three professionals that assessed the level of obviousness (from very much obvious to not at all) of indicators found previously in the literature to indicate symptoms or traits of children who experienced CSA, CPA, and CEA.

2.3. Data Analysis

In this study, continuous variables were reported by means and standard deviations, while categorical variables were reported by frequencies and proportions. Associations between drawing indicators and CTQ, MSDQ, and DTQ scores were assessed using Spearman's correlation coefficients. Univariate analysis was performed using chi-square or one-way ANOVA to test for association of the demographics and drawing indicators with groups of child abuse (CSA, CPA, and CEA). Post hoc pairwise comparisons adjusting for Tukey multiple testing were performed to compare between pairs of groups.

In order to test whether experiencing CSA, compared with experiencing CPA and CEA, to moderate the relationship between CTQ and MSDQ total scores, as well as subscales of DTQ and drawing indicators, PROCESS macro was used for model no. 1 as outlined by Hayes [61]. The same procedure was employed to test moderation of experiencing CSA compared with experiencing CPA.

The ROC technique was implemented to find an optimal cutoff of CTQ, MSDQ, and DTQ total scores that will best differentiate between subjects who experienced CSA compared with those with no experience of CSA. Additionally, the ROC technique was used to find an optimal cutoff that will determine the difference between subjects who experienced CPA compared with those who experienced CSA and CEA. These cutoff points were chosen by point maximizing the Youden function, which is the difference between sensitivity rate and specificity rate over all possible cut-point values [62]. All analysis was performed by SAS 9.4 for Windows.

3. Results

3.1. Characterizing Drawing Indicators and Demographical Differences by Groups of Abuse

Table 1 presents a comparison of demographics, drawing indicators, and scales' means among CSA, CPA, and CEA participants. In the drawings of CPA participants, the hair indicator was more emphasized than those of CEA participants (MCPA = 2.17 vs. MCEA = 1.95, $p = 0.005$). CPA participants emphasized face line, ears, and hands and arms more than

CEA participants (face line: MCPA = 2.30 vs. MCEA = 1.91, $p < 0.001$; ears: MCPA = 2.47 vs. MCEA = 1.26, $p < 0.001$; hands and arms: MCPA = 2.12 vs. MCEA = 1.94, $p = 0.029$). Of the three types of abuse, CSA participants showed the most emphasis on the face line part (MCSA = 3.67 vs. MCPA = 2.30 and MCEA = 1.91, $p < 0.001$). Concerning the ear indicator, there is a greater emphasis in the drawings of CSA participants compared with those of CEA participants. However, when compared with the drawings of CPA participants, those of CSA participants showed less emphasis (MCSA = 2.01 vs. MCEA = 1.26 and MCPA = 2.47, $p < 0.001$). CSA participants scored higher on the genital indicator than CPA and CEA participants (MCSA = 1.05 vs. MCPA = 1.00 and MCEA = 1.00, $p < 0.001$).

Table 1. Characterizing Drawing Indicators and Demographical Differences Across Groups.

	CEA N = 984	**CPA N = 560**	**CSA N = 163**	***p* Value**
Head (disproportionate size)	2.10 (1.27)	2.10 (1.29)	2.07 (1.29)	0.973
Forehead (emphasized, shadowed)	1.05 (0.36)	1.06 (0.39)	1.07 (0.42)	0.826
Hair (stand, emphasized)	1.95 (1.26)	2.17 (1.34)	2.04 (1.34)	0.005
Face line (double, hollow, shaded)	1.91 (1.23)	2.30 (1.34)	3.67 (0.52)	<0.001
Ears (emphasized, shadowed, double)	1.26 (0.77)	2.47 (1.47)	2.01 (1.38)	<0.001
Eyebrows (emphasized)	1.40 (0.95)	1.50 (1.04)	1.52 (1.10)	0.082
Eyes (dots, shaded, hollow, crossed)	3.36 (1.22)	3.38 (1.20)	3.40 (1.20)	0.923
Eyes (omitted)	1.11 (0.56)	1.16 (0.66)	1.17 (0.69)	0.261
Nose (emphasized, big, shadowed, nostrils)	1.57 (1.04)	1.61 (1.07)	1.64 (1.13)	0.581
Teeth (presence)	1.17 (0.68)	1.17 (0.68)	1.19 (0.72)	0.919
Moustache/beard (thick, shadowed)	1.03 (0.29)	1.05 (0.38)	1.02 (0.23)	0.346
Shoulders (broad)	1.72 (1.14)	1.77 (1.19)	1.80 (1.17)	0.621
Arm position (asymmetry, horizontal)	1.52 (1.02)	1.54 (1.04)	1.53 (1.06)	0.931
Hands/arms (clinging, detached, shadowed)	1.94 (1.35)	2.12 (1.45)	2.12 (1.38)	0.029
Hands/arms (omitted, cut off)	2.67 (1.45)	2.59 (1.45)	2.71 (1.45)	0.508
Fingers (large, pointed, clawed)	1.09 (0.47)	1.10 (0.50)	1.12 (0.57)	0.627
Genitals (shaded, blocked, disconnected)	1.00 (0.00)	1.00 (0.04)	1.05 (0.37)	<0.001
Legs/feet (distorted, disproportionate)	1.46 (0.72)	1.43 (0.70)	1.48 (0.76)	0.688
Legs and/or feet (omitted, cut off)	2.22 (1.47)	2.28 (1.47)	2.31 (1.48)	0.646
Posture (strong, stable)	1.15 (0.55)	1.16 (0.59)	1.07 (0.39)	0.145
Reluctance to talk	36.6 (11.8)	40.0 (12.2)	41.8 (11.6)	<0.001
Urge to talk	28.8 (9.18)	29.5 (8.53)	29.3 (7.72)	0.339
Emotional reactions	25.1 (8.80)	28.3 (10.3)	30.5 (9.61)	<0.001
DTQ total score	90.4 (22.9)	97.8 (25.2)	102 (22.4)	<0.001
MSDQ total score	2.10 (0.51)	2.41 (0.57)	2.48 (0.53)	<0.001
Somatization	2.10 (0.65)	2.45 (0.72)	2.53 (0.72)	<0.001
Depression	2.66 (0.74)	3.00 (0.76)	3.09 (0.71)	<0.001
Dissociation	1.66 (0.45)	1.93 (0.55)	1.98 (0.54)	<0.001
CTQ total score	1.80 (0.26)	2.17 (0.35)	2.36 (0.45)	<0.001

The MSDQ scale and the DTQ subscales (i.e., reluctance to talk and emotional reactions) are significantly lower for CEA participants than for CPA or CSA participants. However, there is no statistical differences between CSA and CPA participants. The CTQ scale is significantly higher for CSA participants compared with CPA and CEA participants. Moreover, the CTQ scale is also significantly higher for CPA participants compared with CEA participants.

3.2. Correlation of Drawing Indicators and CTQ, MSDQ, and DTQ Scales for All the Sample

Table 1 reports the Spearman's correlation coefficients between CTQ, MSDQ, and DTQ scores and drawing indicators for all the sample. Correlation coefficients are all very low and smaller than 0.1. Due to the large sample size, correlation coefficients of absolute value of 0.08 are significant at 0.001 value. Reluctance to talk is positively correlated (r = 0.08–0.10) with hair, face line, and legs and/or feet (omitted, cut off). Emotional reactions are negatively correlated with arm position (r = −0.09). DTQ total score is positively correlated with legs and/or

feet (omitted, cut off) (r = 0.09). Furthermore, depression is negatively correlated with arm position (r = −0.09), while dissociation is negatively correlated with nose (r = −0.08).

3.3. Experiencing CSA as Moderator of the Relation between CTQ, MSDQ, and DTQ Scales and Drawing Indicators

Experiencing CSA moderated the relationship between the MSDQ total score, the CTQ total score, the reluctance to talk score and urge to talk score, and the genital indicator (MSDQ: $\Delta R^2 = 0.04$, $F(1, 1703) = 64.2$, $p < 0.001$; CTQ: $\Delta R^2 = 0.01$, $F(1, 1703) = 19.75$, $p < 0.001$; reluctance to talk: $\Delta R^2 = 0.03$, $F(1, 1703) = 58.5$, $p < 0.001$; urge to talk: $\Delta R^2 = 0.04$, $F(1, 1703) = 74.5$, $p < 0.001$).

As illustrated in Figure 1, the direction of the relationship between the MSDQ total score, the CTQ total score, and the urge to talk score and obviousness of the genital indicator is different for CSA participants compared with non-CSA participants. For CSA participants, higher scales' values are associated with less obviousness of the genital indicator. The higher reluctance to talk score is associated with a higher rating of obviousness in the genital indicator for CSA participants. However, for non-CSA participants, there is no relation between the MSDQ total score, the CTQ total score and urge to talk score, and the obviousness of the genital indicator.

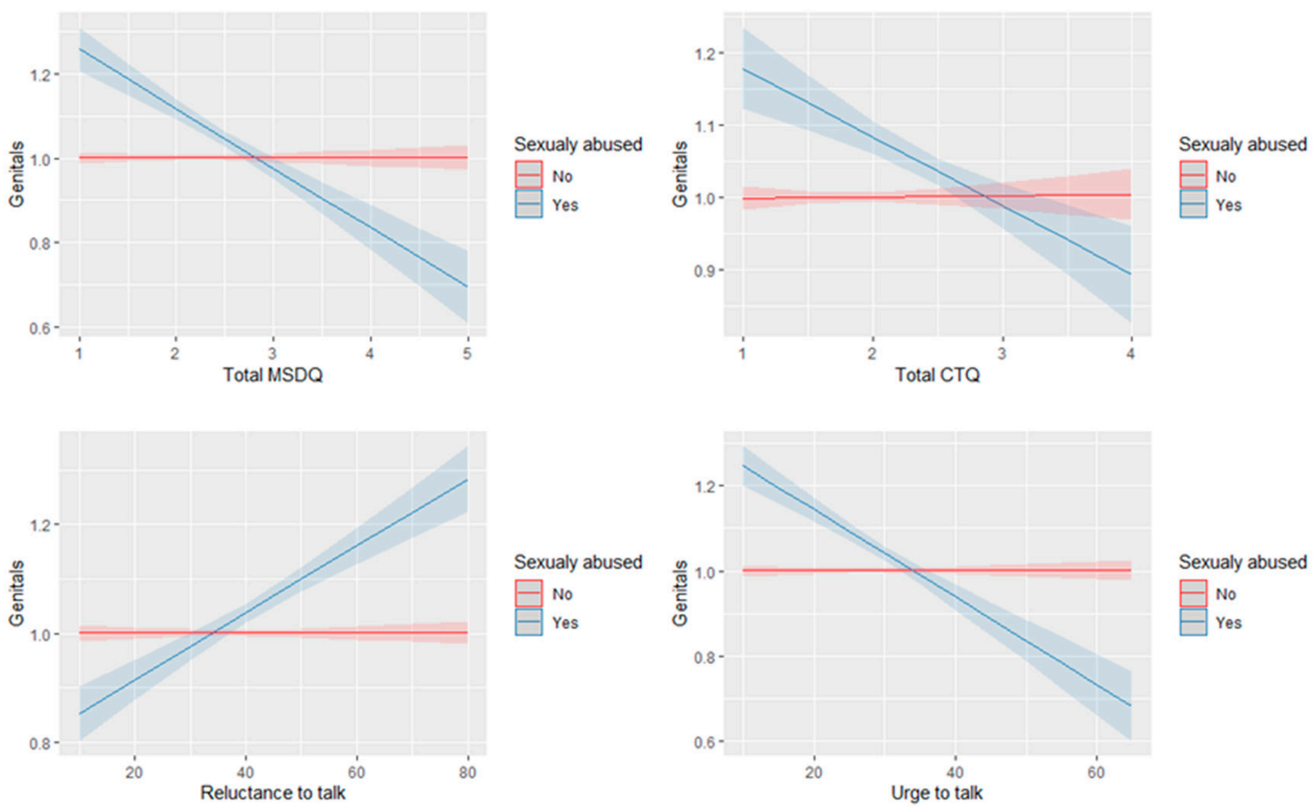

Figure 1. Visualization of significant interaction effect between experiencing CSA and MSDQ total score, CTQ total score, reluctance to talk score and urge to talk score, and the genital indicator.

Experiencing CSA moderated the relationship between the urge to talk score and the hair indicator, ($\Delta R^2 = 0.005$, $F(1, 1703) = 7.6$, $p = 0.006$). As illustrated in Figure 2, for CSA participants, a higher urge to talk score is associated with more obviousness of hair and ear indicators. For non-CSA participants, there is no relation between the urge to talk score and the obviousness of hair.

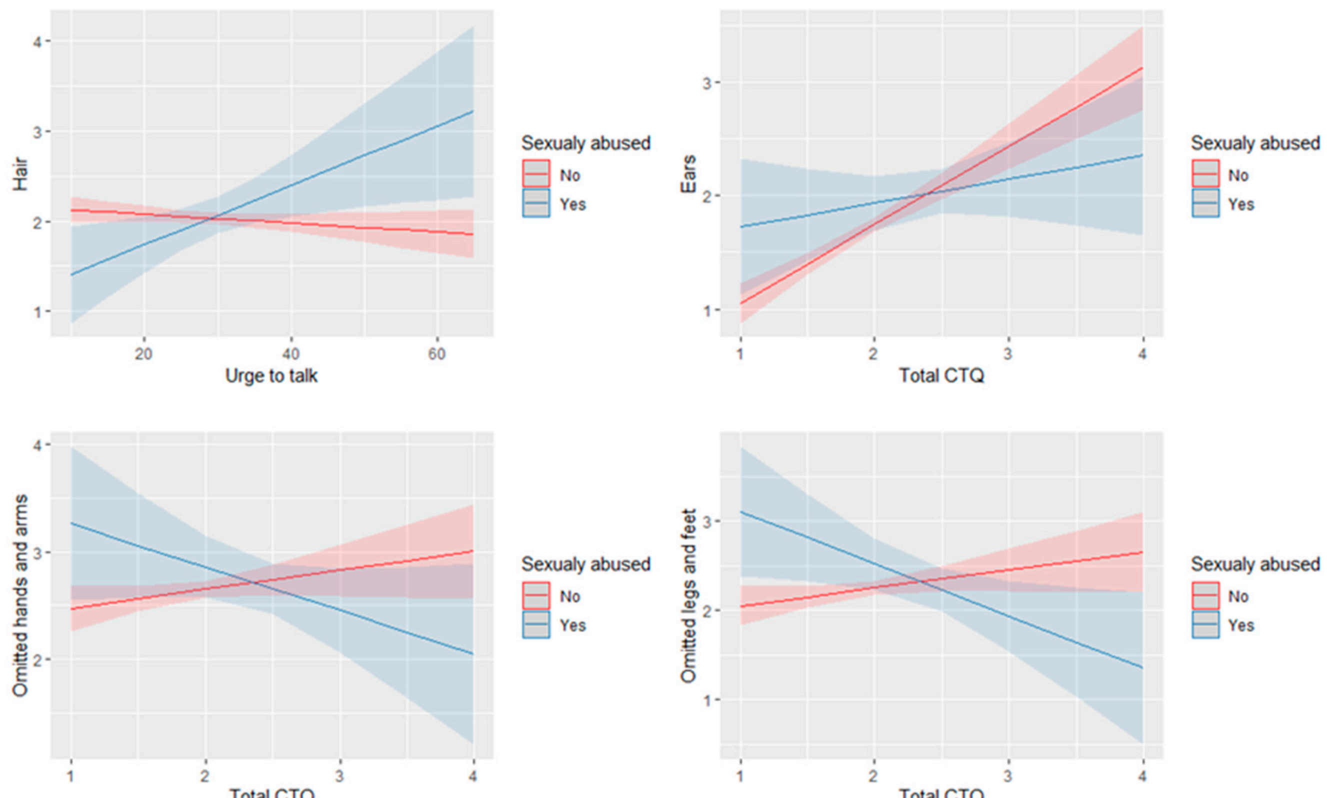

Figure 2. Visualization of significant interaction effect between experiencing CSA and urge to talk score or CTQ total score and the hair, the ear, the omitted hand and arm, and the omitted leg and feet indicators.

Experiencing CSA moderated the relationship between the CTQ total score and the ear, the omitted hand and arm, and the omitted leg and feet indicators, (ears: $\Delta R^2 = 0.003$, F(1, 1703) = 4.4, $p = 0.036$; omitted hand and arms: $\Delta R^2 = 0.003$, F(1, 1703) = 4.5, $p = 0.035$; omitted legs and feet: $\Delta R^2 = 0.005$, F(1, 1703) = 7.9, $p = 0.005$).

As illustrated in Figure 2, for non-CSA participants a higher CTQ total score is associated with a higher rating of obviousness in the ear indicator. Meanwhile, for CSA participants there is no relation between the CTQ total score and the obviousness of the ear indicator. In addition, for CSA participants a higher CTQ total score is associated with less obviousness of the omitted hand, arm, leg, and feet indicators. For non-CSA participants, there is no relation between the CTQ total score and the obviousness of the omitted limb indicator.

3.4. Experiencing CSA Compared with Experiencing CPA as Moderator of the Relation between CTQ, MSDQ, and DTQ Scales and Drawing Indicators

Results reveals the significant and directional relation of the MSDQ total score, the CTQ total score, the reluctance to talk score and the urge to talk score, and the genital indicator. For CSA participants, higher scores of MSDQ, CTQ, and urge to talk are associated with less obviousness of the genital indicator. Meanwhile, a higher score of reluctance to talk is associated with more obviousness of the genital indicator.

For CPA participants, there is no relation between the MSDQ total score, the CTQ total score, the reluctance to talk score and urge to talk score, and the obviousness of the genital indicator. Additionally, regarding the significance and direction of the relation of the urge to talk score and the hair indicator, a higher MSDQ total score, CTQ total score, reluctance to talk score and urge to talk score are associated with more obviousness of the hair indicator for CSA participants. However, there is no relation between the MSDQ total score, the CTQ total score, the reluctance to talk score and the urge to talk score, and

the obviousness of the hair indicator for CPA participants. Furthermore, considering the significance and direction of the relation of CTQ and the omitted leg and feet indicator, a higher MSDQ total score, CTQ total score, reluctance to talk score and urge to talk score are associated with less obviousness of the omitted leg and feet indicator for CSA participants. As for CPA participants, there is no relation between the MSDQ total score, the CTQ total score, the reluctance to talk score and the urge to talk score, and the obviousness of the omitted limb indicator. There is a significantly negative relation between the MSDQ total score and the obviousness of the ear indicator for CPA participants, while there is no such relation for CSA participants. Additionally, a higher MSDQ total score is associated with less obviousness of the ear indicator for CPA participants ($\Delta R^2 = 0.008$, $F(1, 719) = 5.9$, $p = 0.015$).

3.5. Cutoff Total Scores for Sexual Abuse, N = 1707

A cutoff value of CTQ, MSDQ, and DTQ total scores differentiating CSA participants from non-CSA participants in all the sample was examined. When the CTQ score ≥ 2.1, the true positive rate (TPR or sensitivity: predicted as sexual abuse and they are truly sexual abused) is 67.5% while the 1-specificity (false positive rate, FPR: predicted as sexual abuse but they are not sexually abused) is 28.3%. When the MSDQ total score ≥ 2.2, the TPR is 73.0%, while the FPR is 48.9%. When the DTQ score ≥ 98, the TPR is 58.9%, while the FPR is 40.7%.

3.6. Cutoff Total Scores for Physical Abuse Compared with Emotional Abuse, N = 1544

After excluding CSA participants, a cutoff value of CTQ, MSDQ, and DTQ total scores differentiating CPA participants from CEA participants was examined. When the CTQ score ≥ 1.96, the TPR is 71.6%, while the FPR is 26.0%. When the MSDQ score ≥ 2.13, the TPR is 68.9%, while the FPR is 43.8%. When the DTQ score ≥ 98, the TPR is 48.4%, while the FPR is 36.4%.

4. Discussion

The current study investigated the differences in the drawings of Thai children aged 13–18 with different types of abuse (sexual, physical, and emotional abuse). The aim of the current study was to examine to what extent self-figure drawing can serve as a tool for assessing child abuse victimization. Specifically, the aim of this study was to investigate whether self-figure drawing can differentiate between forms of abuse. The three measures (CTQ, MSDQ, and DTQ) were also implemented in order to compare the scores among the three types of abuse. The findings indicated significant differences in the drawings that were associated with CTQ, MSDQ, and DTQ measures. Consistent with previous studies, different drawing indicators were found among groups of people who reported CSA, CPA, and CEA.

4.1. Drawing Indicators

In most cases, drawings offered symbols of the experienced abuse and/or depicted the abuse of an individual. The study examined the self-figure drawing in Thai culture, with a comparison to Israeli culture as the drawing indicators were based on the study with Israeli participants [63–65]. There were no differences found between the correlations between MSDQ and drawings in the Israeli, Thai, and Indian participants [66]; significantly, the emphasized face lines that were presented in the drawings of CSA participants compared with those of CPA and CEA participants (see Figure 3). This could denote the predicament in deciding between hiding or disclosing the traumatized experience as the emphasized face and the double cheeks or chin symbolized the willingness to vomit or swallow the said experience [11], while the pressure lines in drawing reflect the muscle tension and the energy level of an individual [67]. Genitals were also significantly presented in the drawings of CSA participants, which could be a positive indicator of sexual abuse [68], especially when combined with the presence of face line (double, hollow, shaded), eyes (dots, shaded,

hollow, crossed, omitted), and hands and arms (clinging, detached, shadowed, omitted, cutoff) [69].

Figure 3. The drawing of a 16-year-old male participant who reported experiencing CSA. The significant drawing indicators included the presence of genitals and the emphasized face line.

Interestingly, as can be seen in Figure 4, the current study found the significant indicators for CPA that are in accordance with the research by Lev-Wiesel et al. [63] in the following indicators: the emphasized or hair standing up (signifying insecurity, helplessness, fear, and anxiety), the emphasized or double ears (symbolizing the ability to receive and deal with the external world) [64,65], and the emphasized hands and arms (indicating helplessness and anxiety in dealing and interacting with the environment or the external world) [67]. The emphasized hair could also act as an indicator to the frontal lobe, suggesting the unconscious feelings of the uncontrolled impulsivity [64,70] or the brain injury as a result of the violence inflicted [71]. In this study, it was found that the emphasized or double face line was significant for the CPA group as well.

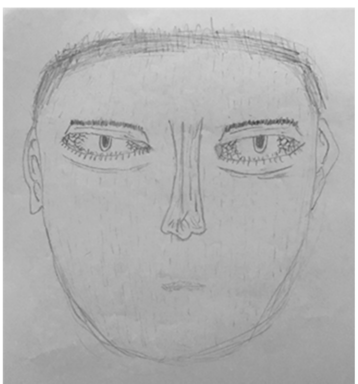

Figure 4. The drawing of a 16-year-old male participant who reported experiencing CPA. The significant drawing indicators included the emphasized or hair standing up, the emphasized or double ears, and the emphasized or double face line.

Contrary to the research by Lev-Wiesel [72], the shadowed eyes (indicating hiding feelings, suspicion of others, anxiety, fear of seeing and being seen), the omission of arms and hands (symbolizing anxiety, helplessness, and fearfulness), and the hair stand indicators did not present significantly more in the drawings of CEA participants when

compared with those of CPA and CSA participants in the current study (see Figure 5). This might be due to the fact that in many cases of child abuse there was more than one type of abuse occurring [73]. Thus, this could be the result of the multi-type abuse where CEA co-occurred with CPA and CSA. Furthermore, another explanation could stem from the cultural differences between the Israelis and the Thais. Some behaviors, i.e., criticism and parents' humiliation of children, appeared to be less considered as an emotional abuse in Thai culture compared with Israeli western culture. Contrastingly, in Thai culture, children were often raised to respect and adore their parents and were obligated to their parents regardless of how they were treated, while in Israel parents were expected to adore their children and were obligated to help their children for life [74].

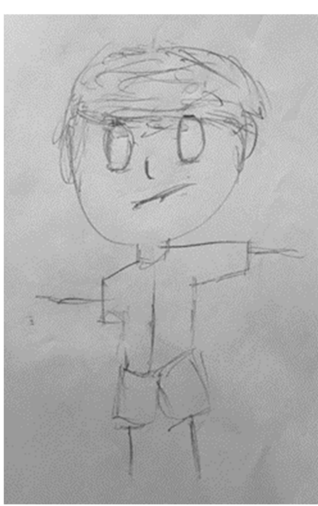

Figure 5. The drawing of a 15-year-old male participant who reported experiencing CEA. The drawing indicators found in the drawing included the hollow eyes, the omission of arms and hands, and the emphasized hair indicators.

4.2. The Association between CTQ and MSDQ

The current study showed the positive association between CTQ and MSDQ. A higher CTQ score indicated a higher MSDQ, suggesting that the child abuse greatly affected an individual. The severity of abuse resulted in higher psychological stress, greater functional disability, and poorer psychological adjustment, as well as increasing the risks of developing internalizing behavior problems (i.e., anxiety, depression, PTSD) and externalizing behavior problems (i.e., physical, verbal aggression, and disruptive behaviors) [75].

MSDQ and its subscales (i.e., somatization, depression symptoms, and dissociation) were constructed to aid the assessment process of physiological symptoms such as chronic pain [37]. Child abuse, especially CSA, played a key role in the manifestation of dissociation [76]. Dissociation is a mental process where there is a disconnection or a separation from thoughts, feelings, memories, and surroundings that affect an individual's sense of identity and perception of time [77]. The current study found a negative correlation between dissociation and the nose indicator (indicating feelings of insecurity, inadequacy, and inferiority). Nostrils emphasized along with the nose suggested aggression and the impulse to act [44], which seemed to be in accordance with how child maltreatment associated with the development of aggressive behaviors [75].

Depression was known to be one of the common consequences of child abuse that extended to adulthood [78]. In this study, there was a negative correlation between depression and asymmetry or horizontal arm position (signifying crying for help, poor self-esteem, and avoiding contact with environment). The impact of early traumatic experiences on poor self-esteem could lead to the inclination of developing depression [79].

4.3. Disclosure of Abuse

Although the experience of child abuse and its short- and long-term effects may have been the topic of numerous studies and research, there was still a distinct difference between occurrences and disclosure rates [80]. Several risks factors had prevented and delayed a CSA individual to reveal what had happened to them, including fear of negative consequences of a disclosure for oneself and the perpetrator as CSA often took place within families or socially close relationships, fear of not being believed, fear of their parents' reaction [81], difficulty in communicating the experiences [75], and the severity of the abuse [53]. In line with previous studies, the current study showed a significantly positive link between the reluctance to disclose and the experience of abuse, indicating that the more severe the abuse the higher the reluctance to disclose.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by Ethics Committee of the Research Ethics Review Committee for Research Involving Human Research Participants, Group 1, Chulalongkorn University. The certificate of approval no. 001.1/64, 11 February 2021.

Informed Consent Statement: Participant consent was waived due to the practicality of the study to be carried out as the study protected confidentiality and anonymity of the participants and involved no more than minimal risk to the participants. The informed consent may have an impact on the disclosure of the information given, thus affecting the validity and reliability of the assessment tools.

Data Availability Statement: The data are not publicly available due to ethical restrictions.

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Conflicts of Interest: The authors declare no conflict of interest.

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Article

Dance Movement Therapy with Children: Practical Aspects of Remote Group Work

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Abstract: The global COVID-19 outbreak has forced psychotherapists to find creative ways to continue treating their clients from afar. Dance movement therapy emphasizes the body–mind connection and offers a unique mode of emotional intervention for supporting mental processes. The present study is the first to examine the distinctive qualities of group dance movement therapy in the context of remote emotional intervention with young children. Fourteen preschool children participated in six DMT meetings. The data generated three themes: 1. play as a platform for transforming technical complexity into an expression of the inner world; 2. accessories and props as means of motivation for movement and imaginative play; 3. playfulness-inhibiting conditions in settings of remote therapy. The discussion examines the significance of bodily expressions in remote therapy for understanding the needs of children in times of crisis and for getting acquainted with feelings and sensations which do not lend themselves easily to verbal expression.

Keywords: COVID-19; dance movement therapy; remote therapy

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1. Group Dance Movement Therapy with Children

Group dance movement therapy (DMT) aims at enabling a sensory and creative experience, using movement, play, and the arts [1]. Each session addresses individual goals, alongside the enhancement of group awareness, interaction, and cohesion [2], and introduces healing elements such as expression, rhythm, synchrony, vitalization, integration, cohesion, and symbolism [3]. Group DMT with children involves free movement, dance, and play, which allow for the discharge of psychomotor energy, symbolization, and projection [4]. Dance movement therapists use various methods, such as creative and expressive dance and movement, role-playing, gross and perceptual motor activities, and a blend of improvised and structured movement experiences [2].

Research has indicated that DMT groups provide experience in creating, organizing, and processing meaningful effective and cognitive information, and are especially significant for elementary-school-aged children [5], inasmuch as most developmental tasks occur in a group context [6]. Belonging to a group helps the child's process of separation from his/her parents and offers a safe and supportive space for developing relationships and identification with one's peer group. Furthermore, a sense of belonging affords the participants an experience of resilience and is an important step in self-development.

Group DMT with children has been found to be applicable with various conditions and in diverse situations, for example: children diagnosed with ASD [7,8], emotionally disturbed children [9], young children and adolescents in a psychiatric unit [2,10], youngsters with learning difficulties [1,11], children suffering from earthquake trauma [4], proactive work with adolescents [12], withdrawn adolescents [13], and refugee children [14].

The group therapist needs to consider developmental processes related to abilities of self-control of psychomotor impulses, expression of emotions, self-adaptation to external stimuli (music and use of space), and the expression of empathy at a young age [6]. A preliminary study of children suffering from earthquake trauma in Taiwan found that group DMT for children in elementary school requires an active presence on the part of the therapists during the session, and they should aim at creating a potential space for playing, imagining, and processing the meanings inherent in symbolization and expression [4]. The session includes references to movements, feelings, emotions, and spontaneous emotional experiences, along with structured guided activities and the use of projective props (balls, scarves, ropes, pillows, etc.) that encourage movement and verbal mediation, which accompanies the in-session movement. The use of props supports creative expression, enriches the spectrum of associations, and offers sensory stimulation which augments the qualities of movement. The use of props can also contribute to the creation of new and more complex experiences of the self, and to the expression of group processes [4,10]. Working through DMT with children under the age of five and their families, Lykou [1] stresses the importance of accompanying the children with an unconditionally positive attitude, and to allow them to move as they please without expecting a specific "correct" move. Moreover, the therapeutic work should take place mainly through movement and play rather than through verbal discourse and discussion of insights, as these capacities are still limited at the age of latency.

Group DMT with children is often based on the work and structure offered by Marian Chace (1896–1970) and is comprised of various stages: The initial phase is established through physical warm-up, from which the central theme of the session derives and develops in the second stage of exploration. The third and final stage of each session is devoted to gathering and sharing the participants' experience and is characterized by a decrease in the level of psychophysical activity and a verbal discussion of the movement experience [2]. The basic assumption of this model is that the consistent, standardized, and predictable structure of the sessions provides a sense of security and trust in the therapist, which allows the participants to engage in movement and personal exploration processes [2,5].

2. Remote Psychotherapy with Children

The global COVID-19 pandemic has induced therapists to adjust their work settings in accordance with the pandemic restrictions and to transfer the therapeutic work from physical settings to virtual remote digital platforms. These adjustments have highlighted the challenges involved in remote psychotherapy for children, in view of their limited attention span and greater need of mobility and non-verbal communication [15].

Fonagy, Campbell, Truscott, and Fuggle (2020) emphasize that in "face-to face" work the therapist responds to both explicit and implicit communications with the child and makes sense of these communications by creating mental models of the intentional state of the client in a remarkably fluid way. When working remotely, however, the adoption of the mentalizing stance of not knowing is even more critical, as the therapist has less access to those implicit forms of communication [16].

The literature on the particularities of remote group psychotherapy for children addresses four obstacles faced by the therapist: First, the treatment framework now depends on the client's access to proper and private space. Second, the virtual environment hinders existing unconscious regulatory processes which occur at times of physical presence, as both bodies impact each other in physical space. Third, the therapeutic presence of the therapists for their clients is obviously qualitatively different from that of a conventional

setting. The fourth obstacle relates to the elements that enter the screen and do not belong to the group-therapeutic scenario. These factors are usually ignored, whereas in interpersonal therapy they would be given a dynamic interpretation [5].

At the same time, in remote psychotherapy for children, the home environment provides therapists with an opportunity to get to know the child's reality outside the clinic and watch interactions with siblings and parents at home as they really occur and in real time [15]. Through the acquaintance with the child's favorite objects, an empathetic view of his/her physical actions (such as rolling, jumping, and dancing), a view of objects produced by the child, and a discussion of the meanings he/she attributes to them, a new intimacy is created between the child and his/her therapist (ibid.). These advantages notwithstanding, the physical absence of the therapist entails major disadvantages: the difficulty in maintaining a therapeutic alliance, the lack of eye contact and the actual, concrete gaze of the therapist at his/her client, the discomfort of the therapists themselves, and difficulties in expressing and conveying empathy, warmth, and sensitivity from afar [17].

These insights, albeit grounded in general clinical experience and theoretical understanding, have yet to be more fully validated through specific research on early childhood. A study involving 28 children and adolescents found that remote CBT is just as, and sometimes even more effective, than face-to-face CBT therapy in reducing symptoms of depression [18]. Additionally, numerous studies describe achievements in remote psychotherapy of children and adolescents with depression [19] and anxiety [20] and various other conditions [21].

In the field of creative arts therapies, Potash et al. (2020) [22] suggest that creative arts therapists can support public health psychosocial guidelines by disseminating information, promoting expression and inspiration, challenging stigma, securing family connections, monitoring secondary traumatic stress, developing coping strategies and resilience, maintaining relationships, and contributing to the enhancement of a sense of hope. Spooner's (2019) [23] insights concerning remote creative arts therapy highlight the advantages of this mode of therapy as a way to strengthen the connections with family and community.

Recent research findings emphasize the importance of creative arts therapies in the education system, both in day-to-day routine and in times of crisis. Despite the numerous difficulties, the study highlighted the therapists' ability to maintain significant contact with their young clients and their parents, and with the educational staff. The factors that support the success of the therapy are defining a therapeutic contract and managing setting and process, as well as creative thinking and support from colleagues and supervisors [24]. These findings reinforce insights which emerge from case studies in the field [20–23] and reviews of therapists' experience around the world [25].

Dance movement therapy is based on the body and its visible movement, but this inherent and essential quality is severely challenged when working remotely and is even more complicated when working with young children. There are few studies which focus on the field of remote DMT. An article which describes DMT by phone with psychiatric clients emphasizes the difficulty in creating synchronized experiences and the continuous need to choose between seeing the client's facial expressions or his/her full body movement [26]. Case studies show that in order to continue sustaining DMT during COVID-19, the therapist must observe all the clients' actions as a dynamic expression of the mind, including their response to computer disengagement, disappearance from the screen, exposure or hiding of certain body parts, etc. [27]. The choice of body parts revealed on the screen, for example, signifies the ability to organize oneself within a new reality, to take into account the other, and convey experiences related to body image and the perception of body boundaries.

During remote psychotherapy sessions clients are often preoccupied with questions of whether their therapist can see, hear, feel, guard, and protect them—perhaps even more powerfully than in the physical therapy room, which often serves as a guarded space in and of itself [27].The dance movement therapist may suggest that the client move his or her body within the confines of the screen and explore possibilities in front of the camera and

the room, and each client may respond to the suggestion in his or her own way. An offer to get closer or farther away from the screen will bring with it countless new stories and new ways of communication. Reference to the physicality of the room (proximity to the wall, space or lack thereof, bed, soft/rigid objects, etc.) can also invite additional movements, and additional ways for the clients to tell the psyche's stories. The sense of visibility in psychotherapy in general and in childcare in particular is crucial, and its control in front of the screen is obviously partial.

COVID-19 called for flexible changes and rapid adjustments on the part of the therapist in order to provide young children with continued support in spite of the instability of external realities. Our brief review of the literature highlights both the complexity of remote psychotherapy with children and its importance in view of the pandemic crisis. This pilot study was designed in response to the current crisis, in an attempt to make a contribution to the community, contribute to the understanding of the dynamics of remote psychotherapy, and fill the lacuna regarding the uniqueness of remote DMT with young children, specifically in group settings. The immediate objective of this project was to explore and identify the main intervention techniques which are available to therapeutic work in this situation.

3. Method

3.1. Participants

The current study involved eight girls and six boys aged six to seven. Participants were recruited through a message posted on media networks targeting parents of preschoolers. A third of the participating children had an early acquaintance with each other from their kindergarten setting. A snowball sample was also used, so parents and children who expressed a desire to participate in a Zoom DMT group referred the researchers to additional potential participants. All participants came from homes of a high–medium socioeconomic level, with no background of emotional/mental problems, as the DMT workshop was offered as a tool of prevention of future difficulties and as a means to process emotional contents which may arise at a time of crisis.

Parents were told that the DMT group is part of a study that examines the meaning of movement intervention in remote sessions aiming for emotional expression and support. It was explained that the purpose of the group is to allow space for personal and interpersonal expression in movement and verbal discourse in order to share emotional contents which the children are engaged with. One of the children stopped attending after the fourth session.

3.2. Tools

3.2.1. Observation

Observations of two remote groups of DMT served as the central tool in the study. Both groups were identical in their structure (see details in Section 3.3) and were openly observed and registered by two DMT students. The observers were postgraduate DMT students during their second year of training in the M.A. program. During the first session, the participants were introduced to the observers so that they could feel comfortable with them, but the observers' actual involvement in the meetings was minimal. The two observers took detailed notes and prepared transcripts of the sessions. The observers aimed for objective viewing as much as possible. One observer documented all the occurrences in the studied environment-objects, behavior patterns, conversations, and events in detail; the second observer paid special attention to the children's bodies and their movement (changes in the use of space, movement intensity, diversity of movement) in order to provide an accurate description as far as possible [28]. This type of observation allows the collection of data during the meeting, reviewing the group processes and the various elements which come up both verbally and in movement. The observers also took personal notes after each session, recording their perception of it.

3.2.2. DMT Student Diary

The workshop was led by DMT students during the second year of their postgraduate M.A. training. Two DMT students led each DMT group and documented their own responses to what had occurred regarding significant moments, choices, and decisions taken. Moreover, following each session, the session observers and the session leaders held a joint Zoom meeting in order to share insights that came up during the session. These were performed immediately after the session to allow associative thinking that contributes to the development of hypotheses, meanings, and themes that arose in the group. These discussions were also recorded in the diaries, served as data, and were later analyzed for this study.

3.3. Procedure

Parents who expressed interest in the group contacted the group leaders. After receiving an explanation about the nature and the aims of the project, a preliminary letter was sent out to the parents, detailing the dates and hours of the meetings, and requesting confirmations of consent. Parents were invited to call the group leaders prior to or between the sessions. Most parents expressed concern that the children would not persist in their participation (based on their previous experience with difficulties in remote educational settings following the COVID-19 restrictions). The DMT students who led the groups received supervision throughout the intervention from movement therapists with over twenty years of experience.

4. The Preparations and the Structure of the Meetings

As part of the data collection, for the research participants were divided into two groups and took part in six remote group DMT sessions (through Zoom). The small number of participants (seven children in each group) allowed for personal relations to develop between the children and the facilitators. Children who knew each other before the sessions were placed in the same group to allow them to feel safe and secure with familiar others. One group consisted of three children with early acquaintance, and in the other group two children had been previously acquainted with each other. The other children were distributed randomly. The groups were held during 2020, at a time when education frameworks were opened and closed intermittently. The data produced by both groups contributed to the triangulation and confirmation of the findings.

The sessions took place twice a week in the afternoon for a three-week period, with each session lasting 30–40 min depending on the attention span and the perceived ability of the participants. Before the meetings, the parents were asked to set up a computer with a camera and microphone for their children, and a private space where they could move freely without interruption. They were asked to prepare several permanent accessories for the sessions: a ball, a scarf/blanket, a pillow, drawing sheets, and paints. Prior to each session, a reminder message was sent to the parents.

5. The Group Intervention and Its Purpose

The meetings had a pre-set structure of opening, development, and closure, beyond which the therapists responded spontaneously and creatively with respect to children's initiatives. The first meeting was introductory and consisted of explanations regarding the group framework and rules, the nature of the group (sharing and creating together), and familiarizing activities in order for the participants to become acquainted with one another and with the setting and its accessories. Each session began with a routine which included an opening song accompanied by movements, for the purpose of warm-up and a sense of group cohesion which would allow a shared experience to develop. At the core of the meeting, the therapists invited the participants to a movement experience in accordance with a central theme that emerged from the responses of the children.

The sessions dealt with topics that concerned the children in their daily lives through movement interventions such as movement reflection, spontaneous movement, movement

with props, movement games, imagination, and verbal discourse. At the end of the session, the group leaders reflected on the main contents that emerged and invited the participants to share their feelings. Each session ended with joint group movement.

6. Data Collection

During the meetings two observers recorded the meetings, and later on, following each session, the observers and the group facilitators recorded their own feelings, thoughts, perceptions, and bodily sensations, and shared their personal impressions with one another. All these materials were used for the study.

7. Data Analysis

The specificity of remote group DMT with children was examined using interpretive phenomenological analysis (IPA) [29] of the session protocols (movement and words), and the personal diaries and notes written after each Zoom summary session. This method is unique in its focus on the subjective experience of the research subject along with its recognition of the role played by the investigator's interpretation [30]. Data analysis was performed by experts in the field of DMT with children. During the first stage, all the diaries and meeting transcriptions were read and re-read, and notes were made regarding thoughts, observations, and reflections that occurred while reading. During the second stage, the transcripts and diaries were analyzed by identifying relevant topics and dividing topics into clusters, and a list of themes was compiled. Throughout the third stage, all the materials were again re-read to ensure that all topics were identified, which resulted in a complete list of relevant themes for each topic. In the fourth stage, the data and the topics were checked by an additional researcher experienced in use of the IPA method and by experts in DMT. At this stage, the participating students were invited to a focus group in which the themes uncovered were conveyed to them, and they were asked to share their feelings, emotions, and thoughts about them with the aim of gaining a more precise familiarity with the less conscious experiences [31,32].

8. Ethical Issues

The project was initially submitted to the in-house ethical committee on 10 February 2020, and was subsequently submitted to the faculty ethical committee of the University of Haifa and Seminar Hakibbutzim on 22 May 2022, both of which approved the proposal (approval no. 2968—the University of Haifa, and approval no. SUF2022_11—Kibbutzim College, Israel). The names used in this paper are pseudonyms to protect confidentiality.

9. Results

The study brought up three themes reflecting the remote intervention techniques and their impact in the enablement or hindrance of the creation of a safe space for personal expression. The first theme, "Play as a platform for transforming technical complexity into an expression of the inner world", emphasizes the importance of providing symbolic meaning to the actions of the body, as a way to translate concrete behaviors into a symbolic game. The theme refers to the way in which limitations related to the use of technology and the distant encounter are expressed through the release of tension and emotional needs. The second theme, "Accessories and props as means of motivation for movement and imaginative play", refers to the meanings generated through the use of projective objects and props from the children's home as a framework for expression, sharing, and playfulness. The third theme, "Playfulness-inhibiting conditions in settings of remote therapy", refers to situations and types of interventions that inhibit symbolic play in the group.

9.1. Play as a Platform for Transforming Technical Complexity into an Expression of the Inner World

One of the main themes which appeared in all the sessions was that by giving symbolic meaning to bodily actions, technical aspects related to the conditions of the remote

encounter became central dynamic content in the sessions. This became evident through the participants' preoccupation with revealing and hiding themselves to and from the group and the therapists throughout the sessions in several different ways: disappearing and returning to the screen (n = 12), hiding and revealing different body parts (n = 9), experimenting with turning the camera and microphone on and off (n = 10), discovery and concealment through sounds and voices (n = 8), changes in the computer display and shifting of it (n = 8), and the use of application filters (n = 14).

9.1.1. Disappearing and Returning to the Screen

During all sessions, participants frequently left the camera while it continued to operate. The highest number of camera exits was observed during the first group meetings (n = 12). The reasons for these camera exits were going to the toilet, searching for an accessory the children wanted to show the others, calling a family member, or for no apparent reason.

For example, Andrew leaned down under the camera range so that he could not be seen. Following the therapist's reference to his disappearance, Yael joined him and left the camera range, and following her, Michael hid behind his chair while turning it. This game was repeated throughout the sessions, especially at the beginning of the first sessions, when it was possible to notice the desire of the children for their names to be called out and their disappearance to be noticed. At times, the children peeked at the screen and went back into hiding, until their names were called out again. During the last group meetings, when the topic of the group ending came up, the pattern of disappearing and appearing returned more fully. For example, Debbie asked the therapists to hide and surprise the other children when they re-joined the group. As soon as Ben heard that more children were joining, he quickly jumped towards the screen and shouted "Boo!". When he realized that Ellie had technical problems signing in and that she still could not see the group, he quickly hid again and, following his lead, John also hid.

9.1.2. Exposure and Concealment of Body Parts

The opportunity to control and choose which body parts to hide or reveal allowed for a movement investigation to develop and for contents related to body image to arise. For example, in the first meeting, Ruth chose to get very close to the camera and show her face in zoom-in, thus hiding the rest of her body. Later in the session, during the time devoted to creative artwork, she turned the camera toward her desk so that only her page, her marker, and her drawing hand could be seen. In contrast, during the artmaking time in the third session, Neomi turned the camera very close to her body so that the screen would only show parts of her body: chest, neck, and half her face. An example of a group discussion on the participants' body parts was seen in the fourth session: Neomi approached the camera with her eye; Layla followed her and said, "I prefer myself whole". Afterwards, Debbie also approached closer to her camera, showed her mouth for a few seconds and then her nose and said, "I also prefer myself whole".

9.1.3. Turning the Camera On-off

The act of turning the camera off and on came up frequently. Certain situations were characterized by an experience of shyness and control. For example, during the first four sessions, Neomi turned her camera off while moving and turned it back on when the movement part ended. Other situations were mostly related to the experience of surprise and control, with transitions between a need for privacy and a sense of visibility. For example, in the last meeting, Gali turned off her camera in order to wear a dancer's costume and put on make-up. She repeated this ritual and every time she turned her camera on, she appeared with a surprising new look.

The introduction of an accessory allowed for the expansion of the theme and the practice of discovery and concealment in a playful way, without turning off the camera.

Neomi placed an umbrella in front of her so that she was completely hidden by it, while occasionally peeking out in diverse ways. Michael and Guy chose to cover their faces completely using a scarf. Andy copied this routine and added, "we see and cannot be seen". He also took a piece of paper and brought it close to his body, hiding with it various body parts. Following this theme, the therapists joined the children in the exploration and invited the group members to join their friends' movements and explore different ways to hide body parts. The therapists proposed that the children should move the accessories either nearer to or away from camera and examine the effect on what can be seen and not seen on the screen, while at the same time helping the children understand what they see and do not see on their screens.

9.1.4. Discovery and Concealment through Sounds and Voices

The participants chose to discover/hide by turning the speaker on and off. For example, Layla preferred to leave her microphone on at every opportunity, even when background noises in her home environment were heard at the meeting. In contrast, Kim and Sam preferred to turn on the microphone only at the moments when they spoke. Michael expressed frustration due to his failure to silence the microphone. He tensed his face muscles and held his gaze and body tightly. He raised his voice and asked: "Do you hear me? Do you still hear me?" He asked again in dissatisfaction with his unsuccessful attempts. Andrew spoke while his microphone was turned off, and he did not notice this until the therapist said that she could not hear him. Following this, he seemed embarrassed, turned his microphone on and asked, "now can you hear me?" over and over again. On one occasion, he approached the screen with a toy microphone, which emphasized the contrast between making his voice heard in the room and the fact that it was not heard in the group.

9.1.5. Changes in the Computer Display and Shifting of It

Realistic events that evoked feelings which were difficult to self-contain (fear of change, separation, and rejection) were worked out through symbolic and imaginary play, using the camera and the screen. For example, in the second session, after Andrew's camera moved quickly, Ben looked on in apparent confusion and apprehension, asking "why is Andrew's house swaying?", and then shook his whole body on purpose. His movement seemed playful as if he was looking for an unstable physical sensation of rickety and frightening ground. Michael, Andrew, Ben, and Yael moved the cameras with amusement and pleasure so that it would seem as if their houses were also shaking. This meeting took place at sundown when it was dark. Michael shared his fear of the darkness saying, "I'm a little scared". Ben answered with a decisive tone, "There are no monsters yet, this is not a city of monsters", trying to reassure both Michael and himself. The therapist encouraged this symbolic collaborative discourse as a way to process emotional experiences of uncertainty related to the outside real world and the inner fears.

9.1.6. The Use of Application Filters

Digital means, such as Zoom app filters, allowed participants to change their appearance and dress up using imaginary bows, hats, and mustaches, and all the participants of the groups used these filters in all the sessions (n = 14). The use of filters evoked much laughter and a spirit of playfulness and stimulated the participants to move freely using their face gestures and upper body. For example, Neomi used a COVID-19 filter and said, "I took the child with the mask to a candy factory".

9.2. Accessories and Props as Means of Motivation for Movement and Imaginative Play

Two types of accessories encouraged imaginative play: projective accessories such as a ball, scarf, and pillow, which the children were asked to bring to the meeting (n = 14), and personal accessories from the child's room and surroundings (n = 13).

9.2.1. Projective Accessories

The findings show that the objects that were prepared in advance were used both as a way of connection between the children and as a method for personal expression and the uniqueness of each one of them. Using these pre-prepared props (scarfs, balls) the facilitator encouraged expression of the inner world. For example, in the third session the group leaders encouraged the children to play as monsters and offered them the help of the scarf they had. Each child chose an image taken from their inner world. Ben said, “I am a green ghost”, as he covered himself with a green scarf and jumped between beds in his room. Michael was a “raven” who made “croaking” sounds while waving his hands and scarf. Neomi wrapped herself in a scarf like Michael and waved her scarf at the sides of her body, but her movements were gentler and smaller: “I am a bird,” she said, making bird sounds in a whisper. Later the kids wanted to become “Superman” and “Spider-Man” and show off their superpowers.

9.2.2. Personal Accessories

The facilitators’ openness to the children’s use of personal belongings from their homes allowed for additional methods of communication and expression to develop within the group. For example, Andrew proudly showed up as “a floating robot”; Michael presented the “Book of the Dead-The Dinosaurs”; and Ben brought “a robot that can surf on ice, do stunts and flips in the air”. Demonstrating the abilities and superpowers of the characters they chose, the children’s bodies moved powerfully. Andrew and Ben jumped eagerly, their transitions in space were fast and surprising, and they moved quickly around their rooms while making enthusiastic noises. In other sessions, the participants dressed up as old people, carrying heavy baggage, bending over with their bodies, and offering each other imaginary bowls of soup.

9.3. Playfulness-Inhibiting Conditions in Settings of Remote Therapy

In both groups, most of the children expressed difficulty in playful and symbolic emotional expression in various situations throughout the sessions, especially during the first and last sessions of the intervention [10], in situations where feelings of insecurity arose [8], and when faced with structured guidance [12].

9.3.1. Functioning of the Children as Affected by the Process of Acquaintance and Separation

The initial sessions were characterized by over-engagement with the app, and lack of attention, sharing, and playfulness. The first session was mainly characterized by the children’s interest in the functions of the Zoom program and getting to know the facilitators and the framework. As the framework of the sessions became more established and stable, the children felt increasingly confident, and more expressions with imaginative content were discovered. Alongside the difficulty to engage in the first sessions, expressions of ending in general and with regard to the Zoom session in particular also came up many times and affected the processes in the group. At the end of the meetings, resistance was expressed though anger, disappointment, and dissatisfaction. For example, Andrew asked, “why do we have to finish now when in kindergarten we have plenty of time?”. Ben expressed frustration that only a few of the accessories were used in the session and said, “so we just wasted the time when we took them”. Michael expressed anger towards the therapists, saying “Naughty you! You are Rude! We need to finish just when I wanted to play this song . . . Bye and never see you again!”.

The last session evoked regressive behaviors, as the children fiddled with personal objects while talking and refrained from looking straight at the screen, moving frantically. Michael said, “this is my worst day I have ever had in my life”. The children moved away and approached the screen, touched the body, or fell into fetal positions in the chair. The processing of sadness and difficulty in parting was also shown through the loss of pets that the children mentioned in the sessions. The children offered to show pictures of their

pets that died and spoke of shared moments with them. Conversely, Ben especially looked for optimistic moments, found it difficult to experience sadness due to parting, and spoke about his plans after the sessions ended.

9.3.2. Feelings of Insecurity

At moments when the external reality was uncertain and the distance from each other was especially present, no imaginary game took place. For example, Andrew fell from a chair in his house and was injured during one of the sessions. The children and the therapist were worried and expressed concern for his safety. In response, the children started playing hide and seek and the therapist reflected the emotional experience, "today it's difficult to be together. Andrew fell in his house, and we could not keep him safe as we are far. We are both together and alone". At these moments, the imaginary game stopped. In other cases, where there was a sense of concern for the safety of the children, for example when Ben jumped from bed to bed in his room while trying to fly, the therapists tried to gain control and warned the children of the danger. Here, too, the imaginary game stopped at that point.

Additionally, changes in the participants' lives as a result of COVID-19 affected the collaboration in the sessions. For example, at a session which took place on the day the lockdown began, the children left kindergarten without prior preparation, and a third of them did not show up for the session. Neomi, who was usually excitedly eager to participate, agreed to join the session only after an encouraging phone call. Yael refused to come, and vehemently opposed the Zoom meetings. Michael wrapped himself in a scarf and made baby noises, put out his tongue, jumped out of turn and leaned on the chair with his body folded and far from the screen. Andrew put various small objects into his mouth; Ben sat in a darkened room; Neomi kept quiet through most of the session and seemed to be not in the mood for anything. Sam was over-aroused and had difficulty regulating himself.

After entering another lockdown, Yael's mother wrote to the therapists: "Yael doesn't want to participate. She says it's too short and ends quickly, and then she is sad. She is now also always sad when she sees her grandparents and then they leave, or when something is over". In this session, Michael brought up the death of his cat without prior connection, "you know my cat is dead … she is no longer in my house … ". He later showed a book he had at home about extinct dinosaurs and explained that they were also dead. Thus, alongside the avoidance that the changes brought to the group, attending meetings allowed for the processing of difficult content and a space for sharing fears and feelings of helplessness, loss, and separation.

9.3.3. Structured Guidance

It was noticed that when the therapists' instructions were more specific, i.e., "shake the scarf and stop," or "bring the ball closer to the screen," the children mostly cooperated, following which the group synchronized, but there were no expressions of imaginary symbolic play.

10. Discussion

In DMT, body and movement are used as a way of communicating experiences that have not yet undergone representation. Associative movement invites an encounter with concealed areas of the psyche [33,34]. The findings of the study show that imaginary and emotional content is also expressed in the body in a group setting that takes place in a remote setting visible on the computer screen. The study indicates that attributing meaning to the children's actions in the context of the new format of the meetings (screen boundaries, speaker and voice control, the mobility of the computer and the various filters) and translating their behaviors into emotional needs which are playfully expressed led to an expansion of the children's emotional expression during the meeting. Furthermore, the type of objects and accessories spontaneously used by the children in their home setting and

those pre-prepared by the facilitator (identical projectable objects) allowed for playfulness, imaginative work, and verbal discourse. At the same time, however, these interventions were not as effective before the establishment of an acquaintance with the facilitator, or at times of stress and in the face of closed structured instructions. The following discussion expands on the findings and formulates some practical conclusions for psychotherapeutic interventions when working with children in a remote setting at times of crisis.

11. Discovery and Concealment of the Body

The findings of the study indicate the participants' extensive involvement in the issues of discovery and concealment/presence and absence. The content appeared through actions whose nature was regressive somatic-sensory, which explore the contrast between the "presence" and the "absence" of the body in the encounter with an observing other. Through the disappearances from the screen and the return to it, as well as the hide-and-seek games, the children practiced the experience of presence and disappearances in a real and concrete way. The game allowed the children to express still unverbalized experiences through their body movement and actions. The presence of the therapists through their gaze, reflection, and resonance gave this experience validity, meaning, and qualities of communication. As the meetings took place from afar through Zoom, we assume that the children's acts of disappearance and discovery were triggered by their awareness of the physical distance that the lockdown brought with it. It seemed difficult for the children to symbolically hold the therapist's presence in mind as a caring, interested, and attentive individual who is there for them. In situations where, in Winnicott's (1963) [35] words, the child is unable to use the object when they are not physically next to it, and to feel protected and safe when not all their senses can recognize it, regressive behaviors may appear. In the sessions presented, we suggest that the children recreated initial regressive experiences, expressed in a somatic-sensory play of presence and absence. Themes of discovery and concealment through hide-and-seek games often appear in psychotherapy as a way of processing developmental processes of separation. This resonates with Freud's (1920) "Fort-Da" (here/gone) game, where the infant masters separation by converting the passive experience into an active one [36]. It is also similar to the "peek-a-boo" game, where the child covers his/her face and "disappears" and then returns with increasing and decreasing stress levels. This allows the baby to practice gaining control over the mother's disappearance and return as part of achieving a sense of object permanence [37].

It can be assumed that the physical distance from the therapist and the therapy room due to the pandemic brought up contents related to instability and insecurity as result of the circumstances, which made for some uncertainty as to the actual existence of the other. Through the hide-and-seek games, the children were able to re-process fears and needs related to internalizing the other's presence, even when the other was not physically close.

In the present study, the theme of "discovery and concealment" may also be interpreted as avoidance and resistance, but in fact, the therapists highlighted the playful and creative qualities that the children expressed and encouraged the development of this content. References to acts of discovery and concealment through witnessing, observing, and echoing without providing interpretation presented the possibility for participants to continue to explore, to be intrigued, and express their emotions more consciously, as their motor expression also developed and became more complex. The legitimacy given to hiding and discovery through movement transformed the meaning of these behaviors from expressions of a defense mechanism to a method of communication, creativity, and play, which, in turn, led to the attainment of a sense of belonging to the group. Furthermore, through acts of discovery and concealment the participants controlled the level of intimacy and the degree of closeness and exposure and played with them. The sense of visibility in psychotherapy in general, and in children's psychotherapy in particular, is essential, and its attainment in front of the screen is necessarily more complex and partial. In remote psychotherapy, clients are preoccupied with whether they can be seen, found, heard, felt, and protected—even more intensely than in the secure protective setting of the therapy

room [24,26]. As mentioned, throughout the sessions, the therapists and the group's attitude towards the acts of disappearance performed by the children was of great significance. The children seemed to have re-experienced this game when they needed to be looked at, noticed, heard, and reinforced. This was especially evident at the introductory stages and when issues of parting came up.

12. The Use of Accessories and Props as Projective Objects Which Regulate Emotion

Remote psychotherapy for children is a challenge due to the great mobility that characterizes the developmental stage of children, their limited span of attention, and the children's need for non-verbal communication [15]. Accessories serve as mediators and bring children closer to a shared group experience, while still serving as means of expression for the children's subjective experience [6]. Similarly, in the present study the accessories helped participants to be involved and share emotions. The use of personal or technological accessories supported group cohesion and a sense of belonging and served both as a container which holds and gathers the group together and as a means of expressing emotional content from the inner world of the children. In DMT, the use of accessories and props such as scarves and balls is very common, as these can offer sensory stimulation and be used to make connections without making physical contact [6]. The present study emphasizes the importance of using projective accessories that encourage movement for a sense of closeness even in remote, online therapy. The participants' use of accessories which support movement (ball, fabrics, ropes), and the frequent use of the Zoom filters on the children's own initiative, created many situations in which all participants collectively engaged in the same accessories. The props allowed participants to externalize their emotions through movement and thus process experiences in a less threatening way. When participants were given the opportunity to bring an object of their choice, they often chose a soft object that accompanied them throughout the session and helped reduce stress. It is possible that the use of an object compensated for the distance from the group members and the therapist, in the same way that the transitional object helps the child in separation while moving away from the mother [38].

The use of props also supported the expression of painful emotions, such as sadness, confusion, and helplessness. Many children chose to play act as elderly characters who are forced to carry heavy weights on their backs. It is thus safe to assume that the shared creative experience allowed the children to express their innermost fears which the global pandemic brought to their daily lives: the confrontation with uncertainty and the fear for relatives. The children's act of making and offering imaginary bowls of soup to each other highlighted the power inherent in working through movement and accessories and expressed the children's need for nourishment by and concern for their loved ones.

Through the therapeutic work with accessories, communication took place between the group members, which accorded with previous findings in clinical literature [4]. Using the props, the participants suggested movement activities to the group and invited the group members to join their imaginary world, as a way to further explore, process, and feel less alone. Taking on such an informal facilitation role by group participants may contribute to their growth process [6].

13. Processing of Psychological Content Related to COVID-19 through Remote DMT

The consequences of COVID-19, such as the closures of educational institutions which prevented children from meeting their peers and the possibility of Zoom therapy, affected the emotional content with which children were engaged in the sessions. Topics such as death, loss, and separation were expressed through physical absence, through various actions in the encounter, and in the verbal content expressed during the session. Participants were supported by the group and used it to process feelings of fear, anger, and sadness, to experience ego forces, and strengthen the sense of agency. Response to separation and termination appeared in spontaneous movements of venting and physical in-drawing, indicative of feelings of insecurity [39], e.g., making baby noises, wrapping oneself in

a scarf, putting objects in the mouth, motions of frenzy and arousal, along with lack of movement and reduced liveliness.

Strong and fast movements appeared in the face of threatening situations, for example, when it seemed to Ben that the house was shaking and unstable, he converted the fear and confusion into movement, and embodied the same frightening tremor. Fear thus became a comic game joined by all team members. This reinforces the understanding in the literature that children use frightening or dangerous metaphors, such as monsters and dragons, and the pretense of magical ability to gain control of the fear of the unexpected and to interpret and process experiences [40]. This research shows that through the moving body, processing emotional experiences is also possible through online, remote therapy, despite the limitation of screen boundaries and the distance among participants and between them and the facilitators.

14. Practical Implications

It is essential to arrange for an inclusive, containing environment in remote group DMT for children, an environment where trust and confidence may be built regardless of the physical distance of the therapists and the absence of clinical frameworks. This type of environment will allow for transitional experiences between the children's inner psychic reality and the outer reality. These experiences are important for processing emotions indirectly through the assembly of stories, images, and metaphors, which also considerably affect movement expression, movement diversity, and quality of movement. It is our understanding that in this type of therapy and circumstances the therapists should give special attention to:

1. Interweaving educational observation and symbolic play—endorsing the role of the therapist as a supporter of conscious translation to unconscious movement.
2. The functional use of media and technology and its projective use to allow the children to lead and show the therapist the endless possibilities of telling the psyche's tale.
3. Using the entire space of the room for movement work—children need space beyond the boundaries of the computer.
4. The projective use of accessories in movement, as a way to support the expansion of movement and get in touch with inner psychic materials.
5. Listening both to the verbal and the non-verbal content that arises in remote DMT sessions enables contact with the children's' emotional experiences, especially those related to coping with stress and changes that the COVID-19 outbreak brought with it.

Notably, the study found that in situations of stress, the therapist's ability to hold the projective and potential space for the children is limited, and that keeping the sense of safety is challenged. Given the daily pressure of such situations, which also effects the stability of home settings, remote therapy may also be less effective. It is precisely in these situations that face-to-face interventions are critical, and remote online work is at best a default intervention in the absence of other options.

15. Limitations and Future Studies

The study was conducted with a small sample of participants with similar characteristics, and the qualitative data were based on the therapists' experience and their impression of the process in the sessions. Additionally, the scope of the meetings was limited. This should be further explored, and the sample size and research tools should be expanded. The participants' point of view and their perceptions of the experience should also be explored and evaluated. Furthermore, the study addresses both the proactive and preventive aspects which can be worked with in remote therapy as well as the importance of studying a population without particular emotional difficulties, as a way of recognizing the uniqueness of the remote DMT sessions with young children. Further studies may relate to other populations with identified difficulties and other diagnoses. Moreover, as we reasoned that it was beneficial for M.A students to have experience in delivering therapy remotely during their studies, second-year DMT students delivered the sessions and observations.

We predicted that competency and efficacy in this area could have important professional and public health implications and that acquiring enhanced clinical skills could later be potentially beneficial for delivering remote services. That said, further studies should involve more experienced and certified therapists who facilitate and study the remote DMT group intervention. Finally, it is important to examine the impact of remote therapeutic sessions versus the impact of face-to-face encounters by examining the clients' feelings and the extent of observable changes before and after the intervention.

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Review

Art Is Fun, Art Is Serious Business, and Everything in between: Learning from Art Therapy Research and Practice with Children and Teens

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Abstract: This paper explores the current theoretical frames of working with children and adolescents, considers the socio-political and developmental considerations for art therapy practice within settings, and systems in which children are embedded. An illustration of the use of art materials, processes, and products for children and adolescents based on an art therapist's clinical experience in school settings, mental health hospital, adolescents' clinic, and private practice then follows.

Keywords: children; adolescents; art therapy; art materials; art process; art products

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1. Introduction

In this paper, I review some of the main art therapy models and research findings that have informed my work with children and teens over the years and organize art therapy considerations from my clinical experience. Admittedly, compared to the growing body of research practices in our field, this report is more anecdotal, and thus likely to be less generalizable to a particular mental health challenge or specific age group. However, it is my hope and belief that it articulates a working frame that is easily applicable for art therapists that are working with children and adolescents, allowing them to benefit from some our research findings and theories while particularizing the work with young clients in different settings. I specifically attempt to illustrate the usefulness of art materials, processes, and products for children and adolescents based on my clinical experiences in school settings, mental health hospitals, community clinics, and private practice.

Over the years, the use of art products and the process of art making with children have undergone extensive study as tools for assessing the normal and abnormal development of pathology in young clients. Prominent evidence-based assessments include the Formal Elements of Art Therapy Scale (FEATS), developed by Gantt and Tabone [1,2], as children respond to an art task called Person Picking an Apple off a Tree. This assessment is likely the most systemically researched and validated tool of art therapy to date. FEATS is a measurement system for applying numbers to global variables in two-dimensional art (drawing and painting). While it was originally developed for use with the single-picture assessment ("Draw a Person Picking an Apple from a Tree" (PPAT), researchers can also apply many of the 14 scales of the FEATS to other types of drawings [2].

Another very well-known model—the Expressive Therapies Continuum—developed by Vija Lusebrink, and later worked on with Lisa Hinz [3] explored the use of materials, art processes, and symbolic products. The expressive Therapies Continuum (ETC) "offers a method for conceptualizing how and why particular art interactions can be therapeutic. It provides a framework for communicating with clients, fellow art therapists, and other professionals about the therapeutic uses of art materials and processes" [3] (p. 43) and has often been used for understanding children's and adolescents' creative engagement focusing on the art process and materials rather on the product.

Art therapists also attempt to systemically investigate children's use of symbols, impacted by collective and cultural aspects [4] as well as the way signs and symbols form a language that is at once unique to the individual and a manifestation of our universal focus on communication as humans [5,6].

Beyond exploring the usefulness of art making to assess and understand the needs and wants of children and teens, art therapy models have articulated the distinctive ways that art can offer therapeutic experiences and integrative opportunities for growth that is less dependent on cognitive and verbal abilities.

In her seminal book, Judith Rubin [7] articulates the main principals of working with children, typically elementary school aged children, through art therapy. She highlights the way that art materials and interventions offer children experiences of freedom as well as deep and broad expressions of self and discusses the art therapist as a figure of actual and symbolic relational relevance for the child. Rubin explains the main ways that making art, specifically visual art, integrates different levels of knowing and connects self and others (therapist, parents, peers in art therapy groups, etc.). Furthermore, Rubin emphasizes the importance of understanding specific challenges and expressive approaches and modalities while maintaining a grounded specialization in the modality one is most knowledgeable of.

While few art therapists have discussed art therapy work with pre-school children [4,8] recent work [9–11] has expanded the scholarship to consider the unique needs of young children, ages 2–5 years old, more systemically, suggesting a need to balance standardizing assessments, using developmental core competencies, and structuring therapy according to current evidence practice with young children and the need to offer empowering, creative, and fun opportunities for individual growth. Outside of the art therapy world, creativity researchers and brain researchers have supported the unique place of art as play and expression for the developing child [12].

Systemic considerations of art therapy work with children are plentiful and critical to understanding our interventions within the holistic realities of children. Such reflections on art therapy originally focused on family art therapy [7,13–16], as well as dyadic art therapy in form of parent-child dyadic work [17,18], couples art therapy [19], or school-based art therapy interventions [20–22].

Findings from family art therapy research over the years has focused on the way art production highlights participants' roles and challenges as well as relational dynamics at the root of those challenges. Current models of parent-child dyads specifically emphasize making implicit aspects of the relationship explicit through standardized assessments [17] or connecting art therapy work with couples to evidence-based practices with clients such as emotionally focused therapy and sex therapy [19]. As work in school settings and with families is so important for child and adolescent art therapy, I will expand a bit more about each below.

Understanding art therapy work within school similarly shifted from anecdotal reports to findings from larger and more systemic exploration. McDonald and Drey [21], for example, assert that the use of art therapy in schools seems to produce some positive impacts and lack of indication of harm, and pointed to the urgent need for larger and more standardized clinical effectiveness studies of such work. When exploring the few systemic studies that were conducted in education settings, Nissimov-Nahum [22], for example, developed an evidence-based model of art therapy intervention in schools that "highlights the dual principal of conveying acceptance and directing toward change, which is applied on three levels: the child, teachers and parents, and the therapist," and Regev et al. [23] similarly reported on the perceptions of teachers, therapists, and clients of art therapy services that were offered in schools in Israel, exploring differences between work in special educational and regular school, and advising art therapists to (1) form collaborations with staff at the educational system; (2) explain the profession and bridge the clinical and educational language; (3) stress the need for additional resources for therapy sessions, equipment, and supervision; (4) create uniform therapeutic framework; (5) ensure therapists' adaptability and appropriate training within the schools; and (6) involve par-

ents in the therapeutic process. Moriyah [24] also researched art therapy treatment in the Israeli system and focused on the ethical considerations of art therapy work in educational settings, similarly, underscoring the need to consider ethical dilemmas resulting from the difference between educational and more traditional clinical settings.

As noted above, family art therapy has often been used art for systemic assessments of clinical and familial needs and roles, power dynamics, and communication patterns. Treatment has focused on the need to realign these methods with family developmental stages and to look at specific clinical demands by creating space that provides psychological safety and the freedom to play, explore, and create. At times, these explorations take place with all members of the family of origin (FOO) present, while at other times, the focus of the work is on intentional sub-units of the family (parent-child art dyads, parental guidance of a child receiving art therapy, sibling dyads, or multigenerational sub-units, when clinically appropriate).

In recent years, models of utilizing parent-child dyads for assessment and treatment had become more standardized and more thoroughly researched (including [9,17,18,25], and others). Based on several large studies, Gavron and Mayseless [17] summarized findings suggesting that “the JPP enabled several dynamic processes such as pleasure and fun, bi-directionality, mutual regulation, mentalization, and mutual recognition, which together created a salient positive transformation in the relationship”.

Linesch [26] reconsiders art therapy work with adolescents and underscores engagement, empowerment, and identity as three critical clinical constructs. She illustrates these constructs through interventions that she led with marginalized adolescents, including incarcerated teens and immigrating and acculturating teens, and marginalized and gang-affiliated teens. She highlights the importance of considering cultural and systemic issues as well as the power dynamic beyond traditional developmental theories and art therapy models. Linesch, following Briggs [27,28], contextualizes the need for teens to not leave childhood, but to find a way to relate and belong to a complicated, post-modern adult reality that is embedded in feminist thinking as they consider their ethnic and racial identity in a world where oppression and privilege structure their growth. Overall, Linesch stresses the importance of considering the sociopolitical and developmental challenges art therapy practice often faces within the settings and systems in which adolescents and their families reside.

Another non-traditional setting in which children and teens are being exposed to art making and art therapy intervention includes the growing field of community art therapy. Such work sets to “promote individual and communal transformation outside of traditional health settings” [29], in such sites, the work focuses on wellness of community members through art making that supports (a) safety (structure), (b) acceptance (nonjudgment, genuineness), and (c) opportunity (authentic self, exploration, creativity, self-care). In such work, the choice of materials should take into consideration a wide range of personal, familial, and developmental needs as well as the cultural relevance of the material and the space of work and handling (storing/sharing/presenting) the art products.

As a whole, open studios and community outreach efforts postulate that creating an organic environment where community members, including children and families, can bring their authentic selves to create together increases their sense of self and wellbeing, individually and collectively. Seminal models of open studio art therapy were created by founders such as Pat Allen [30] and Timm-Bottos [31], and more recent social action frames further articulate the needs to which these models respond [32]. Community initiatives have grown in recent years as they seek to enhance the wellbeing of people living with disabilities [33], support processing grief [34] in psychiatric hospitals [35], for refugees, unhoused and displaced individuals, and survivors of domestic violence in shelters [36,37], or undertake an intensive intervention after disasters [38,39] Children and adolescents are of course part of the communities that are served by these art therapy approaches and seem to greatly benefit from the intergenerational and social opportunities that they bring. In

the last couple of years, due to the COVID-19 closures and a necessary shift to Telehealth, some programs started offering online open studios that serve children as well [40].

This brief review of the literature situates this paper's aim to categorize art therapy research findings and theoretical models into applicable clinical considerations that are based on my own clinical experience working with children and adolescents in myriad settings.

2. Materials and Methods: Reflecting on Learning from My Clinical Experiences

In preparing to write this paper, I reviewed my clinical files and considered my work with children and adolescents over the years. Specifically, as I looked over my clinical files, I considered my different roles as an art therapist working with children, adolescents, and families in different settings. I then looked at the theoretical models that have grounded my work and recent publications on effectiveness and relevant interventions, as discussed above. Table 1 summarizes some of the overarching considerations that might be useful for other art therapists.

Table 1. Working with Children in Context: Summarizing art therapy research findings and theoretical models into applicable clinical considerations.

Setting	Art Materials	Art Process	Art Products
School settings	- Materials that are accessible and safe in educational settings - Offering new techniques and materials that are not often available in classrooms and empower the child (such as supervised work with hot glue gun)	- Providing opportunities to engage in a process that offers safety and freedom - Considering the child/teen's ecological and systemic needs and engaging parents, teachers, and peers to enhance therapeutic impact	- Focus on art products as "bookmarks" or "steppingstones" reflecting diversity of internal and external experiences to be integrated (radical acceptance) - Model caretaking of art products as extension of self and relationship
Medical and psychiatric art therapy	- Materials that are accessible and safe for hospital - Art materials that increase expressive opportunities but do not cause further stress or sense of physical or mental limitations	- Providing opportunities for non-medical play, joy, connecting to hope, health, and processing impact of fear, sadness, and trauma within a wellness frame - Understanding transitional nature of art therapy sessions as a one-session brief therapeutic experience	- Understanding the transitional nature of art therapy in a transitory space: 1. The possibility for the product to transform the environment through small creations, and 2. Practicing non-attachment and acceptance of the often-limited ability to store and transport physically.
Community clinics, community centers, and open studios	- Considering individuals' goals within their community and its resources impacting choice of materials - Exploring ways community and public engagement and interaction can enhance therapeutic goals (finding spaces for exhibitions, storage, and clinical practice that empower community members and respond to needs)	- Exploring ways community and public engagement and interaction can enhance therapeutic goals (through exhibitions, collaborative/intergenerational work, team-work, etc.) - Utilizing therapeutic process and structure to build on the community strength and offer culturally appropriate interventions	- Considering the meaning of artifacts created in art therapy sessions as potentially meaningful to the community and consider the possibilities of shared growth through creative collaborations - Considering the meaning of privacy/confidentiality, as well as use of care (extended families?) and the role of the therapist and their relationship to community leaders to enhance sustainability

Table 1. *Cont.*

Setting	Art Materials	Art Process	Art Products
Family/Dyadic Art Therapy	- Considering materials that are appropriate and engaging for age range of participants. - Creating work environments and spaces for collaborations as well as parallel work	- Paying attention to relational dynamic: initiation and hesitations, decisions about engagement, collaboration, imitation, and boundary forming - Exploring similarities and differences between verbal and non-verbal aspects of engagement	- Using reflective and verbal tools to process and validate individual and shared experience - Support exploration of art products to increase self and other's understanding, connect here-and-now to ongoing relational experiences and therapeutic goals
Individual art therapy in Private Practice	- Offer choice of materials that does not overwhelm client yet allows for expression of needs and wants, allows for experimentation and hesitation as well as familiarity - Create rituals of presenting materials and storing them away that creates safety and structure, while allowing expressive freedom and pacing during the session	- Developmental/age considerations to instruct use of creative intervention, place of verbal/cognitive processing, and therapeutic goals - Cultural and systemic considerations of needs and values underlying client's perception of health, therapy, individual identity, and family/community belonging	- Exploring meaning of art products for individual clients within the confines of confidentiality and standards of care for minors - (e.g., consider how and when to encourage sharing art products with parents, how to empower child/teen to own communication, and what to do with art products as therapy comes to a close)
Group Art Therapy	- Materials and space considerations that engage a group of children or teens in an age-appropriate manner, and that offers freedom to explore and express while maintaining structure and safety	- Creating sound structure (through opening and closing rituals, consistency of rules of engagement, and responding clearly to attempts to breach or assault set structure) while offering freedom to create and express with unconditional support and validation	- Considering movement between shared group and individual presentation and discussion of artworks to sustain and reflect group members' needs of belonging as well as separation-individuation within a group
Art Therapy Assessments	Consider appropriateness of standardized or un-standardized Use of Materials Art Therapy Assessments (i.e., PPAT, KFD, JPC)	Considering clients foci/level of work and possibility of integration (ETC, self and other, cultural aspects)	Standardized or un-standardized understanding of products within developmental and cultural/ecological realities

To review my clinical work with children and teens, I first identified all of the primary settings in which I have worked over the years, creating categories and organizing my files into these categories. For transparency and clarity, I discuss the actual settings in which the services were delivered without disclosing information that might compromise the privacy and confidentiality of my clients.

2.1. School Settings

One of my formative experiences as an art therapist was my work with a unique school-based program called Share and Care, which offered art therapy services at local schools as part of the psychological trauma outreach program at Cedars-Sinai, a large medical facility in Los Angeles (https://www.cedars-sinai.org/community/programs/share-care.html (accessed on 5 August 2022)). During my years of employment with Share and Care, I was assigned to a local elementary school in the community and worked closely with the principal, teacher, and parents to explore the multiple ways individual, group, and parent-children services can support the identified needs of students. For a year, I also worked in an elementary school on the east side of LA, where families were much more impacted by immigration, challenges with legal status and employability, and violence (gang-affiliated activities) impacting children's social lives.

In both settings, while there was no other art therapist on site, I was grateful to work alongside a devoted and open-minded staff who were able to gradually adapt schedules, goals, and procedures that were predominantly educational to ones that were more focused on the socioemotional needs that arose. A prominent challenge nevertheless was the ongoing effort to structure the work to be confidential, student-centered, and developmentally/psychologically focused in an environment where others (teachers, parents, principal) had rights and needs that were associated with information I often glean more exclusively in sessions. Another challenge was maintaining the privacy and emotional wellbeing of students who struggled with the sessions taking place in school, the firm time limit of the session, and its proximity to breaks and other classes. Clarifying priorities and goals, such as when it is best for a student to see a therapist while in school and when that decision leads to more challenges (educational, social, familial), was another focus. Finally, my work was also guided by the importance of considering various developmental uses of art and adapting to the needs of children ranging from kindergarten to fifth grade, and intentionally learning with children and their parents about ways their cultural background informed their understanding of art, therapy, and their challenges and strengths.

2.2. Medical and Psychiatric Art Therapy

I first learned about art therapy as a psychology undergraduate student working in a psychiatric-intensive program for teens in a large psychiatric hospital in Israel. I was employed there as a psychological mentor and facilitator. It was there that I learned firsthand the power of creative expression for teens as I struggled with not-knowing and learned the importance of setting clear boundaries while holding on to care and hope. While there, I first considered the meaning of therapeutic use of art versus art therapy. Later, in Tallahassee, Florida, I served as the art therapist in three psychiatric units in a large hospital (Tallahassee Memorial HealthCare). Unlike working in a semi-open, ongoing intensive program serving the same adolescents for months, I learned how to create brief art therapy interventions for acute situations, often not knowing if I would get to see my clients when I was there next. When I later collaborated with expressive therapists at the Children's Hospital Los Angeles to research similarities and differences between art therapy and music therapy. During this time, I was again reminded of the importance of systemic thinking—specifically, understanding the way medical procedures and the physical environment of the hospital impacts the choice of art materials, their use, and what one does with the products. Similarly, art therapists constantly negotiated medical and psychiatric goals with humanistic and existential ones, trying to strike a balance in advocating for client's unaccounted wants, giving voice, and providing a sense of freedom.

2.3. Community Clinics, Community Centers, and Open Studios

As a beginning art therapist, I constantly looked for ways to offer opportunities for the therapeutic use of art for the community in a way that supported social justice. I learned from the best—I was lucky to be mentored by Debra Linesch at the time she had created the workshop for teens at risk in the Museum of Tolerance [27] and was an active facilitator as part of that team.

I later facilitated art therapy work with pregnant and parenting teens for a couple of years through the Helen B. Landgarten Art Therapy Clinic, which served adolescent girls between the ages of 13 and15 who attended Thomas Riley High School, an alternative school in South Los Angeles. I also had the unique opportunity to be part of the art therapists of Katrina Through the Eyes of the Children (https://www.nytimes.com/2007/09/17/arts/design/17ther.html (accessed on 5 August 2022)), offering an intensive art therapy workshop for two to three days bi-monthly for a community of Hurricane Katrina survivors who had been evacuated from New Orleans to a temporary housing (Renaissance Village) in Baton Rouge. In recent years, I co-directed community outreach projects, both physical and through Zoom, offering art therapy services in Latin America and Israel, which similarly continue to inform my thinking.

Specifically, seeing children and adolescents in community and non-clinical settings, where the focus of the work is often layered and includes shared socio-environmental strife impacting a community is humbling and life-affirming for me. Witnessing the power of art to hold, explore, and communicate how each of us is so different and yet belong so deeply to our community, and how our context shapes us, is at the core of my belief in our work. Working in these setting also continuously sheds light on my own privileges and cultural assumptions and sustains the imperative to be flexible yet consistent and professional within fluid, constantly changing settings with limited resources.

2.4. Family/Dyadic Art Therapy

As an art therapist in private practice for the last decade, I have had the opportunity to serve families and parent-child dyads. The focus of art psychotherapy with families and parent-child dyads is, naturally, the relationship AND the individuals rather than the individuals primarily, as is often the case in other forms of therapy. Art making within these settings has served me as a therapist in pacing (myself, my clients), holding all experiences as valuable as they are captured through the art and can be considered later in therapy.

As I reviewed notes from different families and dyads I had worked with, the importance of creating a shared understanding of the purpose of therapy emerged. Art had often showcased the strengths of family members and the dynamic (and challenges that were associated with that dynamic) among them in a way that was concrete and integrative, personal, and shared.

Offering services in private practice also asks for different involvement of the therapist as a business owner as well as the sole holder of legal and ethical responsibility. These aspects of private practice as a setting often limit, shape, or stretch the roles of the therapist with the adults who pay for these services and can impact their response to art and verbal interactions.

2.5. Individual (Child) Art Psychotherapy

Again, when reexamining my work with children and teens in my private practice as individuals, the negotiation of communication and control of parents as the consenting adults comes up. With some parents, the challenge was to engage them more in therapy and encourage more of an understanding of their child or teen's needs, while for others my role was to assist the child or teen in creating a discrete and autonomous space. In this setting, I often anchored my interventions in relational and developmental theories, attempting to assert my position as a trusted adult friend for the child or teen even as I held on to the importance of the parents in their child's wellbeing.

Within this context, art—exploring materials, allowing young artists to experiment and practice regulation, working through frustration, illuminating inner experiences—was always my most helpful tool. Storing artworks overtime often helped communicate to both the child and the parents who were not present in all sessions what journey their children were on.

2.6. Group Art Therapy

I led groups in many of the above settings (schools, hospitals, community outreach workshops); yet I think it is worth considering the unique aspects of creating a clinical group with the focus of the group as the healing environment rather than as a byproduct of a system in which many clients need to be seen. In other words, I explored children's and teen groups whose setting was essential to promoting the goals. For example, when offering groups for teens that were housed in a residential facility for adolescents that were at risk (Penny Lane, Los Angeles), the group of participants also lived together and were essentially a sub-family of a sort. There, increasing empathy and communication supported problem solving of daily challenges.

Similarly, for children that were temporarily housed together in an inpatient psychiatric hospital, art therapy for teen mothers, or for adolescents that were placed in juvenile

detention offered a normalization and validation to their journey. So, understanding the merit and limitations of each group directed the goals as well as the art interventions that were used.

2.7. Art Therapy Assessment

Although art therapy assessment can take place in any setting in which children and adolescents are seen by an art therapist, as I reviewed my clinical work, attempts to use more formalized assessments stood out from the process of using art making for ongoing therapy.

Specifically, I recalled how I attempted to study art therapy assessments for 0–5-year-olds while integrating evidence-based practices, play therapy models, and developmental frames [41]. I also remembered the use of formal assessments such as the FEATS [2] and Kinetic Family Drawing [42] when trying to learn from teens in schools and in Central Juvenile Hall (Los Angeles) about their perspectives, and the use of Helen Landgarten's Family Art Assessment [14] when working with new families. These assessments provided structure both for myself and for my clients during our first meeting, set the tone of professional yet creative engagement, and yielded rich information about main interests, challenges, and responses to art upon which to build.

3. Results/Case Illustrations

As I organized my insights, I noticed two overarching considerations that continuously inform my thinking: First, considerations of clinical settings (where the child is seen, referred, when and where therapy takes place, considering the bio-psycho-socio-cultural affiliation, etc.) in which children or adolescents are seen. And second, considering how children and teens utilize art materials, art processes (interventions), and art products within the developmental and environmental conditions they experience. Accordingly, in the table below, I attempt to summarize some of the main points that emerged from the research and theoretical frames that were discussed above that were meaningful in my clinical experience. Later, I offer brief case vignettes as examples of applying some of the noted considerations within the different settings. These derive from my experience as an art therapist with the hope they can be considered an illustration as well as support for other art therapists' application of their own work.

In the section below, I illustrate the way different settings and systemic considerations are entwined with reflections for using art materials and art interventions (process) and the resulting art products in art therapy with children and adolescents. In other words, while the first section presented research findings and theoretical models for art therapy with children and adolescents, then summarized the clinical considerations, those considerations are now applied to concrete examples and case vignettes in this section.

3.1. Working in School Settings

As explored above, evidence-based practice of art therapy in school settings is now well anchored in substantive research [20,22,23] and often highlights the unique place that art therapy creates within a complicated system involving children, teachers, parents, and administrators. Both systemic and developmental variables impact goal-setting that is often relevant for both educational/academic needs as well as mental health ones. The choice of art materials, time, and space in which sessions take place, as well as the available art products are often an outcome of negotiation between the therapist and other school players. The role of the therapist in a unique relationship and as an adult trusted friend [26] must also be negotiated with the fact that the therapist must communicate with the child's parents, their teachers, and report formally as part of the school system.

An illustration of the above considerations within the school system is demonstrated in my work with D, a 10-year-old child who was originally referred to art therapy by the school principal due to repeated bullying and violent behaviors and failure to thrive academically. As a school-based art therapist at the time, I had an initial assessment

with him and a follow up conversation with his mother, a single parent, in which many insecurities and hesitations about the school and how he could succeed in it were raised. It was clear to me that a main goal of therapy was to increase D's sense of safety and trust in the school system and in his interaction with me, and that he desperately needed to be seen as capable and valued.

The art piece (Figure 1) shared here allowed D to use materials that were novel and appropriately challenging for his age (hot glue gun) and produced an art product (construction of found objects) that he was proud of (he did not feel comfortable drawing). The fact D could choose the materials enabled me to support the creation of a scene he developed and controlled, which fostered his sense of safety and freedom to explore and allowed him to reveal aspects of himself—in essence, his fragility—that he rarely presented in the classroom. The resulting three-dimensional piece allowed us to interact with the child behind the "Don't enter" sign while keeping him safe psychologically behind the play and metaphorical figure. His ability to share more vulnerable sides helped me better advocate for his needs in the classroom and generate more empathy from his school staff.

Figure 1. Working with a child in the school system.

3.2. Medical and Psychiatric Art Therapy with Children

Some of the considerations in working with children and teens who are hospitalized (for either medical or psychiatric reasons) bear systemic similarities to working in educational settings; for example, the system of care (program, hospital), the need to consider safety and limited resources in material choice, as well as the storage of art materials and art products. It is also important to think about team approaches (working with a treatment team) and holding a private safe space for a minor, keeping in mind that a therapist is bound legally, ethically, and clinically to have some transparent communication of progress with caretakers.

Clinical goals often also need to be developmentally attenuated, but the focus of the work tends to be on very brief crisis intervention. In hospital settings, art often provides opportunities to play and summon joy and distraction from physical and psychological strife, even as art contains the emotional gravity of the situation and helps the child face the challenges that brought them to be hospitalized. Notably, art therapy in hospitals is

often structured as a one-time intervention with no clear plan for the child to be seen again by the therapist.

Preliminary studies comparing the effectiveness of art therapy and other expressive modalities, such as music therapy, suggest that the child's source of agony—for example, struggling with physical pain compared to alleviated anxiety and depression—might be better treated by one modality versus another [43]. In Figure 2, for example, a 15-year-old child (L) who was meeting the art therapist before a scheduled surgery in her pelvic area was cutting shapes from black cardboard paper, which she said was a way to play and relax. One of the shapes that emerged developed into a monster which she later pasted onto a white paper as a background. As she continued to embellish the overall creation, a shift occurred from tactile a focus to a more emotional cognitive, and later symbolic, processing [3], and she was more able to process the image to communicate her fear of the illness, the surgery, and their potentially dangerous outcomes.

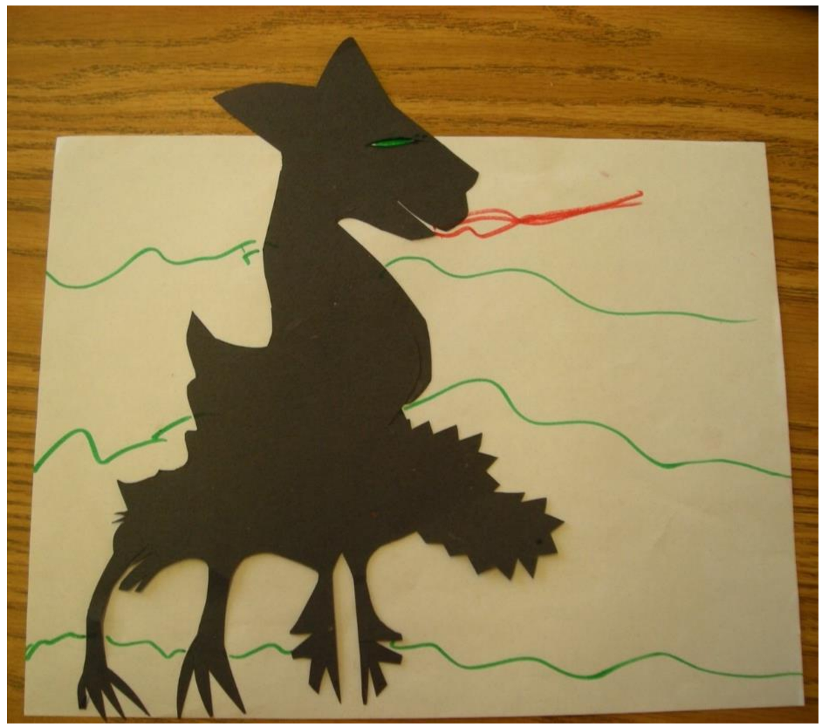

Figure 2. L's cut paper monster emerges before her surgery.

3.3. Working with Children and Teens in Community Centers and Open Studios

More and more, art therapy work takes place in non-traditional settings that benefit communities and individuals through less clinical frames such as open studio and community outreach models [29,35]. Work of this sort often takes place in community centers, NGOs, shelters, hospitals, community events, and places of worship and gathering. As such, the settings provide a more natural and less confidential, less private meeting space, and the art making becomes a way to enhance wellness and express oneself while engaging within a relevant community. Some considerations, therefore, include having a clear rationale and clinical goal with an identified community where one's shared experience can be meaningfully expressed. Considering the space that is available and how to open the doors to the public in a way that at once invites all who can benefit yet maintains structure, safety, and intimacy is an important challenge. Working with prominent community leaders to make sure the setting and interventions are culturally appropriate, and continuity of care is available within the community should additional services be required are also of great importance.

I had been fortunate, personally, to offer art therapy services of this nature as part of several wonderful community outreach projects, including Karla Leopold's initiative "Katrina Through the eyes of the Children", community art therapy workshops that were offered in Mexico at the Instituto Mexican de la Mujer" in San Miguel de Allende, Mexico, and—in the last few years—offering art therapy workshops virtually in Latin America through an art therapy international collaboration of three art therapy programs from the United States, Mexico, and Israel.

In my experience, working in non-clinical settings requires the therapist to remain professional yet very flexible and open. The focus on relationship forming (with community members, and theirs' with art making and art products) are supported by safety, acceptance, and opportunity [29], which are held and modeled by the therapist. When R and F, a mother and daughter who had been displaced due to Hurricane Katrina, attended an outreach open studio I facilitated, they first arrived in my space searching for water and a place to sit and eat. Here, already, is an example of the clinical settings being stretched—they joined an already working group of families and individuals engaging with available materials and minimal direction. They were welcomed to join us and eat, and of course to explore the materials and join the art making. I introduced myself and the team and explained that our purpose in art making was to relieve stress and connect with one another after their terrible experiences of displacement. I then described our terms of engagement with materials and each other in the room and after they observed quietly and ate, they created a dragonfly (Figure 3) from sticks, fabric, and so on. As they worked, I could see that their interaction with the materials and each other lifted their spirits. They discussed color choices and reminisced about a dragonfly they used to see. Slowly but surely, they began to engage with other participants, sharing stories of their homes, of the trauma brought by their displacement, and ultimately came back to make more dragonflies several days in a row. The dragonfly became a symbol they could carry with them, a symbol of hope and transition, which they repeated and perfected, while the setting offered a place of freedom, mastery, and connection in a time of great uncertainty and strife.

Figure 3. R and F create a dragonfly in an open studio in a shelter/community work.

Working collectively, in my experience, offers an additional therapeutic value through a sense of belonging and having connections and support from others who become consistent witnesses to their joys and struggles. As noted earlier, art therapy that takes place in a non-clinical community space (whether temporary housing, a school, a community center, a gallery, etc.) often has positive impacts on the individual and the community when children work together with others on collective projects (such as a mural, a shared exhibit, etc.). In such community projects, the children's voices and needs become amplified by art making and the images bring pride and empowerment beyond the sterile and confidential setting of traditional therapy.

3.4. Working with Children and Their Families

There is so much that had already been written about working with families in art therapy, parent-child dyads, and so on. My intent here is thus to highlight the considerations that stand out to me—from all the models and research I have explored—as most relevant to my own work with families. Beyond general considerations of materials (so they are appealing to the adults as well as he children or teens) is the need to pay attention to relational dynamics. Art making, both the process and product, showcases initiation and hesitation, decisions about engagement, collaboration, imitation, and boundary forming. The art also elucidates cultural and systemic considerations of needs and values underlying clients' perceptions of health, therapy, individual identity, and family or community belonging, all of which can be shared between family members or illuminate gaps between family members while the art supports processing these dynamics.

An example of such a use of art can be seen in Figure 4, an image a mother created for her daughter in a joint session in which she addressed her hopes and fears that were related to her daughter being a 12-year-old girl. Much of the conflict between them revolved around the mother's behavioral expectation from her daughter, which diverged greatly from what the daughter wanted and what she perceived as expected and validated by her peers. When exploring her own image and reflecting on it, the mother could see that in her drawing her daughter seemed younger than her current age (realizing part of the challenge was developmental). She could also see that her own wishes and experiences as a girl and the difficulties of becoming a woman were projected on her daughter. When both mother and daughter could process these insights, a greater empathy emerged, and the image itself was later replicated and modified—a reflection of their evolving perception of themselves and their relationship.

Figure 4. A mother-daughter dyad explore differing gender identities through art.

3.5. Working with an Individual Child in Private Practice

I love working with children and teens through art. There is magic and play and an intimacy of deep knowing that is hard to explain. I sense no verbal therapist, as sensitive and wise as she is, gets to experience the internal life of a child or a teen in the same way that is facilitated by playing and creating as the child leads. When we utilize the art therapy setting with opening and closing rituals, consistency of engagement and materials, and a clear structure of time and place, children and teens thrive in the freedom and empowerment of validated self-expression.

Children and teens can get stuck in dark corners of shame and guilt, get stuck facing families or systems that do not see them or do not work for them. The art, and the art therapist, can shed light into the deserted and unexplored spaces within. Figure 5 depicts A's bottled emotions. He presents each member in his family through a different container and the way they contain or release their emotions. A came to see me after a very challenging family crisis that had a public presence and led to the separation of his parents. He could barely say anything at the beginning and was always careful to be positive and diplomatic in all of his responses. Art and made-up characters and metaphors allowed some distance from the realities of his life, giving him a bit more freedom of expression. Only after a few sessions was he able to create the bottled emotions piece (Figure 5), carefully letting me know how pent up and sealed within himself he feels.

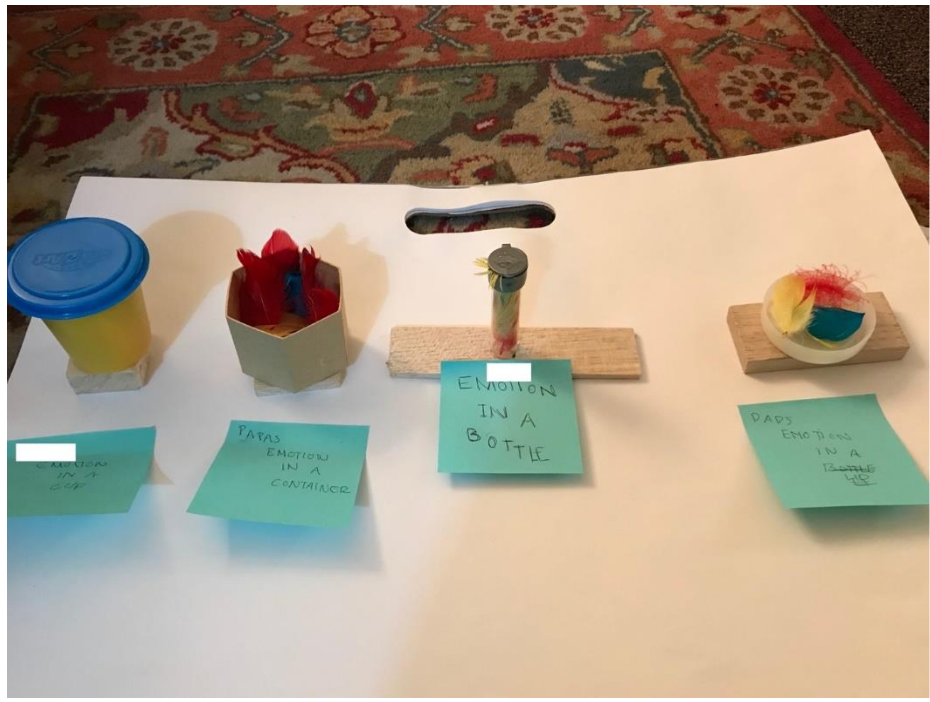

Figure 5. A's emotions in a bottle (private practice individual art therapy).

3.6. Working with Groups of Kids or Teens

Children's and teens' developmental needs are increasingly centered around peer interactions, as they continuously explore and modify who they are relative to others and as part of peer and family formations. As noted in the literature, art therapy groups for children and teens that are suffering from challenging life experiences (grief and loss, divorce, illness) are common, as are groups that are centered around mental health struggles (attention disorders, behavioral challenges, addiction disorders, or anxiety). For adolescents, because of the developmental stage of individuation and increasing sociopolitical awareness, the reflective and expressive aspects of art making serve as tools for engagement, empowerment, and identity formation [26]. All the above were central to my own experiences as a therapist working with teens in residential settings, in psychiatric hospitals,

and with parenting and pregnant teens. As a therapist working with adolescents, the art helps me with the intensity and multiplicity of teens' emotional experiences even as I insist on the boundaries in their relationships with me and with other group members, so I can consistently and compassionately support their exploration of self and others. The art making and exploration create the frame of the group within which group members have the freedom to engage, explore, express, resist, negate, and push back [41].

Figure 6 demonstrates the work of a 16-year-old who presented to our parenting and pregnant teen groups with a hostile attitude and a clear need to test the boundaries that were set by engagements with peers. Redirections, attempts to give her a (verbal) voice and place in the group did not make much difference. However, after sitting down with a list of emotions (provided) and an invitation to express the emotions that were stored within her body, a powerful image emerged. As she sat with the multiplicity of experiences within her and recognized many of those in her peers' images as well, she found meaning. In the group, in the art, and in the presence of her peers.

Figure 6. Normalizing and validating with peers: pregnant and parenting teens' groups.

3.7. Utilizing Art Therapy Assessment in Art Therapy and Family Therapy

When working with clients of any age, it seems to me that we therapists must constantly consider the known and unknown, the general and the particular, the universal and personal. Thus, when a client suffers from a mental health or a pathology, we must know something about the norm (behavior, mood, experience) from which there is a diversion, typical manifestations, etiology, and prognosis, and hold onto those as we attempt to understand the person in front us (and their behaviors, experiences, and symptoms). When we work with children, the need to constantly assess and evaluate the needs of our clients is doubled by the need to consider their developmental stages as typical and atypical. Naturally, any assessment of merit must consider the client's educational environment, socio-cultural background, family and living situation, and so forth,

Although I am not trained as a psychologist or an administrator of most psychological tests, I do find that using our standard art therapy assessments can be immensely helpful in holding the unique and particular aspects of clients' experiences while also paying attention to normed features or socio-cultural aspects. A simple example is my use of the kinetic family drawing (KFD) assessment with a 15-year-old teen of Middle Eastern background (Figure 7). The simple guidance—"Draw you and your family doing something together"—as part of our initial time together opened the door to exploring his personal memories of his childhood home and his story of immigration. It also offered a glimpse into the shared cultural understandings of family of origin (FOO), which was defined differently than in the United States, an exploration of a typical living environment for him, and the way touch and space representations differed from the typical KFDs I see.

Figure 7. Kinetic Family Drawings with teens—cultural considerations of FOO.

4. Conclusions

This paper attempted to integrate clinical considerations through a systemic exploration of my clinical work as an art therapist with children and adolescents over the years, informed by current research and the main art therapy models that have shaped my thinking. As I reflected on this work, three main points that have guided my art therapy work with children and adolescents emerged:

(1) Art offers a uniquely profound tool for children and adolescents, one that is easily adaptable to different developmental stages. Choice of materials, ways of facilitating the process of art making, and utilizing the art products to augment the therapeutic experience also stood out.

(2) Systemic thinking enhances the impact of therapy for minors—one has to particularize with whom and how we work based on the therapy setting, and the bio-psycho-socio-cultural aspects of client's experiences, as I attempted to illustrate above.

(3) Art therapists hold therapeutic structure that fosters freedom for children to reinvent themselves through creative engagement. Put differently, an art therapist offers art opportunities while being an adult trusted friend, as conceptualized by Brems and Rasmussen [44]. They often must hold a clear structure of engagement that keeps the child or teen safe, physically, and psychologically. At the same time, she offers empathy and validation, curiosity, and flexibility steeped in commitment to the freedom creative expression summons from each child or teen.

The three points above are general ones, and none of them is novel in the field of art therapy. Nevertheless, my hope was that a review of the breadth of art therapy work with children in conjunction with clinical considerations and illustrations of such work in a wide range of settings and developmental stages would be helpful. Mostly, as a therapist who truly appreciates what art does for children therapeutically, my take-home reminder is that art is fun just as much as it is seriously helpful for kids and those who care for them.

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Informed Consent Statement: Informed consent was obtained from all clients whose experiences and artwork informed this review; All narratives and artworks were substantively altered to avoid conflicts with confidentiality, privacy, or other impact due to this paper.

Data Availability Statement: Data available on request due to restrictions of privacy or ethical stipulations. Namely, the data presented in this study are available on request from the corresponding author. The data regarding specific cases and contexts of treatments are not publicly available due to ethical and clinical obligations of art therapy practice.

Conflicts of Interest: The author declares no conflict of interest.

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Review

Drama Therapy for Children and Adolescents with Psychosocial Problems: A Systemic Review on Effects, Means, Therapeutic Attitude, and Supposed Mechanisms of Change

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Abstract: Drama therapy is applied to children and adolescents with psychosocial problems. Drama therapy is an experimental form of treatment which methodologically uses drama and theatre processes to achieve psychological growth. Although in clinical practice, drama therapy has been applied successfully, little is known about how and why drama therapy contributes to a decrease in psychosocial problems. A systematic narrative review was performed to obtain more insight into this issue. Eight databases were systematically searched. Ten out of 3742 studies were included, of which there were four random controlled trails, three non-controlled trials, and three pre-and post-test design studies. We identified the results, drama therapeutic means, attitude, and mechanism of change. Positive effects were found on overall psychosocial problems, internalizing and externalizing problems, social functioning, coping and regulation processes, social identity, and cognitive development. An adaptive approach was mentioned as the therapeutic attitude. The means established contribute to a dramatic reality, which triggers the mechanisms of change. These are processes that arise during treatment and which facilitate therapeutic change. We found ten supposed mechanisms of change to be frequently used in all studies. No direct relations were found between the results, drama therapeutic attitude, means, and mechanisms of change.

Keywords: drama therapy; children; adolescents; youth; review; psychosocial problems; mechanisms of change; psychodrama

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1. Introduction

Psychosocial problems consist of a combination of emotional, behavioral, and social problems [1,2]. One out of five children and one out of seven adolescents suffer from psychosocial problems, including mental disorders [3–6]. The mean global coverage of prevalence for mental disorders in children aged 5–17 years was 6.7% in 2016, subdivided into conduct disorder (5.0%), attention deficit/hyperactivity disorder (5.5%), autism spectrum disorders (16.1%), eating disorders (4.4%), depression (6.2%), and anxiety (3.2%) [7]. As an expression of dysfunction related to psychosocial problems, a distinction can be made between internalizing and externalizing problems. Internalizing problems concern emotional problems that focus inward, such as depression, (social) fears, withdrawn behavior, and psychosomatic complaints. Externalizing problems concern behaviors that are more outwardly directed, such as hyperactivity, aggressive behavior, and attention problems [8,9]. Children and adolescents who suffer from psychosocial problems are more likely to be a victim or a bullying perpetrator [10–12], experience lower academic performance [13,14], and have an increased risk of suicide [3,13,15,16]. Failure to identify and treat psychosocial problems in time increases the risk of problems in the future [17], for example, of physical

disorders [18]. These problems have economic consequences which create additional costs for the society [19,20]. Many psychosocial problems in children and adolescents are not recognized and treated in time [21]. Addressing these problems at early age is necessary to prevent them from getting worse [22].

The most common treatment for children and adolescents with psychosocial problems are cognitive behavior therapy focusing on cognitive behavior, psycho-education, emotion regulation, communication, interpersonal skills, or parent training [23–27]. Some studies suggest that cognitive-behavioral therapy is less appropriate for young children and for children and adolescents who have difficulty expressing themselves verbally [28–33]. Activating strategies, such as role-playing, are emphasized as effective elements in treatment for these children and adolescents. In particular, role play is seen as important for modeling behavior, to expose fears, and as an opportunity to develop coping skills [27]. Activating strategies, and role play, in particular, are important elements in drama therapy to treat psychosocial problems in children and adolescents [31,34,35].

Drama therapy is an experiential form of psychotherapy which methodologically consists of drama and theatre processes, fictional reality created by a wide range of verbal and non-verbal dramatic techniques aimed to achieve psychological growth and change within a therapeutic relationship [36–38]. Drama therapy is one of the creative arts therapies (together with psychodrama, art therapy, dance and movement therapy, music therapy, and bibliotherapy). In drama therapy, drama and theater processes are influenced by and based on different psychological perspectives such as psychodynamic, cognitive behavioral therapy, attachment theory, and developmental psychology, client-centered therapy, or narrative theory [30,39–43]. Drama therapy is considered suitable for children because of the underlying play. Dramatic play is seen as one of the core processes in drama therapy [39,44–47]. Dramatic play gives children the opportunity to express (non-)verbally, gain control of their thoughts and feelings, and understand others. A variety of means, i.e., forms and techniques, are used in drama therapy, such as role-play, storytelling, puppet play, and theater games. These are aimed at creating a playspace where children can play in a fictional world. Although playing takes place in a dramatic ("as if") reality, behavior, thoughts and feelings can be real at the same time. Hence, there is both a distance and a connection between play and daily life [39,46–48].

Attunement within the therapeutic relationships is important. The drama therapist adaptively matches the drama therapeutic means (e.g., drama role, themes) to the needs, expression, and wishes of the client [49–51].

In clinical practice, drama therapy is successfully applied by drama therapists using a variety of drama therapeutic approaches and theories based on good practice, theoretical insights, and intuition [30,49,52]. In a qualitative study, drama therapists reported several effects of drama therapy in children and adolescents, such as improvement of social skills, regulation of emotions, better child and adult relationship, increased assertiveness and self-expression, and more resilient responses to bereavement, separation, and loss [53]. These outcomes are important effects that may promote self-esteem that buffers the negative effect of stressful life events in adolescence [54]. Drama therapy experts assume that drama therapy is used to promote understanding of one's own and others' behavior in terms of mental states (mentalization) [55–57], executive functions [58,59], working memory [60,61], and resilience [39,62,63]. Most studies on the effects of drama therapy in children and adolescents are based on expert opinions reflecting on their clinical work. An overview of effects based on empirical studies using cohort studies and (randomized) controlled trials is still lacking.

Besides the effects of drama therapy on children and adolescents, little is known about what and how drama therapy leads to a positive change in psychosocial problems of children and adolescents [27,34,64]. There is a growing interest in insights into the effectiveness of drama therapy works and which processes contribute to changes of the client's wellbeing. These processes are called mechanisms of change, referring to processes that arise during the treatment that facilitates the therapeutic change [65,66]. A few mecha-

nisms of change are described in drama therapy. For example, drama therapists and adult clients describe the importance of a positive therapeutic relationship, working within a safe distance, being actively involved in the therapy, and having physical experiences that facilitate the development of new awareness and language skills through which clients can communicate to themselves and others [67].

The existing body of literature provides a first insight into the effects of drama therapy and how this may lead to a decrease in psychosocial problems in children and adolescents. However, overarching research specifically addressing the effectiveness of the different means of drama therapy on positive change is lacking. Therefore, an overview of the literature is necessary. The aim of this systematic review was first to identify the effects of drama therapy for children and adolescents and second to gain more insight into what kinds of drama therapeutic means, therapeutic attitude, and specific drama therapeutic mechanism of change are related to these effects.

2. Methods

2.1. Study Design

A systematic narrative review was performed for study identification, selection, data extraction, and quality appraisal, using the guidelines from the Cochrane Collaboration [68].

2.2. Search

We systematically searched for articles. The following database and journals were searched: PsychINFO (EBSCO), Pub Med, ScienceDirect, Medline, Cinahl, Academic Search, Google Scholar and Drama Therapy Review. The search terms for all databases were ("drama therapy" OR dramatherapy) AND (child* OR youth OR adolescent). For all search terms, see Figure 1 Search terms. The literature study covers a period up to 1 September 2020. This study followed the guidelines of Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) [69].

("drama therapy" OR dramatherapy OR psychodrama) (puberty OR adolescent OR child OR infant OR "mental disorders diagnosed in childhood" OR "Juvenile Delinquency" OR infan* OR child* OR adolescen* OR pediatric* OR paediatric* OR pube* OR juvenil* OR school* OR newborn* OR new-born* OR neo-nat* OR neonat* OR premature* OR postmature* OR pre-mature* OR post-mature* OR preterm* OR pre-term* OR baby OR babies OR toddler* OR youngster* OR preschool* OR kindergart* OR kid OR kids OR playgroup* OR play-group* OR playschool* OR prepube* OR preadolescen* OR junior high* OR highschool* OR senior high OR young people* OR minors OR teen OR teens OR teenager* OR youth OR youths OR under age OR underage OR middle school OR pre-pube* OR boy* OR girl* OR schoolage* OR school age* OR elementary school* OR primary school* OR grade school* OR kid OR kids OR junior school* OR youngster* OR tween* OR school child* OR schoolchild* OR "family therapies" OR "family therapy")

Figure 1. Search terms.

2.3. In- and Exclusion Criteria

Studies on the effects of drama therapy for children and adolescents until 18 years were included. Regarding study design, we included randomized controlled trials (RCT's), non-controlled trials (CCT's), and pre- and post-test designs. Furthermore, we only included studies in which drama therapy was applied by a drama therapist. Only articles and theses written in English were included. We excluded studies in which the intervention was applied by another profession than a drama therapist, e.g., teacher or a nurse.

2.4. Selection of Studies

In two phases, the articles were selected based on the inclusion criteria using the web application Rayyan [70]. In the first phase, the researcher independently selected the articles based on title and abstract in four pairs. In the second phase, eligible articles were selected based on reading the full text. The first author was contacted when insufficient information was provided on our inclusion criteria. If there was doubt or disagreement in selecting a study, it was solved by discussion until consensus was reached.

2.5. Quality Assessment of Individual Studies

We coded whether the study was strong, moderate or weak with the "Quality Assessment Tool for Quantitative Studies" [71]. By providing a comprehensive and structured assessment of the concept of study quality, this tool assesses the quality of a study [72] The content and construct validity of the "Quality Assessment Tool for Quantitative Studies" has been reported [73,74]. The quality of the studies was assessed independently by four raters in a group of three duos, and then scores were compared. In case of disagreement, it was solved by discussion until consensus was reached.

2.6. Data Collection Process and Analysis

The data following were extracted from each study on: formal characteristic of included studies, i.e., first author/year, design/time points, quality assessment rate, study population, n = (treated/control), type (group or individual or both), frequency, duration, and control invention/care as usual (see Table 1), and results and description of effects drama therapy intervention, i.e., psychosocial outcome domain/measure, results, effect sizes (see Table 2), and characteristics of drama therapy interventions, i.e., goal of the study, intervention, therapist attitude, and drama therapeutic means and supposed mechanism of change of the intervention (see Table 3). When information was missing, we emailed the corresponding author of the study with a request for more information. A content analysis was performed on the effects of the interventions, the means, therapist attitude, and the described mechanisms of change [28]. A narrative approach was applied to synthesize the findings.

Table 1. Formal characteristics of included studies.

First Author/Year	Design/Time Points	Quality Assessment Rate	Study Population	n = (Treated/Control)	Type (Group or Individual or Both), Frequency, Duration	Control Intervention/Care as Usual
Anari, 2009 [75]	CCT Follow-up: 3 months	Moderate	Age 10–11 Social anxiety disorder Elementary school	14 (7/7)	Group 12 times 120 min per session Twice per week	No intervention
D'Amico, 2010 [76]	Pre- and post-test design	Moderate	Age 1–12 Asperger's syndrome or High-Functioning Autism and Pervasive Developmental Disorder Not Otherwise Specified Social service center	6	Group 21 sessions 75 min per session Once per week	-
Ghiaci 1980 [77]	CCT Follow-up: 1 month	Weak	Age 3–5 Young children Day nursery	12 (6/6) Follow up: 8 (4/4)	Individually in a group setting 6 sessions 60 min per session Six successive weekdays	No intervention
Hoogsteder, 2014 [78]	CCT	Weak	Age 16–19 Delinquents (combination of conduct disorder n = 30, oppositional disorder n = 24, Attention Deficit Hyperactivity Disorder n = 11, mental disability n = 15) Secure juvenile justice institution	91 (63/28)	Individual and group Average duration in weeks 46.86 Average hour of treatment per week 1.72 Individual: 60 min, once per week Group: 12–14 sessions 90 min	Care as usual
Hylton, 2019 [79]	Pre- and post-test design	Moderate	Age 14.71 (mean) Students affected by the February 14th shooting at MSD High School in Parkland Florida Summer arts trainings camp	11	Group Four days per week over two weeks 3.5 h for a total of eight sessions (28 h) The two-week camp was held three times, four, five and 5.5 months after the date of the shooting.	-
Irwin, 1972 [80]	RCT	Weak	Age 7–8 Emotionally disturbed children Outpatient treatment center	12 (4/4/4)	Group 20 sessions 60 min per session Once per week	Group II: activity psychotherapy group in which regular group social work principles were applied Group III: recreation group in which the workers assumed the role of recreation leaders

Table 1. *Cont.*

First Author/Year	Design/Time Points	Quality Assessment Rate	Study Population	*n* = (Treated/Control)	Type (Group or Individual or Both), Frequency, Duration	Control Intervention/Care as Usual
Lowenstein, 1982 [81]	RCT	Weak	Age 9–16 Extreme shyness in maladjusted children School psychological service	5	Individual and group 6 months	No intervention
Mackay, 1987 [82]	Pre- and post-test design	Weak	Age 12–18 Girls who have been sexually abused, Special organized location: drama studios at Concordia University in Montreal	5	Group 8 sessions 4–5 h per session Once per week	-
Rousseau, 2007 [83]	RCT	Strong	Age 12–18 Newly arrived immigrant and refugee adolescents Integration classes in a multiethnic high school	123 (66/57)	Group 9 sessions 75 min per session Once per week	No intervention
Rousseau, 2012 [84]	RCT	Strong	Age 12–18 Immigrant and Refugee High school serving an underprivileged neighborhood of immigrants	55 (27/28)	Group 12 sessions 90 min per session Once per week	No intervention

Table 2. Results and description of effects drama therapy intervention.

First Author/Year	Psychosocial Outcome Domain/Measure	Results	Effect Sizes
Anari, 2009 [75]	Self-report Leibowitz social anxiety scale for children and adolescents (LSAS-CA) [85] Performance anxiety subscale Performance avoidance Social anxiety subscale Avoidance subscale	The experimental group showed significant decline in symptoms of social anxiety (all subscales) compared to the control group ($p < 0.05$). The therapeutic changes lasted after three months, and these scores of three months differ from the scores of the control group	No information given

Table 2. *Cont.*

First Author/Year	Psychosocial Outcome Domain/Measure	Results	Effect Sizes
D'Amico, 2010 [76]	Social skills improvement system-rating scales (SSIS-RS) [86] - Social skills (SK) - communication, cooperation, assertion, responsibility, empathy, engagement, self-control Problem behaviors (PB) - externalizing, bulling, hyperactivity/ inattention, internalizing. On the parent form as well as autism spectrum problem behavior	Student Form: The overall mean score on SK and PB did not change significantly after the intervention. There was a significant decrease in the symptoms on the mean score on the subscale hyperactivity/inattention ($p < 0.05$) after the intervention. All other subscales did not change after the intervention Parent Form: There was a significant decrease in the symptoms on the mean score on the overall the SK and PB score ($p < 0.05$) after the intervention. Regarding the subscales, there was a significant decrease after the intervention for externalizing problem behavior, engagement, hyperactivity/inattention, autism spectrum problem behavior ($p < 0.05$). Other subscales did not change after the intervention	No information given
Ghiaci 1980 [77]	Repertory grids * were employed to depict the systems of personal constructs, since these permit a description of an individual's cognitive structure to be given in his own terms	Compared to the control group, the experimental group showed a larger increase from pretest to posttests on both the original constructs ($p < 0.025$) as well as the focused constructs ($p < 0.01$)	No information given
Hoogsteder, 2014 [78]	Structured assessment of violence risk in youth (SAVRY) [87,88] Three risk domains (1) historical factors (2) social/contextual risk factors (3) individual dynamic risk factors Aggression incidents was based on the data registered by prison staff * Self-control, assertiveness and dealing with anger assessed by juvenile- and mentor report * Self-report Utrecht coping list (UCL) [89,90] Cope with stressful situations: - Problem-focused coping - Palliative coping - Social support - Reassuring thoughts Self-report Brief irrational thoughts inventory (BITI) [91] Measure cognitive distortions on aggression (externalizing) and sub-assertive (internalizing) HIT [92] Self-report on physical aggression and opposition-defiance	All analyses were controlled for pre-test score, gender, length of stay, and participation in EQUIP, a CBT based module Risk of recidivism and aggressive behavior The experimental group had a significant lower violent recidivism risk ($p < 0.001$), higher score on assertiveness ($p < 0.05$ reported by the mentors and $p < 0.001$ reported by the juveniles), lower scores on self-control skills ($p < 0.001$ reported by the mentors and by the juveniles), and on dealing with anger ($p < 0.001$) after the intervention compared to the control group. Fewer incidents were registered in the experimental group, but there was no significant difference Coping skills The experimental group scored significantly better on coping skills problem solving ($p < 0.001$), palliative coping ($p < 0.001$), social support ($p < 0.001$), reassuring thought ($p < 0.001$), and lower scores on stress and poor coping ($p < 0.001$) after the intervention compared to the control group Cognitive distortions Compared to the control group, the experimental group showed significantly lower on aggression/justification ($p < 0.001$), physical aggression ($p < 0.001$), opposite behavior scales ($p < 0.001$), and sub-assertive ($p < 0.001$) after the intervention. There was no significant difference after the intervention on negative attitude Responsiveness The experimental group scored compared to the control group significantly better for motivation for treatment ($p < 0.05$), attention deficits ($p < 0.05$), and scored significantly lower on medium to large for distrust ($p < 0.001$), and impulsivity ($p < 0.001$) after the intervention	SAVRY Recidivism Risk 1.01 Dealing with anger 0.84 AR-list Juv. Self-Control 2.36 Assertiveness 1.99 AR-list mentor Self-Control 1.38 Assertiveness 0.35 UCL Problem Solving 1.37 Palliative Coping 1.73 Social Support 1.05 Reassuring Thought 0.92 SAVRY Stress—Poor Coping 0.49 BITI Aggression/justification 1.38 Sub assertiveness 0.55 HIT Oppositional behavior 0.95 Physical Aggression 1.45 SAVRY Negative Attitude 0.30 SAVRY Motivation for treatment 0.42 Distrust 0.73 Attention deficit 0.45 Impulsivity 0.73

Table 2. *Cont.*

First Author/Year	Psychosocial Outcome Domain/Measure	Results	Effect Sizes
Hylton, 2019 [79]	Depression was measured by self-report Patient Health Questionnaire (PHQ-8) [93] Anxiety was measured by the self-report Generalized anxiety disorder (GAD-7) [94] Posttraumatic stress was assessed using the self-report child's reaction to traumatic events scale (CRTES) [95] Positive and negative affect were assessed using self-report positive and negative affect schedule (PANAS) [96] Satisfaction of the treatment was assessed using an evaluation questions * especially developed for the camp	The drama treatment program resulted in significant decreases in symptoms of posttraumatic stress ($p < 0.023$), anxiety ($p < 0.007$), depression ($p < 0.034$), and in increases in positive affect ($p < 0.009$). There was no effect on the negative affect after the intervention in the drama group. Participants of the creative arts therapies camp, including visual arts ($n = 15$) music ($n = 8$) and drama ($n = 11$), evaluated: 93.3% agreed or strongly agreed and 6.1% indicating neutrality and 0% disagreed or strongly disagreed on having fun at the camp; 79.8% agreed or strongly agreed and 15.2% indicating neutrality and 6.1% disagreed or strongly disagreed that they learned something new about myself; 84.4% agreed or strongly agreed and 12.5% indicating neutrality and 3.1% disagreed or strongly disagreed that they felt safe at the camp; 87.9% agreed or strongly agreed and 6.1% indicating neutrality and 6.3% disagreed or strongly disagreed that engaging the creative arts gives me a deeper understanding of myself and others	No information given
Irwin, 1972 [80]	Rorschah Index of Repressive Style (RIRS) [97] indicate the extent to which images, emotions and past experiences are verbally labeled and thus available in consciousness in communicable terms Verbal Fluency (VF)—assessing each child's response to a set of thematic pictures which was designed to elicit projective material through a verbal modality Semantic Differential (SD) * – specifically designed to measure attitude changes: three dimensions: evaluative, potency, activity. Each had six concepts (me, grown-ups, feelings, sharing, imagination, other kids) Parent Competence Scale (PCS) *—to measure mastery of major areas of functioning both at home and with peers and consisted of concrete descriptions of child behavior: Factor I perception degree of interest and participation in activities vs. degree withdrawal and associated depression. Factor II perception of relative degree cooperation and compliance compared to child's anger and defiance in daily interpersonal relationships	Comparing the change scores, the intervention group showed more positive changes from pre- to posttest in RIRS score ($p < 0.05$) and verbal fluency ($p < 0.01$) compared to the control groups. In addition, change scores between pre- to post were significantly higher in the intervention group compared to the control groups on two of the three semantic dimensions of the SDC, namely "evaluating" (Me and Other kids; $p < 0.05$), and "potency" (Me, Other kids and Grown-up; $p < 0.05$). There were no significant differences in either the activity or recreation group after the intervention. From the parent competence scale: Factor I and of factor II rating score differences yielded no significant results for all groups after the interventions	No information given
Lowenstein, 1982 [81]	Maudsley Personality Inventory self-report scale [98] Timidity scale on a 1–5 rating scale, 1 = very timidity, 5 = moderately outgoing Assessed in reading, spelling, and mathematics.	The experimental group had a significantly less severe timidity score ($p < 0.01$) after the intervention compared to the control group. In addition, there was a significant difference changed in intelligence ($p < 0.05$) ** between the groups after the intervention. No differences between groups were seen in attainments in reading, spelling and mathematics after the intervention	Severity of timidity: 2.075 MPI extraversion: 0.998

Table 2. *Cont.*

First Author/Year	Psychosocial Outcome Domain/Measure	Results	Effect Sizes
Mackay, 1987 [82]	Beck depression Inventory (BDI) [99] self-report scale to assess depression level SCL-90 self-report [100] depression, anxiety, somatization, interpersonal sensitivity, obsessive-compulsiveness, hostility, phobic anxiety, paranoid ideation and psychoticism Texas social behavior inventory-self-report short form (TSBI) [101] to assess self-esteem Attributional Style Questionnaire (ASQ) self-report [102] attributions were assessed along three dimensions: internal-external, stable-unstable, global-specific Social support questionnaire (SSQ) self-report [103] assess number of social supports and satisfaction with level of social support The Marlowe–Crowne Social Desirability Scale (MCSDS) self-report [104] employed to assess the tendency of the participants to seek social approval by responding in a culturally appropriate manner.	The experimental group showed significant reductions on the levels of hostility ($p < 0.01$), depression ($p < 0.10$), and psychotic thinking ($p < 0.10$) after the intervention. No significant changes between pre- and posttest were found on self-esteem level (TSBI), attribution style (ASQ), number of social supports or reported satisfaction with social supports (SSQ), or social desirability score (MCSDS)	SCL90 Overall intensity of symptoms 1.042 Hostility 0.642 Depression 1.813 Psychoticism 0.561 Anxiety 0.492 Interpersonal sensitivity 0.795 Paranoid ideation 0.345 Obsessive compulsive 0.562 Phobic anxiety0.688 Somatization 0.574 Beck Depression Inventory 1.022 Self-esteem (TSBI) 0.603 Attributional style questionnaire Internal, stable. Global Attributions: bad events 0.309 good events 0.308 Social support questionnaire Number of social supports 0.374 Satisfaction with social supports 0.135 Marlowe-Crowne Social Desirability Scale 0.037
Rousseau, 2007 [83]	Strengths and Difficulties Questionnaire (SDQ) [105]: Emotional and behavioral symptoms Impairment perception: Self-report: Difficulties distress me Interfere with home life Interfere with friendships Interfere with classroom learning Interfere with leisure activities Teacher's report: Difficulties Distress adolescent Interfere with friendships Interfere with classroom learning Self-Esteem Scale (SES) [106] School performance was assessed on the basis of the first and the last report cards of the school year *	There were no significant differences on emotional and behavioral symptoms at post between both groups, controlling for group differences at baseline The participants in the experimental group reported less impact in all categories except learning at posttest, whereas those in the control group reported more impact on distress ($p < 0.022$) impairment of friendships ($p < 0.033$), and a higher total impact score ($p < 0.035$). No significant group differences were found in the teachers' reports of the impact scores. Girls in the experimental group showed a significant decrease in the total impact score ($p < 0.001$), whereas boys in the control group showed a significant increase in the total impact score ($p < 0.028$). No age effect was observed School performance comparing the first and last report cards of the school year showed a significant difference in oral expression ($p < 0.000$) for the experimental group and ($p < 0.001$) for the control group and a significant improvement in mathematics ($p < 0.005$) for the experimental group. Controlling for group differences at baseline, results showed posttest differences between both groups in mathematics. No significant improvement was reported between the first and the last report cards with regard to overall French results of both groups. With regard to self-esteem, the analysis did not show significant differences within groups between pre and post assessment	No information given

Table 2. *Cont.*

First Author/Year	Psychosocial Outcome Domain/Measure	Results	Effect Sizes
Rousseau, 2012 [84]	Strength and difficulty questionnaire (SDQ) self-report [103]	Total SDQ symptom score did not change after the intervention on both, experimental and control, groups. The students of experimental group showed significant decrease in the impact on the impairment ($p < 0.021$) after the intervention. The symptom score of the subgroup of youth who did not report difficulties in school in the countries of origin also decreased following the intervention but not significance ($p < 0.053$)	No information given

* Measurement developed by researchers. ** Results cannot be traced in the study.

Table 3. Characteristics of drama therapy interventions.

First Author/Year	Goal of the Study	Intervention	Therapist Attitude	Drama Therapeutic Means and *Supposed Mechanisms of Change of the Intervention*
Anari, 2009 [75]	This study examines the effectiveness of drama therapy in reducing symptoms of social anxiety disorder in children	Emunah's Integrative Five-phase Model [107]: Focusing on group play and direct teaching of social interactions	No information given	**Participation in a drama activity such as storytelling, movement, voice, role play, pantomime** *Experience positive human relations* *Experience and recreate life situations and actualities*
D'Amico, 2010 [76]	To determine the efficacy of drama therapy in addressing the children's performance or acquisition deficits across the social skill domains targeted over the course of the project (determined by the results obtains on the SSIS-RS forms)	The weekly sessions using each skill from the SSIS as a theme for the two subsequent weeks. Therapeutic modality based on the child's social and behavioral needs The drama therapy techniques centered on making connections among the group members, while discovering commonalities and shared interests, and encouraged self-expression. Used components of drama therapy: dramatic projection; dramatic reality; role-playing; and storytelling	Adaptive approach	**Dramatic projection through improvisational scenes** *Express their own ideas* *Emotional expression* **Dramatic reality within a playspace using improvisational scenes with both conflict and cooperative activities where children act out different social issues.** *Creativity* *Experiencing (social connection)* *Explore their vulnerabilities and psychological issues and reflection on experiences, feelings, and emotions of oneself and others* **Role-playing** *Explore new identities* *Embody the personas* *Share experiences and feelings* *Observing (non-verbal) behavior and interpreting behavior of others* **Storytelling** *Expression of experiences, feelings, emotions, and thoughts* *Reflection on experiences, feelings, and emotions of oneself and others* *Self-control, participants become active participants in their own treatment* **General** *Fun and playfulness* *Use imagination*

Table 3. *Cont.*

First Author/Year	Goal of the Study	Intervention	Therapist Attitude	Drama Therapeutic Means and *Supposed Mechanisms of Change of the Intervention*
Ghiaci 1980 [77]	Cognitive change	Each session comprised five stages: 1. act out an event individually in a group setting 2. children divided themselves into pairs and carried out a cooperative activity 3. children divided themselves into groups of three and performed 4. children divided themselves into two groups and enacted a short piece of drama 5. relaxation individually enactment in a group setting	No information given	No information given
Hoogsteder, 2014 [78]	Decrease severe aggressive behavior	Re-ART: a cognitive behavioral approach combined with drama therapeutic techniques, role-playing games in order to practice perspective taking and problem solving skills. All arts therapists targeted self-image, emotions, and social interaction (especially situations that elicit aggressive behavior), but they did not use any form of established manualized treatment	No information given	**Role-playing games** *Perspective taking*
Hylton, 2019 [79]	Improving mental health status by decreasing symptoms of PTSD, depression levels, anxiety levels and lower levels of negative affect and by increasing positive affect. Drama therapy Role theory and method: participants explore life roles in order to gain insight into group dynamics and internalize new roles that help expand individual resilience and strengths	Improvisation exercises: Participants activate imagination, try new roles, and explore spontaneity. Participants share and enact a personal story with group members in order to promote empathy, insight, and interpersonal connection. Projective technique: each participant chooses and object that he/she feels connected to and verbalizes how he/she feels through the use of this projective	The therapist gave the participants the freedom to share the traumatic memory however they felt comfortable	**Improvisation exercises to imaginal exposure, explore life roles and acting out stories through bodily and verbal processing** *Explore life roles* *Reflection on experiences, feelings, and emotions of oneself and others* *Embodied emotional experience* *Share experiences, feelings, and emotions of oneself and others* *Activate imagination* *Explore spontaneity* *Internalize new roles* **Projective technique** *Emotional expression* *Verbal expression* *Reflection on experiences, feelings, and emotions of oneself*
Irwin, 1972 [80]	Exploring the feasibility of using drama therapy as a form of treatment with emotionally disturbed children. Prepare inarticulate non-communicative children emotionally for more traditional forms of verbal psychotherapy by learning a progressive sequence of communication skills through dramatic play	Improvisational dramatic play to express and play out wishes, conflicts and fantasies	No information given	**Repeated experiences in improvisational dramatic play** *Share feelings* *Making emotional discrimination* **Play out** *Share feelings* *Witnessing* *Immediate feedback and reflection on experiences, feelings, and emotions of oneself and others* *Express internal states in verbal terms* **Playing a role** *Expression in a role*: - *Verbal expression* - *Nonverbal expression*

Table 3. *Cont.*

First Author/Year	Goal of the Study	Intervention	Therapist Attitude	Drama Therapeutic Means and *Supposed Mechanisms of Change of the Intervention*
Lowenstein, 1982 [81]	Treat the problem of timidity by reducing anxiety, increasing assertiveness, promoting the ability to communicate effectively with other people, treating feelings of inadequate, influencing parental background and decreasing over-sensitivity	Drama therapy, in which timid children were given especially extroverted and assertive parts in contrast to their normal introverted or non-assertive demeanor.	No information given	No information given
Mackay, 1987 [82]	A primary goal of the program, structured drama therapy, was to help establish feelings of power and control to combat the feelings of worthlessness and loss of integrity and power often associated with rape and incest	Improvisation, roleplaying and storytelling	The views of Carl Rogers where expression of self is best fostered in an atmosphere of psychological safety	**Symbolic role playing (as a projective technique)** **Improvisation** **Storytelling** *Expression of feelings, thoughts, and their identity* *Creativity* *Share thoughts or experiences* *Experience:* *- Fun and playfulness* *- of acceptance and being heard* *- of getting close to each other* *- acting out ideas and feelings* *- control in their role play*
Rousseau, 2007 [83]	The goal of the drama therapy program was to give young immigrants and refugees a chance to reappropriate and share group stories, in order to support the construction of meaning and identity in their personal stories and establish a bridge between the past and present	The program is based in Augusto Boal's forum [108] and Jonathan Fox's playback theater [109]	No information given	**Pairs technique** *Reflect on a person's contradictory feelings* *Reflect different points of view of the same situation or experience* **Storytelling, acting** *Exploration of ideas and feelings associated with key experiences* *Sharing strong emotions and subsequent relief* *Feeling of agency* **Symbolic play** *Expression* *Witnessing others*
Rousseau, 2012 [84]	The goal is to alleviate problems associated with distress, behaviors stemming from the losses of migration and the tensions of belonging to a minority in the host society, as well as to improve social adjustment, academic performance, and to provide schools and teachers with tools for adapting their teaching methods to suit the emotional and social needs	Each session includes a warm-up period composed of theatrical exercises and of a language awareness activity which also uses dramatization	No information given	**Theatrical exercises, dramatization, play out stories** *Sharing of stories* *Creation of links among participants*

3. Results

This section may be divided by subheadings. It should provide a concise and precise description of the experimental results, their interpretation, as well as the experimental conclusions that can be drawn.

3.1. Study Selection

The search resulted in 3742 studies on drama therapy and psychodrama (as a part of a wider review research) for children with psychosocial problems. In the first search, 3369 articles were found (June 2018) and 373 articles in the second search (September 2020). We removed 350 duplicate articles and excluded 3205 articles based on title and abstract. A total of 187 articles were selected for full text. Of these, we excluded 164 studies, 70 had the wrong study design, 34 studies were written in the wrong language, 12 articles had the wrong publication type such as a book, 25 studies had the wrong intervention, and 23 studies consisted of the wrong population. In total, ten studies on drama therapy were included. See Figure 2, flow chart of the search results, for a flow diagram of article eligibility for inclusion in the current review.

PRISMA 2009 Flow Diagram

Identification

Records identified through database searching (n = 3742)

Academic Search n = 277
Cinanhl n = 1567
Medline n = 311
PsychINFO n = 1198
PubMed n = 278
Drama Therapy Review n = 13
Science Direct n = 26
Google Scholar n = 63
Bath n = 9

Screening

Records after 350 duplicates removed (n = 3392)

Totally 3205 records excluded on title and abstract

Eligibility

Totally 187 full-text articles assessed for eligibility

Full-text articles excluded (n = 164)

Wrong study design n = 70
Wrong language n = 34
Wrong publication n = 12
Wrong intervention n = 25
Wrong population n = 23

Studies included (n = 23)

Included

Studies included
Drama therapy n = 10
Psychodrama n = 13

Figure 2. Flow chart of the search results.

3.2. Quality of the Studies

Of the ten included studies, two studies were evaluated having a high quality [83,84], three studies a moderate quality [75,76,79], and five studies a weak quality [77,78,80–82]. The studies evaluated as strong were both RCT studies. Of the studies with moderate

quality, one had a CCT design [75] and two a pre- and post-test design [76,79]. Of the five studies having weak quality, two had a RCT design [80,81], two a CCT design [77,78], and one a pre- and post-test design [82]. See Table 4, quality of the studies.

Table 4. Quality of the studies.

First Author/Year	A. Selection Bias	B. Study Design	C. Con-founders	D. Blinding	E. Data Selection Methods	F. Withdrawals and Dropouts	Overall
Anari, 2009 [75]	Moderate	Strong	Weak	Moderate	Strong	Strong	Moderate
D'Amico, 2010 [76]	Moderate	Moderate	Weak	Weak	Strong	Strong	Moderate
Ghiaci 1980 [77]	Weak	Moderate	Weak	Weak	Weak	Weak	Weak
Hoogsteder, 2014 [78]	Moderate	Moderate	Weak	Weak	Moderate	Moderate	Weak
Hylton, 2019 [79]	Moderate	Moderate	Strong	Moderate	Weak	Moderate	Moderate
Irwin, 1972 [80]	Weak	Moderate	Weak	Moderate	Weak	Weak	Weak
Lowenstein, 1982 [81]	Moderate	Strong	Weak	Weak	Strong	Strong	Weak
Mackay, 1987 [82]	Moderate	Moderate	Weak	Weak	Strong	Strong	Weak
Rousseau, 2007 [83]	Moderate	Moderate	Strong	Moderate	Strong	Strong	Strong
Rousseau, 2012 [84]	Moderate	Strong	Moderate	Moderate	Strong	Strong	Strong

3.3. General Study Characteristics

There were four studies with an RCT design [80,81,83,84], three studies with a CCT design [75,77,78], and three studies with a pre- and post-test design [76,79,82]. The control group did not receive intervention [75,77,81,83,84], care as usual [78] or other interventions (psychotherapy or recreation activities) [80]. In total, there were 334 participants involved in the included studies of which there were 178 participants in the experimental group, 143 participants in the control group and 22 participants in the non-controlled design studies. Sample sizes varied from $n = 5$ to $n = 123$. See Table 1, formal characteristics of included studies.

3.4. Clients Characteristics

The study population consisted of emotionally disturbed children [80], children with a developmental disorder such as high function autism [76], children who coped with anxiety such as social anxiety [75], children who were shy and maladjusted [81], girls who had been sexually abused [82] and (newly arrived) immigrants and refugees [83,84]. In addition, one study included adolescents with several problems, i.e., a specific mental disorder, attention deficit hyperactivity disorder with aggression regulation problems, or a moderate-to-high recidivism risk [78]. One study did not provide a description of the population [77]. The age range of the total population of the studies included was 3.5 to 19 years. One study in total focused on 12 children in the age of 3–5 years [77], one study involved 12 children in the age of 7–8 [80], two studies in total focused on 31 children in the age of 10–14 [75,76,79], three studies focused on a total of 183 adolescents in the age of 12–18 years [82,84], one study focused on 91 adolescents of 16–19 years [78], and one study involved a broader age range of 5 participants of 9–16 years [81]. Four settings were related to school: day nursery [77], elementary [75], high school [76,83], and school psychological service [81]. Three settings were specialized centers: a secure juvenile justice institution [78], a specified social service center [76], and an outpatient treatment center [80]. Two settings were especially organized for the studies [71,74,79,82]. See Table 1, formal characteristics of included studies.

3.5. Drama Therapy Characteristics

In eight studies, drama therapy was the main treatment. In two studies, drama therapy was part of behavior therapy [81] or responsive aggression regulation therapy [78]. The frequency of the sessions in eight studies was once per week [76,78,80,82–84], in one study twice per week [75], in another six successive weekdays [77], and in one study four

days per week [79]. One study did not mention the frequency of the sessions [81]. The duration of the drama therapy was from 6 to 21 sessions. Most studies had a duration of 6–14 sessions [75,77–79,82–84], two studies of 20–21 sessions [76,80], and one study did not mention the duration [81]. The length of the session was 60 min to 4–5 h. The length of the sessions in most studies equaled 60–90 min [76–78,80,83,84], and other studies reported a length of 2 to 5 h [75,79,82]. One study did not mention the length of the session [81]. Drama therapy was group based [75,76,79,80,82–84] or a combination of individual and group drama therapy [77,78,81]. Overall, we found that the drama therapy interventions were not consistently described. Two studies described the method of which the intervention was based on: Emunah's Integrative Five-phase Model [75], Augusto Boal's forum theatre, and Jonathan Fox's playback theater [83]. One study described the elements of drama therapy: dramatic projection, dramatic reality, role-playing, and storytelling [76]. Two studies mentioned the drama therapy techniques, such as imagination, roleplaying games, and exercises where adolescents were stimulated to adopt new roles [78,79,81]. Two studies described the goal of the drama therapy intervention [80]. Three studies gave a description of the structure of each session [77,82,84]. See Table 1, formal characteristics of included studies; and Table 3, characteristics of drama therapy interventions.

3.6. Outcomes

Data were collected via self-reports [75,76,78,79,81–84], parents' reports [76,80], teachers' or staff members' reports [78,83], or by tests (IQ, (neuro)psychological tests) [77,78,80,81]. Seven studies used current and valid questionnaires/measurements [75–79,82–84]. One or more questionnaires/measuring instruments of four studies were outdated [79–82]. Five studies did not use existing questionnaires and made use of their own developed reports/measuring instruments [77–81]. The results of one study [77] and the results of the Rorschah Index of Repressive Style test [80] could not be interpreted for meaning and therefore were not included in the analyses of the outcomes. See Table 3, results and description of effects drama therapy intervention.

3.7. Outcome Psychosocial Problems

The included studies focused on a range of outcomes. We categorized the outcome in seven categories, i.e., overall psychosocial problems, internalizing problems, externalizing problems, social functioning, coping and regulation processes, identity, and cognitive development.

3.7.1. Overall Psychosocial Problems

Four studies focused on overall psychosocial problems [76,79,83]. This category consists of outcomes on overall psychosocial problems, problem behavior related to autism, and effect as an underlying concept for emotional functioning. The studies involved six children in the age of 10–12 years [76] and 199 adolescents in the age of 12–18 [79,83,84]. Two studies had a RCT design [83,84], and the other two studies had a pre- and post-test design [76,79]. One study examined effects on psychosocial problems reported by the adolescents and their teachers [83]. The study showed differences between psychosocial problems reported by the adolescent versus the teacher: a decrease in overall psychosocial problems was found reported by adolescents, while no effect was found reported by teachers [77]. A positive effect reported by adolescents was also seen in another study examining effects on psychosocial problems [84]. One study examined autism problem behavior, both reported by the parents as well as by the students themselves. No effect was found on the autism problem behavior after the intervention [76]. There was one study examining the effects of intervention on negative and positive affect. An increase in positive affect was found, but no effect was found for negative affect [79].

3.7.2. Internalizing Problems

Six studies focused on the effects of drama therapy interventions on internalizing problems [75,76,79,81–83]. The category internalizing problems consisted of outcomes regarding anxiety, depression, (di)stress and posttraumatic stress, timidity, obsessive compulsive disorder, interpersonal sensitivity, and somatization. The studies involved 164 children in the age of 9–18 years. Two of the studies had a RCT design [81,83], one study had a CCT design [75], and three studies had a pre- and post-test design [76,79,82]. One study examining the effect of drama therapy interventions on internalizing problem behavior rated by the parents and students did not show an effect on this outcome [76]. Two studies examined the effect on anxiety [79,82]. The results of one study showed a decrease in anxiety [79], and the results of the other study did not show any effect on anxiety. Two studies examined effects on specific anxieties, i.e., social anxiety [75] and phobic anxiety [82]. Only a decrease was seen for social anxiety. Two studies examined the effects on depression. Results of both studies showed a positive effect on this outcome [79,82]. Two studies examined the effects on stress, i.e., distress [83], and symptoms of posttraumatic stress [79]. The results of both studies showed a decrease in distress rated by the students, and in one study, there was also a decrease in symptoms of posttraumatic stress, while the results rated by the teachers did not show an effect on distress. Other studies examining the effect on psychopathology symptoms showed a decrease in symptoms of psychotic thinking [82] and in severe timidity [81], while there was no effect on somatization, paranoid ideation, interpersonal sensitivity, and obsessive compulsive disorder [82].

3.7.3. Externalizing Problems

Three studies focused on the effect of the drama therapy interventions on externalizing problems [76,78,82]. This category consisted of outcomes on overall externalizing problem behavior, impulsivity, hyperactivity, (in)attention, assertiveness, hostility, violent recidivism risk, and the number of registered incidents. The studies involved six children in the age of 10–12 years [76], five adolescents in the age of 12–18 [82], and 91 adolescents in the age of 16–19 years [78]. One study had a CCT design [78], and the other studies had a pre- and post-test design [76,82]. One study examined externalizing behavior, hyperactivity, and inattention, both self-rated as well as rated by their parents. No effect was found for externalizing behavior rated by the students. However, parents' ratings showed a decrease in externalizing problems behavior. In addition, both student and parents reported a decrease in hyperactivity and inattention [76]. Another study examining inattention and impulsivity showed a decrease in symptoms on both inattention and impulsivity [78]. One study examined results on hostility [82], and one study examined assertiveness and violent recidivism risk behavior [78]. The results of these studies showed a decrease in hostility and violent recidivism risk behavior and an increase in assertiveness, but there was no increase in the number of registered incidents [78].

3.7.4. Social Functioning

Three studies [76,82,83] focused on the effect of drama therapy intervention on social functioning. This category consisted of outcomes related to social skills, more specially the perception of the students and teachers regarding the extent to which psychosocial problems interfered with home life, friendship, leisure activities, the outcome on self-esteem in social behavior and the satisfaction with social support. The studies involved 134 children in the age of 11–18 years. One of the studies had a RCT design [83], and the other studies had a pre- and post-test design [76,82]. One study examined effects on overall social skills rated by the children and by their parents. The results showed a positive effect on overall social skills rated by the parents, while the results rated by the children did not show any effects of intervention on overall social skills. Results regarding more specific socials skills, such as communication, cooperation, responsibility, empathy and self-control, rated by the children and by their parents, did not show any effects. However, the amount of engagement rated by the parents showed an increase after the intervention [76].

One study examined the effects on satisfaction with social support and social desirability behavior; no differences were found after the interventions [82]. Another study examined to what extent the psychosocial problems interfere with friendship, with home life, and with leisure activities from the perception of students and their teachers. A positive effect was observed when the scores of the students were analyzed, while no effects were found for the scores of the teachers [83].

3.7.5. Coping and Regulation Processes

Three studies focused on the effects of the drama therapy interventions on coping and regulation processes [76,78,82]. This category consisted of coping skills, cognitive distortions, self-control and regulation processes. The studies involved 102 children in the age of 10–19 years. Two of the studies had a pre- and post-test design [76,82], and one study had a CCT design [78]. Two studies examined the effects on self-control. The results of one study showed a positive effect on self-control rated by the adolescents and their by mentors [78]. However, results of the other study did not show any effects on self-control rated by students and by their parents [76]. One study examined dealing with anger, assertiveness, distrust, and coping skills (problem solving, palliative coping, social support, reassuring thought, stress, and poor coping) rated by the juvenile and rated by the mentors. These results showed a positive effect on dealing with anger, assertiveness, and on coping skills (problem solving, palliative coping, social support, reassuring thought, stress, and poor coping). The same study examined the effect on cognitive distortions (aggression, justification, physical aggression, oppositional behavior, sub assertive behavior, and negative attitude) and found a decrease in cognitive distortion, but did not find an effect on negative attitude [78]. In addition, an increase in motivation for treatment was found. One study examined the effects on the attribution style in good and bad situations, but no effect was found [82].

3.7.6. Social Identity

Three studies focused on the effects of drama therapy interventions on social identity [80,82,83]. This consisted of attitude change and self-esteem. The studies involved 12 children in the age of 7–8 years [80] and 128 adolescents in the age of 12–18 [82,83]. Two of the studies had a RCT design [80,83], and one had a pre- and post-test design [82]. One study examined the effect on attitude change. The results showed a positive effect on the way the children evaluate themselves and other children. Furthermore, the results showed a positive effect on the amount of potency the children saw for themselves, other children and adults. There was no effect on attitude change regarding activity, sharing, imagination, and feelings [80]. In the study examining the effect on self-esteem, no effect was found [82,83].

3.7.7. Cognitive Development

Four studies focused on the effects of drama therapy intervention on cognitive development [78,80,81,83]. This category consisted of a subset of cognitive functions and abilities: language skills, academic performance, attention deficit and cognitive structure. The studies involved 12 children in the age of 7–8 [80] and 229 adolescents in the age of 9–19 years [78,81,83]. Three of the studies had a RCT design [80,81,83], and the other study had a CCT design [78]. Two studies examined the effect on academic performance in mathematics and one study on reading and spelling. The results in one study showed a positive effect on mathematics [83], and the results of the other study did not show effects on mathematics, reading or spelling [81]. Two studies examined the effect on language development in terms of oral expression [80,83], and results showed an increase in oral expression. One study examined the effect on attention deficit as a neuropsychological outcome. The results showed a decrease in attention deficit [78]. One study examined the effect on the perception of the extent to which the impairment interfered with classroom

learning. The results rated by the students and by the teachers did not show an effect on the perception of the extent to which the impairment interfered with classroom learning [83].

3.8. Outcome Drama Therapy Characteristics

To gain more insight into the effects of drama therapy treatment on psychosocial problems in children and adolescents, we analyzed the drama therapeutic intervention, means, therapeutic attitude, and mechanism of change.

3.8.1. Drama Therapeutic Means

The drama therapy means are the forms and techniques of drama therapy that were applied during the drama therapy sessions. Two studies mentioned *dramatic reality* [76] as a means where children and adolescents create a fictional reality based on their imagination [76] or based on personal stories [84] and dramatic reality as a projective technique where the children and adolescents project inner feelings on dramatic representations [84].

Three studies applied projection as a means in different forms such as *dramatic projection* [75], *projective techniques* [79], *symbolic play as a projective technique* [82] where the children and adolescents project unconscious inner feelings at a safe distance [76,82] and verbalize how they felt [79]. *Role playing* was also mentioned as a projective technique in one study [76]. This is where the children had the opportunity to empathize with the role and project their ideas about how their feelings.

Storytelling [76], *symbolic play* [83] and *pairs techniques* [83] were also mentioned as a reflective technique where the adolescents reflect on their points of view and feelings [83]. *Storytelling* was also mentioned in three other studies. One study used storytelling as a technique to create a symbolic and safe distance from reality [82]. Another study mentioned storytelling as a means that was used to share strong emotions and subsequent relief [83]. One study used storytelling focusing on group play and social interaction. In this study, *movement*, *voice, role play*, and pantomime were used focusing on group play and social interaction [75].

Four studies [79,80,83,84] used *acting out* personal stories as a means to transform these stories into alternative scenarios developed by group members [83] or to express feelings [80,84].

Three studies mentioned *improvisation* [79,80,82] as a means where the children and adolescents adopt new roles, and explore spontaneity [79], express and play out feelings [80], and can play a variety of roles attuned to their needs and requests [82].

One study used *role-playing games* to practice perspective-taking exercises [78]. One study mentioned *theatrical exercises* as a means to transform the experience of adversity [84]. *Playing a role* was mentioned by one study as a means to express the inner characteristics of the role in a way that can be understood by others [80].

3.8.2. Drama Therapeutic Attitude

Three studies reported the therapeutic attitude [76,79,82]. All of them described an adaptive approach where the drama therapists created opportunities to cooperate, build cohesion, share feelings and where the children and adolescents are accepted as being of unconditional worth. One of the studies mentioned specifically that the adaptive approach was based on the view of Carls Rogers [82].

3.8.3. Supposed Mechanisms of Change

We categorized the mechanisms of change into two categories: specific drama therapeutic mechanisms of change and general mechanisms of change.

Specific Mechanisms of Change

Nine categories were identified reflecting specific mechanisms of change which contribute to the effectiveness of the drama therapy intervention. The first category was related to the process where *expression is stimulated in drama therapy*. These processes concern

those that stimulate participants to express their own ideas [76], emotions [76,79,83], experiences [76], thoughts [76,82], internal states in verbal terms [79,80], verbally and non-verbally in a role [80,83], and their identities [82]. The second category concerned the process of sharing experiences and feelings [72,76,79,83], emotions of oneself and others [79], and personal stories [84]. The third category was the process that allows participants to *gain experiences in the drama therapy*. Experiences that were mentioned are related to positive relations [76], social connections [76], fun and playfulness [76,82], getting closer to each other [82], acting out ideas and feelings [82], control in the role-play [82], and recreating and experiencing life situations [75]. The fourth category concerned processes in the drama therapy where participants *become aware* of their vulnerability and psychological issues [76], new identities [76], life roles [79], and ideas and feelings (which associate with key experiences) [83]. The fifth category was the *process of reflection* on experiences [76,79,82], feelings [76,79,80], different points of view [78,83], oneself [76,79,80] and others [76,79,80] in the drama therapy. The sixth category was the *process of embodying* the personas [76] and emotional experience [79]. Embodiment is considered as a process to internalize new roles [79] in the drama therapy. The seventh category was the process in which participants *witness others in the drama therapy* [80]. The eighth category is the processes in which participants *gain self-control in the drama therapy* by becoming more active during their own treatment [68] and gain a sense of agency [83]. The ninth category is the process in which participants are *stimulated to be creative in the drama therapy* [76,82] and are *stimulated to use their imagination* [76,79].

General Mechanisms of Change

One general category of mechanism of change was found. This is drama therapy as a group process where participants *share* experiences [76,79], feelings [72,76,79], emotions [79], thoughts about experiences [82], strong emotions and subsequent relief [83] and their stories [84].

4. Discussion

The aim of this systematic review was to gain insight into the effects of drama therapy on psychosocial problems in children and adolescents. To this aim, the means and the general and specific mechanisms of change were identified that contribute to a decrease in psychosocial problems. This review showed that studies focused on a variety of psychosocial problems and age groups. In addition, drama therapy was applied as both curative and preventive. Most drama therapy interventions described in the studies were group based, in which there is room to pay attention to individual therapeutic goals. Furthermore, the content, duration and timing of the treatment varied from 6 to 21 sessions. This wide range of both client and drama therapy characteristics showed that drama therapy is applied within a diversity of target groups with psychosocial problems at all ages (3.5–19 years), both individually and in a group, within different (specialized) settings, both preventive and curative.

Results of this review showed that drama therapy can contribute to a decrease in psychosocial problems in children and adolescents. Positive effects of drama therapy were found for overall psychosocial problems and positive affect. Regarding internalizing problems, a decrease in depressive symptoms and symptoms of posttraumatic stress was observed. We also found a decrease in distress reported from the perspective of the children, while this was not reported by teachers. Reduction in anxiety symptoms was less consistently demonstrated. In one study [82], no positive effects were shown, while in two other studies, a reduction in anxiety [79] and specifically social anxiety [75] was shown after drama therapy. Regarding externalizing problems, we found a decrease in externalizing problem behavior reported by parents, while this was not seen from the perspective of the children [76]. In addition, drama therapy resulted in a decrease in inattention in two studies; more specifically, positive effects were seen for hyperactivity [76] and impulsivity [78]. In one study [78], in which drama therapy was a part of the larger treatment program, we

also found a decrease in aggressive behavior in the form of hostility, violent recidivism risk behavior, and an increase in assertiveness. It is unclear to what extent drama therapy contributed to these effects.

Positive effects of drama therapy on social functioning were not found consistently. In one large-scale (n = 123) study [83], adolescents showed a decrease in the extent to which the symptoms impacted their social functioning in terms of their friendships, family life, and leisure activities, while this was not reported by the teachers. Regarding social identity, one small study [80] had suggested promising results, since drama therapy appears to result in a change in attitude of the children or adolescents toward themselves and how they evaluate themselves and others. No positive effects were found on self-esteem in this review. This is remarkable, since in clinical practice, drama therapy is often applied to increase self-esteem [46,47,49,50,52,53,110–113]. This discrepancy between clinical practice and the results of the included studies can be explained by the fact that both studies investigated brief therapies that were not directly aimed at enhancing self-esteem. In addition, in clinical practice, drama therapy is often applied to learn new coping skills and regulate behavior. In our review, only one study [78] found positive effects on coping skills and regulation processes, while this was not confirmed in two other studies [76,82]. In this study, drama therapy was part of a broader treatment, and therefore, it is unclear to what extent drama therapy contributed to these effects. Finally, four studies examined effects on cognitive development. Results showed better performance on mathematics, oral expression, and a reduction in attention deficit. This can be considered an indirect effect, since drama therapy interventions were not targeting these school abilities. Possibly, drama therapy improves prerequisites for learning, such as feeling safe, less anxious and less distracted, which has a positive impact on school abilities.

Some of the positive effects were dependent on perspective, i.e., whether the child/adolescent or the parent/teacher filled out the questionnaire. Overall, parents and teachers reported positive effects on behavior (i.e., fewer externalizing problems, and improved social functioning, and social identity), whereas these positive changes were not found when children or adolescents were asked. Furthermore, children and adolescents often reported positive effects when asked about their inner states, such as internalizing problems, whereas these positive effects were not found when parents/teachers filled out the questionnaire. It could be that explicit or externalizing behavior is better and earlier observed from an external perspective, whereas this is not the case for internalizing behavioral problems. In addition, it is not clear how parents and teachers were involved in the treatments.

Since not all studies systematically described the means, therapeutic attitude or supposed mechanisms of change in the drama therapy intervention, a narrative approach was applied to synthesize the findings in the literature. These results showed a broad variety of drama therapeutic means that were used in drama therapy. These means ranged from means focusing on group play and social interactions such as storytelling, movement, voice, role play, pantomime [75] or theatrical exercises [84] to projective techniques such as dramatic reality [76], dramatic projection [76] and symbolic play [82], and reflective techniques, for example, storytelling [76] and symbolic play [83]. Some means have more than one purpose, e.g., to reflect as well as to project. In addition, in some means, the exploration, expression, and experience of new roles were central. Examples of these means are acting out [80,83,84], improvisation [79], and playing a role [80]. Finally, in some means, perspective taking was emphasized, such as role playing [78].

The means are all forms or techniques that were applied during the drama therapy sessions and which contributed to the creation of dramatic play and eventually a dramatic reality. During dramatic play, clients are encouraged to respond spontaneously and to explore, create and play different characters with different feelings and behaviors. This takes place in a "playspace", where clients can act and play at a safe distance from experiences in daily life [62]. This is where dramatic play feels "real", but not overwhelming, as may be the case in real life. In such moments, it becomes a dramatic reality [48]. Experience in the dramatic reality may trigger a change. Dramatic projection is considered as one of the core

processes of drama therapy [46,114]. Dramatic projections are techniques used by drama therapists to translate clients' feelings and inner experiences from real life into dramatic representations so that these feelings can be externalized and expressed [46,114–116]. In addition, reflective techniques are important in drama therapy. The clients can reflect on different perceptions and perspectives in play in relation to everyday responses. This will be a crucial step to explore the expression of inner states into more appropriate responses in dramatic reality, by means of symbolic play, storytelling and/or pair techniques applied by the drama therapist [46,47,117,118]. The means found in this review are considered some of the basic means of drama therapy which prompt children and adolescents to explore feelings, behavior, and wishes in different forms of dramatic reality [62,116,119,120]. In this respect, there is a triangular relationship between the client, drama and theatre processes, and the drama therapist [43,47,121]. In all studies, the drama therapeutic means were considered as a third dimension in the therapy besides the communication between the therapist and the client. The drama and theatre processes have a crucial role in drama therapy interventions and may contribute to therapeutic change.

In the triangular relationship between client, drama, and drama therapist, these means require a continuously adapted approach from the drama therapist to the client. This is in line with three included studies [76,79,82] in which the authors describe the adaptive therapeutic attitude as an open attitude where the drama therapist is constantly attuned to the fun and playfulness from the perception of the client. From there, the drama therapist first creates a variety of opportunities to teach the client how to use drama and play. Subsequently, the drama therapist encourages the children and adolescents to express their wishes for specific roles and personal themes and facilitates playing out personal problems. In parallel, the drama therapist encourages the children and the adolescents to work together and build cohesion and share personal stories [76,79,82]. This is in line with the drama therapy interventions described in the included studies, where drama therapy is provided in groups where there is room to pay attention to individual therapeutic goals. This is confirmed by previous literature and theoretical insights where the drama therapist offers the client the opportunity to explore new roles (including different behavior, feelings and thoughts) within the interactive play by continuously tuning in [42,46,47,49,51,67]. This variety of means combined with adaptive therapeutic attitude is considered an important trigger of mechanism of change in drama therapy [34,46,47,52].

Mechanisms of change are therapeutic processes which arise in the here and now during drama therapy sessions. We found nine mechanisms of change. Regarding these mechanisms, we found three mechanisms of change that arise in common psychotherapeutic processes. These are the psychotherapeutic processes activated by the drama therapeutic means where expression is stimulated, where clients become aware of themselves and others, and where the clients gain more self-control. In addition to common psychotherapeutic processes, we found six mechanisms of change that can be considered as creative arts processes. These are the processes activated by the drama therapeutic means where the clients reflection, creativity, imagination, witnessing, and sharing are stimulated, and where clients gain experiences. Finally, we found two specific drama therapeutic mechanisms of change. These are the processes of embodying a role and expressing emotions of the drama activity. This is in line with previous literature and theoretical insights where these mechanisms of change are considered as the core processes of the drama therapy and creative arts therapies [34,46–48,114,115,122–124]. All nine mechanisms of change were frequently mentioned in the various studies. That is, the mechanisms were used to focus on different therapeutic targets and treat different psychosocial problems, resulting in a significant change. Therefore, these mechanisms can be considered transdiagnostic mechanisms of change [125].

The aim of this review was to investigate the effects of drama therapy for children and adolescents and to identify the drama therapeutic means, attitude and mechanisms of change that lead to these effects. The conclusions of this review need to be phrased carefully, since the methodological quality of the included studies varied substantially.

Only two studies had a strong quality, three studies were rated to have a moderate quality, and five had a low quality. Suboptimal quality was due to measurement instruments that were not investigated for reliability and validity. In addition, some of the studies included a small number of participants. In addition, in one study [78], drama therapy was part of a responsive aggression regulation therapy, and only the whole therapy program was evaluated. Therefore, it is unclear to what extent drama therapy contributed to the effects. Finally, some studies did not show any results on goals that were not the studies' primary aim. Hence, we need to be careful with conclusions, and more research is imperative. The interventions in the included studies are based on good clinical practice. However, the descriptions of the interventions were brief or described in general terms. No direct relations were drawn between the effects, drama therapeutic attitude, and mechanisms of change. Likewise, the individual means, attitude, and supposed mechanism of change were not empirically investigated in the included studies. Finally, we did not perform a meta-analysis on the effect sizes, because only three of the included studies reported effect sizes. Thus, given these limitations, further research is warranted.

In future research, it is important to make a clear description of the drama therapy intervention, explicating goals and expected effects, and defining the general and drama therapeutic means, therapeutic attitude, and mechanisms of change that are applied. This is not only important for empirical reasons but also for the professionalization of drama therapists. Detailed descriptions allow clinical practice to transfer interventions into common practice among drama therapists as well as to disentangle the effects of specific elements of drama therapy interventions. Future studies should provide detailed descriptions that allow us to relate the drama therapeutic means and therapeutic attitude to the beneficial effects of (different elements of) drama therapy interventions. Moreover, a detailed description of supposed mechanisms of change in drama therapy interventions allows us to investigate why drama therapy may lead to specific effects.

Besides working on clear descriptions of interventions, future studies should investigate designs that fit clinical practice and apply these in a stepwise manner, e.g., starting with single-case experimental designs, feasibility studies, and eventually—when promising—randomized clinical trials. It might be necessary to use a personalized research approach. Personalized research with individual goals and clearly described tailored interventions can give more insights into the effects and how drama therapy contributed to the intervention outcome. The Goal Attainment Scale (GAS) may be considered useful for a more personalized research. This review showed that first steps have been made, where drama therapists explore theoretically how drama therapy influences cognition, emotions, and behavior. It is important to further clarify the relationship between cognition, behavior and emotions and drama therapeutic means, attitude, and working mechanisms to develop a theoretical foundation for further research. For instance, Frydman [59] described the link between the role theory [126–128] and executive functioning (EF).

The results of this review provide a starting point to give an overview of the interplay between drama therapy and neuropsychology.

5. Conclusions

This study has shown that drama therapy can decrease psychosocial problems in children and adolescents. Our review shows positive effects of the drama therapy intervention on psychosocial problems overall, a decrease in depressive symptoms, (social) anxiety, posttraumatic stress, inattention (especially on hyperactivity and impulsivity), aggressive behavior such as hostility, violent behavior and an increase in assertiveness. In addition, drama therapy had an indirect effect on school behavior, i.e., a positive effect on learning behavior and on school abilities. The drama therapeutic means were applied to create a dramatic reality. The use of the drama therapeutic means was flexible within an adaptive approach. Several mechanisms of change were proposed and partly overlap in different treatments. These mechanisms of change can be considered as transdiagnostic. Overall, descriptions of the means, drama therapeutic attitude, and mechanisms of change in the

studies included in this review were described poorly. Therefore, further research is needed to obtain more insight into the effective elements of drama therapy and their mechanisms of change. When we know which and how these elements can contribute to a decrease in psychosocial problems in children and adolescents, then drama therapy can be applied (even) more effectively.

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Article

Qualitative and Arts-Based Evidence from Children Participating in a Pilot Randomised Controlled Study of School-Based Arts Therapies †

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Abstract: (1) Background: There is limited evidence on the impact of arts therapies as a tool for the prevention of mental health difficulties in childhood. This pilot randomised controlled study aimed to investigate the impact of arts therapies on children's mental health and well-being; the qualitative and arts-based evidence is presented in this article. (2) Methods: Sixty-two children (aged 7–10) with mild emotional and behavioral difficulties were recruited across four primary schools and were randomly assigned to either art therapy, music therapy, dance movement therapy, or dramatherapy. All children were interviewed individually after their participation in arts therapies. (3) Results: Children verbally and artistically expressed that they experienced positive changes in their mental health and well-being, such as improved self-expression, safety, empowerment, hope, and optimism for the future. The arts were particularly important for expressing complex emotions and feelings that cannot be easily verbalised. Recommendations are provided to improve the quality of group arts therapies in future interventions, such as through smaller groups, longer sessions, and strategies to protect the therapeutic environment. (4) Conclusions: This study embraced all arts therapies as one research domain and set children's verbal and non-verbal responses at the heart of outcome evaluation. This article highlights the importance of incorporating qualitative and arts-based methods to capture changes in children's mental health well-being in future experimental studies.

Keywords: art therapy; music therapy; dance movement therapy; dramatherapy; children; schools; randomised controlled study (RCT); mental health; well-being; prevention

1. Introduction

Children's mental health and well-being has become central to global policy, such as the United Nations Sustainable Development Goals for Good Health and Well-Being [1] and the World Health Organization [2] call for the integration of mental health provision within the school curriculum. Despite that, the National Healthcare System (NHS) in the UK reported an increase in mental health disorders among children and adolescents from 1 in 9 in 2017 to 1 in 6 in 2020, with a sharp rise in self-harm, eating disorders, sleep disturbance, depression, and anxiety [3,4]. Following the COVID-19 pandemic, 1 in 5 children in the UK (equating to 1.1 million) have reported feeling unhappy with their lives [5], while clinically significant mental health conditions, loneliness, and isolation in childhood increased by 50% [5]. These figures are estimated to be even higher for children from vulnerable groups, such as low-income households, special educational needs/neurodevelopmental differences (SEN/ND), or children exposed to adverse childhood experiences [6]. Another concerning issue is that, although the rate of domestic abuse rose by at least 30%, the number of children coming to the attention of services has fallen dramatically since the first

lockdowns and school closures [7]. In addition, the economic uncertainty exacerbated by the pandemic [8] and the environmental uncertainty due to the climate crisis have added significant burdens to children and young people across the globe [9,10]. Children's mental health needs are now believed to have drastically exceeded the capacities of the NHS and Children & Adolescent Mental Health Services (CAHMS), and there is an urgency to radically rethink the scope of support that children receive [5,8].

Children spend an inordinate amount of time in school, a place where children's emerging needs can be identified and appropriate and timely support are provided. Schools are often the only place that can facilitate equity of access to mental health services without excluding children who need it the most. Their remit as educational institutions can reduce stigma and increase inclusivity, while also accessing supportive networks of peers, teachers, healthcare professionals, and parents [11,12]. Furthermore, school-based counsellors and psychotherapists can streamline the referral process and target children experiencing barriers due to lack of transportation, parent work schedules, funding, and inadequate treatment from other sources [13].

Nevertheless, a major challenge for school mental health services is that the focus relies heavily on the treatment of severe difficulties or disorders, whereas early detection and prevention may be equally important [2,14]. When opportunities for prevention are missed, chances for school drop-out, self-harm, aggressive or violent behaviour, or even suicide are increased. The centrality of early prevention and intervention has been a consistent theme within governmental policies [15] with a longstanding recognition of the importance of schools in the early identification of children's mental health difficulties [16,17]. Delayed identification of mental health difficulties in children may culminate in costly crisis interventions, alienation from school, and long-term impacts on children, their families, and communities [17,18]. For example, 7000 children are being excluded from schools annually in the UK (equivalent to 35 children/day), while 1300 of these exclusions come from primary schools [19]. These exclusions could have been avoided with prevention and timely interventions at the early stages of children's education [20]. In contrast, it is estimated that more than 70% of children lack supportive services at a sufficiently early age [21], 30% of referrals are turned away and waiting lists can take up to a year [19]. Such delays have long-lasting and potentially irreversible negative effects for children's mental health and well-being.

Despite growing evidence around the impact of arts therapies on children's mental health and well-being, the central focus on workforce training and intervention implementation in schools has tended toward traditional and empirically recognised approaches such as counselling, Cognitive Behavioural Therapy (CBT), and talking therapies. Arts therapies is an umbrella term referring to art, music, drama, and dance movement therapy; psychotherapeutic approaches that aim to facilitate psychological change and personal growth using arts media. Arts therapies have been defined as, "the creative use of artistic media for non-verbal and/or symbolic communication, within a holding environment, encouraged by a well-defined client-therapist relationship, in order to achieve personal and social therapeutic goals appropriate for the individual" [22] (p. 47). In the UK, arts therapies are recognized professions; art therapy, music therapy, and dramatherapy are regulated by the Health and Care Professions Council (HCPC), while dance movement psychotherapy is regulated by the UK Council for Psychotherapy (UKCP).

Arts therapies have been used widely for children and young people in a wide range of settings, such as hospitals, clinics, and outpatient treatment facilities [23]. More recently, arts therapists have seen a substantial growth of employment in educational settings, bridging the gap between health and education. It is estimated that more than half of all registered arts therapists in the UK are working with children and young people [23], but this may vary for the different types of arts therapies. The latest workforce survey in music therapy [24] showed that schools were the most reported setting, while working with children and adolescents was the most reported post (78% of all posts). The latest workforce survey in art therapy [25] showed that 68% of all art therapies were working with children

and young people, while 35% of them were based in schools. In dance movement therapy, it was estimated that 33% of dance movement therapists were working with children and young people, while schools were the third most reported setting (28% of all posts) [26]. Following contact with the British Association of Dramatherapists in 2020, it was estimated that approximately half of the registered dramatherapists were working with children and young people, the majority of whom were based in schools. Despite that, the inclusion and integration of arts therapies into regular mental health provision in educational settings has only recently begun. Underpinning arts therapies with rigorous research will strengthen such an integration [27].

We designed and conducted a pilot cross-over randomised controlled study aiming to (a) explore whether all components of the study (i.e., recruitment, randomization, and follow-up) can work together and run smoothly in a larger trial; and (b) investigate the impact of arts therapies on several quantitative, qualitative, and arts-based outcomes. The protocol was published before the beginning of the study [28]. Furthermore, the first research question (a) was addressed in a separate publication which presented the quantitative evidence of this study [20]. The current article aims to address the second research question (b), presenting the qualitative and arts-based evidence from the children who participated in the arts therapies.

2. Materials and Methods

2.1. Methodology

Because of the complexity of health difficulties, complex interventions require information from various perspectives and methods [29]. A mixed methodology was adopted in this study, using quantitative, qualitative and arts-based methods to investigate the process and outcomes of arts therapies, both from children's experiences and with standardized questionnaire-based measures. The mixed methodological approach is philosophically underpinned by pragmatism [30,31], which embraces the positivist/postpositivist and constructive paradigms with the aim to gain a comprehensive understanding of the research phenomenon or problem both from quantitative data (measured facts) and qualitative methods (personal experiences) [32,33]. Epistemologically, there are times in the study when an objective approach is adopted that requires distance from the participants, while at other times the researcher adopts a subjective approach supported by close interaction with participants to understand their realities [34] and produce socially useful knowledge [35]. Therefore, the use of both approaches can offer more breadth, depth, and richness, adding insights that may be otherwise missed [31]. In our study, we took advantage of the strengths of using mixed methods in a complementary way, rather than for cross-validation and triangulation purposes. For example, the aim was not to validate what the children said in the interviews through the standardized questionnaires, but to inform the findings from both approaches and better understand the impact of arts therapies on children's mental health and well-being.

2.2. Study Design

We conducted a pilot cross-over study using a randomised controlled trial design [31] to evaluate the effects of an arts therapies intervention for children in primary schools. Half of the participants were randomly assigned to the arts therapies intervention immediately and then switched to the control group, while the other half acted as a control group in the beginning and received the intervention at a later stage. As such, it was a partial cross-over design. This method has the advantage of reducing the number of participants required, since each participant serves as both a participant in the intervention as well as a control. It also ensured that all children received equal opportunities and benefits from their participation in this study.

As per the National Institute for Health Research [36] (p. 2) definition of pilot studies, the primary aim was to test whether all components of the study (e.g., recruitment, randomization, treatment, follow-up assessments) can work together and run smoothly in a larger

trial. Within the pilot, however, certain elements were tested for feasibility [37], particularly: (a) the acceptability of the randomization process to schools; (b) the implementation of the arts therapies protocol; and (c) the methods of process and outcome evaluation.

2.3. Study Procedure

Following ethical approval from the Ethics Committee at Edge Hill University, Faculty of Health, Social Care and Medicine, we created a list of primary schools through the public catalogue of public schools in a Northwest region of England. We randomly selected and contacted schools until four schools agreed to participate. The research team and the arts therapists had no prior relationship with any of the schools involved.

The head teachers from these schools were asked to identify two classes having a greater need for psychological support. The teachers of these classes completed the Strengths and Difficulties Questionnaire [38] for each child; this questionnaire was used as a screening tool. Children who were rated as having mild emotional and behavioural difficulties were the targeted participant cohort. The inclusion and exclusion criteria, used at the recruitment stage, are presented in the study protocol [28] and the author's PhD thesis [39].

An equal number of children were targeted from each school (i.e., 16 children per school). Children were randomly selected through random number generator software and were evenly randomized to the intervention or control groups (i.e., eight children in the intervention and eight in the control group per school). Only the music therapy group had seven children per group, as the music therapist expressed concerns around the noise that would be generated by a larger group of children. In the unusual case where 7/8 participants were of the same gender, the last participant was replaced by a participant of the different gender. For example, if seven girls and only one boy were randomly selected, the seventh girl was replaced by another randomly selected boy. This approach was used to ensure that at least two children of the same gender were allocated in each group, to avoid gender biased findings and outgroup gender isolation. If the selected children (or their parents/legal guardians) declined the invitation to participate in this study, we continued the randomization process until sixty-two children agreed to participate. The recruitment and dropout rates are presented in Table 1.

Table 1. The recruitment and dropout rates (with reasons) for each type of arts therapy.

Type of Arts Therapies	No. of Children Recruited	No. of Children Completed	Dropouts (Group)	Dropout Reason
Art therapy	16	14	2 (control group)	1 hospitalisation 1 left school
Dramatherapy	16	14	2 (1 from each group)	2 did not want to keep missing the PE classes
Dance movement therapy	16	16	N/A	N/A
Music therapy	14	12	2 (intervention group)	1 left school 1 did not want to keep missing the assemblies
Total	62	56	6	

The parents or legal guardians of these children received the participant information sheet by the school and were invited to a workshop to understand more about arts therapies and the nature of the study. A separate workshop was also delivered to children, which entailed further explanations through child-friendly methods. The arts therapists were present in these informative sessions, offering examples of activities that would take place during the sessions. A different arts therapies intervention was delivered to each school, i.e., either art therapy, music therapy, dance movement therapy, or dramatherapy.

2.4. Arts Therapies Intervention

Prior to this study, we conducted two systematic reviews [40,41] which informed the development of the therapeutic protocol based on the evidence of "what works best" for children at schools. The intervention was also influenced by the Arts for the Blues, an evidence-based creative group psychotherapy that was originally developed for adults [42]. A detailed description of the therapeutic ingredients and framework, as well as the activities that took place in each session, are presented in the study protocol [28] and the author's PhD thesis [39]. Arts therapies sessions were delivered once a week for one hour, over eight consecutive weeks, always at the same day and time.

The recruitment of the arts therapists was made through advertisements in the respective British associations for the four arts therapies. Arts therapists were trained on the protocol application and were encouraged to make their own clinical judgements moderating the structure of the sessions when needed. These modifications were recorded for fidelity purposes. The protocol was used to ensure arts therapists adhered to the overall therapeutic model and to allow future replications. A summary of the therapeutic model is presented in Figure 1.

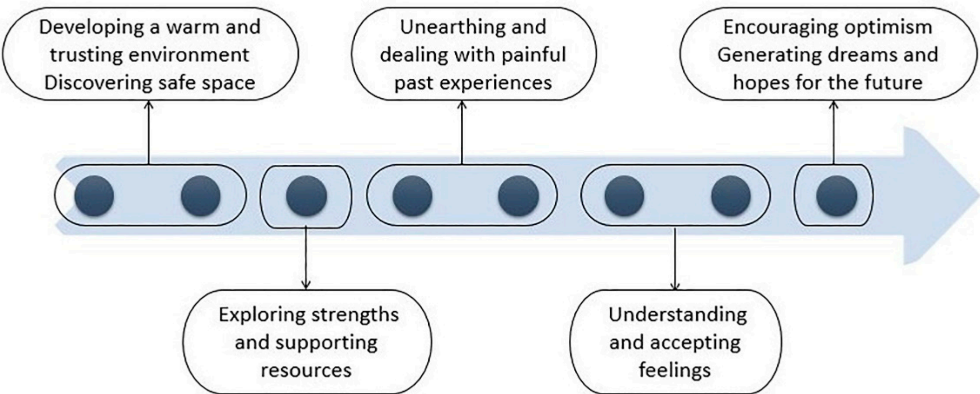


Figure 1. The therapeutic model followed in the arts therapies intervention protocol.

2.5. Methods of Data Collection and Analysis

The process and outcome evaluation were completed through interviews, arts-based methods, standardized questionnaires, and biomarkers (FitBits). Data collection took place before, during and after the arts therapies in the same room as the sessions were conducted but were separate from the sessions themselves. In this paper, only the qualitative and arts-based methods will be presented, as the quantitative methods has been published separately [20].

2.5.1. Interviews with Children

Semi-structured one-to-one interviews were used to understand children's experiences of participating in arts therapies. All children were interviewed individually one week after the end of arts therapies, for approximately half an hour. Follow-up one-to-one interviews were also conducted at three-, six-, and twelve-months post-intervention to explore any further insights or changes in children's perspectives. These interviews were shorter and lasted approximately 15 min with each child. All interviews were conducted by the research lead [ZM].

The main themes of interest during the interviews were: (i) what children found helpful or unhelpful, (ii) what they did or did not enjoy; (iii) their most outstanding memories from the sessions; and (iv) whether they practiced any of these activities/techniques in their day-to-day life after the end of arts therapies. To facilitate memory retrieval, the researcher selected and showed 1 or 2 photographs from each session and invited children to share their thoughts and reflections on them.

The interviews were analyzed through reflexive thematic analysis [43] and, as such, the process of coding was fluid and flexible so that codes could evolve and change. Through this open coding process, reflexive thematic analysis allowed us to reflect on how the research team was conceptualizing the data, and how these conceptualizations were evolving, growing, or deepening alongside increased understanding of the data [43].

2.5.2. Children's Arts Work

The creation of arts work was used as an arts-based method to explore potential changes in children's emotional expression before and after their involvement in arts therapies [44,45]. During the interviews, children were provided with colours, paper, musical instruments, and materials such as scarfs and fabrics. The same materials were provided to all children, regardless of the type of arts therapies they participated in. They were then invited to close their eyes (if they felt comfortable) and contemplate how they felt at that moment. After taking as much time as they needed, they were invited to demonstrate what this feeling would look like if it was a drawing, movement, gesture, or a sound, using the provided materials.

Hervey's analytic frame of "open dialoguing" [44] was considered the most appropriate to explore the aesthetic qualities of children's arts work, especially since some of the younger children were expected to find it difficult to vocalise their feelings. For example, for movements, gestures, or postures, the focus was on children's effort to express their emotions, whether they used their full body or parts of it, the space they used, or the flow and rhythm. For visual data, emphasis was on aspects such as, colour, background, self-image, or the space that children used on the paper. Similarly, for musical data, the primary focus was on the degree of rhythmic freedom (i.e., limited, unstable, complete), the force beating (i.e., chaotic, creative, emotional) and responsiveness to the mood. A thematic analysis [43] was also used to develop themes around children's verbal descriptions of their feelings and emotions. In addition, the lead researcher [ZM] included these in the analysis notes from her observations during the process of children's arts-making.

3. Findings

3.1. Interviews with Children

Below, we describe the most helpful elements of arts therapies that contributed positively to children's mental health and well-being, as well as the unhelpful elements which should be addressed in future research and practice.

3.1.1. Helpful Elements of Arts Therapies for Children's Mental Health and Well-Being

Children expressed that the most helpful elements of the intervention were: self-expression through engagement with the arts; safe spaces; stress relief; empowerment; and the development of coping mechanisms.

Engagement with the Arts and Self-Expression

Self-expression through engagement with the arts was one of the most fundamental elements of the changes that children experienced and expressed during the interviews. Children were re-assured from the beginning that all emotions and feelings were welcome in this group. During the interviews, they expressed that the non-verbal communication through the engagement with the arts allowed them to share experiences and feelings that had never been shared before:

> *"I was sharing things that I was not used to share with anyone else."* (9 years-old-dance movement therapy)

Although drawing was the most familiar medium for children to express both pleasant and unpleasant emotions and experiences, familiarity with other types of arts was developed over time. For example, storytelling and story enacting offered children "permission" to act in any manner they preferred without being judged, which is potentially why they

showed a strong preference towards enacting "crazy" or "silly" characters (Figure 2a). A child said:

(**a**)

(**b**)

Figure 2. Engagement with the arts and self-expression. (**a**) Puppets—dramatherapy; (**b**) Sand trays—art therapy.

> *"I made it [the character] look like crazy, you know, like my auntie used to be before she passed away. I want to be like my auntie so this [character] was actually me."* (9 years-old-art therapy)

They also enjoyed the process of choosing their own character(s), a choice they rarely had in school plays and performances. Children especially enjoyed the stories that allowed characters with different energy levels to emerge and co-exist. For example, during a role-play, some children pretended that they were pirates on a boat, while others were relaxing on a peaceful island. Children had the opportunity to change roles when they wanted, giving them the time they needed to remain still or active:

> *"One of my favourite [role-play] was the pirates on the island, where we could choose to fight with the pirates on the boat if we wanted, or stay still on the island."* (9 years-old-dance movement therapy)

Puppetry was also used as a metaphor and medium to allow children to talk about difficult things they would not have otherwise shared. For example, in a dramatherapy session, children were invited to enact how "a difficult day feels like" and communicate it to others non-verbally through their puppets. In the interviews, most children said this was one of their favourite sessions because it gave them the chance to share their own stories, but also keep them private as nobody knew whether they were real or not:

"I could tell my own story through my own puppet, but nobody knows if it's a true story or if I made it all up." (8 years-old-dramatherapy)

Similarly, in music therapy, self-expression was facilitated by music making and song writing. Children shared that their chosen lyrics were related to their real life, and they were curious to hear about other children's life experiences through their songs.

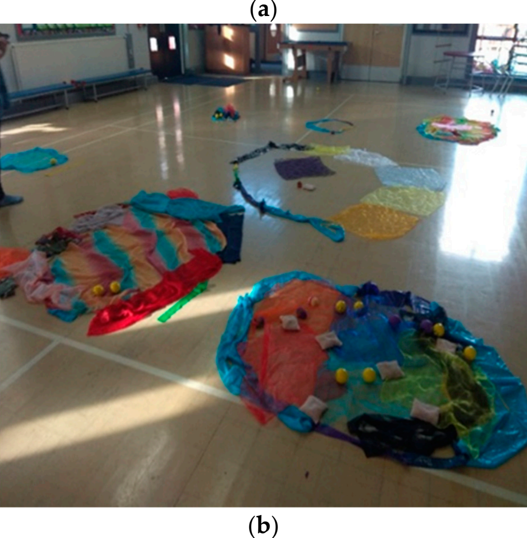
Regardless of the type of arts that children chose to engage with, materials that enabled them to use their senses facilitated emotional expression and made a strong impression on children who could describe, even a year later, how it felt smelling the clay, listening to the sound of an unusual instrument, or touching the sand (Figure 2b):

"I placed all my family in my sand tray, some trees around and a lake that I go with my parents to relax and spend the weekend sometimes [. . .] the sense of the sand was very relaxing, reminded me of our weekends away." (10 years-old-art therapy)

Safe Space

In all arts therapies, children had the opportunity to reflect on the importance of having a safe space and how it feels to be safe. In art therapy, children made their own "safe bench" (Figure 3a), in dramatherapy they made birdhouses that make birds feel safe (with "birds" as a metaphor for their own self), in dance movement therapy they made their "safe home" with scarfs, blankets, and other materials (Figure 3b), while in music therapy children explored the sounds that made them feel safe or unsafe.

(**a**)



(**b**)

Figure 3. A safe space. (**a**) "Safe bench"—art therapy; (**b**) "Safe home'"—dance movement therapy.

Another element that contributed to children feeling safe in the sessions was the awareness of the importance of confidentiality, which was one of the key ground rules established from the first session. All children agreed that what was being said in the sessions had to stay in the group and not be shared with people outside the group. This offered children with a sense of responsibility the means by which to protect other members of the team:

> *"We all know that it's not like gossip what we say and we have to protect each other."* (9 years-old-music therapy)

Some children expressed how they started to treat other conversations with their friends or families as confidential, which appeared to result in developing more trusting relationships and safety in sharing personal experiences with others:

> *"It was easy to share when I choose the people I want to share with and I know that we all do the same [. . .] confidentiality was very helpful."* (9 years-old-dance movement therapy)

Some groups started by dancing and singing to the "Confidentiality Rap", which was a symbolic activity to create a clear boundary between the class and the arts therapies sessions. Similarly, ending the sessions with the same song or activity gave children time to prepare for the transition back to class:

> *"I liked the sessions that started and finished with the same song to know that I am not in the class anymore, and to prepare me to go back to the class. The song in the end was my favourite; it made me happier and ready to go back to class."* (8 years-old-music therapy)

Stress Relief

Some children were experiencing stress that affected their day-to-day life, as well as their performance at school. Almost all sessions included activities with relaxation techniques, such as deep breathing, which were beneficial especially for these children:

> *"When I feel upset I focus on my breath and it helps me calm down."* (9 years-old-dance movement therapy)

> *"It made feel less stressed than I was used to be. I am still stressed in the inside but not on the outside anymore. Before I would be stressed in the inside and also the outside."* (10 years-old-art therapy)

Some children shared that the calmness they experienced during the sessions was transferrable to the rest of their day and enabled them to have better quality of sleep:

> *"It made me sleep better because I felt less stressed."* (10 years-old-dramatherapy)

> *"I try to relax for ten minutes before I go to bed and I sleep better than before."* (9 years-old-dance movement therapy)

Several children said they maintained this practice even three months later.

Empowerment

Children mentioned that the sessions that involved empowerment activities improved their self-esteem and self-confidence. This also became apparent through the arts-based methods, as described below. The empowerment activities that children found the most helpful was creating their dreamcatchers, exploring their "superpowers" and making their "boat of difficulties". In the "dreamcatchers" activity, children reflected on their dreams and hopes for the future, and how they can achieve them. One child said:

> *"My dream is to become a head teacher, that's the wish I wrote down on my dreamcatcher and I hope this dream will come true one day [. . .] to help other children feel good, take good grades, have fun at school and be fair."* (10 years-old-art therapy)

Pretending to be "superheroes" and reflecting on their "superpowers" made children feel "*special*" and "*confident*". When some children found it difficult to think of any "superpower", the rest of the team would help them realise what their strengths are, which also facilitated team building and collaboration between the group. As one child shared:

> *"I had a vision of myself as a volcano which has superpowers. When I'm angry, I look like the fire. When I'm calm, I look like the water. When I'm in the middle, I look like the clouds. I notice non-stop different things in my mind; water, fire, clouds . . . but most of the time I feel like the fire."* (10 years-old-art therapy)

In the "boats of difficulties" activity, children were provided with materials to make their own boats and were invited to put difficulties inside that they were dealing with, as well as past experiences or memories that they did not want to keep. All boats eventually came together and sailed away. A child expressed that "*it was a relief*" seeing his difficulties sailing away, but also that he realised that "*everyone has difficulties*". Another child mentioned that:

> *"When we were sharing the boat of our difficulties, I was thinking that things will get better and I felt better."* (9 years-old-art therapy)

Coping Mechanisms

Children referred to several coping mechanisms, with the most common being the development of patience, active listening, and the gradual control over the behavioural reactions that arise from uncomfortable situations. For example, one child acknowledged the lack of listening skills and sense of control over his feelings prior to the arts therapies:

> *"I used to be really angry, I wanted to destroy everything. I had never listened in my life, never. I couldn't even concentrate."* (10 years-old-art therapy)

Another child noted that as she became more patient, she experienced less conflicts with her siblings and they were able to develop a warmer relationship:

> *"I'm fighting less with my brothers, and I control my anger. I try not to respond immediately when something happens and take my own time when I need it."* (10 years-old-dance movement therapy)

There were also indications that some children started taking ownership over their emotions, behaviours, and actions:

> *"When I am frustrated, I know that there are better ways than being mad at other people when they haven't really done anything and it's not their fault."* (9 years-old-dramatherapy)

Perspective was another coping skill discussed by children. For example, some mentioned that arts therapies helped them to zoom out of what was not going well in their life, keeping a wider perspective and focusing on what was going well:

> *"I got to forget about all the bad things, or most of the bad things in my mind."* (9 years-old-dramatherapy)

Finally, some children mentioned that this sense of perspective and appreciation of the peer support they received during the sessions changed their attitude towards school:

> *"I feel happier coming to school."* (7 years-old-music therapy)

3.1.2. Unhelpful Elements of Arts Therapies for Children's Mental Health and Well-Being

The most unhelpful elements of the intervention that children expressed were a lack of time for tasks that they enjoyed; a lack of time to build group cohesion in groups in which it was lacking; and a small number of sessions, as well as a large number of children per group.

Lack of Time

Children expressed that they preferred to have less activities with adequate time to fully focus on each one, rather than rushing quickly from one activity to the other.

> *"I could spend hours, no, I could spend days in each craft we did. I didn't want to feel in a rush."* (8 years-old-art therapy)

However, they also mentioned that they did not want to spend the entire time on the same activity, because they felt that they were potentially missing out from other creative activities. For example, in music therapy, children would have liked to spend more time playing music and less time in the opening and closing group discussions. In dance movement therapy, children mentioned that, although they enjoyed the relaxation activities, they did not want it to last for too long because they were falling asleep and found it challenging going back to the class. Having one brief opening activity, one main and longer activity, and one brief closing activity appeared to be the ideal timeframe for most children to take advantage of the benefits of each activity.

Lack of Group Cohesion

On several occasions, the randomization led to creating groups with members that did not get along well with each other. When this was the case, children were unwilling to discuss or collaborate with each other, to resolve their conflicts, and to openly share with the rest of the group:

> *"I didn't feel comfortable to share around S, we fight a lot in the class and I can't concentrate when he is around."* (10 years-old-art therapy)

Even if their relationships were getting better over time, there were concerns as to whether things were actually resolved affected the children and their participation:

> *"It was when we did the mirroring that D said "I don't want to do this, I don't like that" but I think he just didn't want to be a partner with me [. . .] I didn't feel good about it."* (9 years-old-dance movement therapy)

Even though the arts therapists contained the group as a whole and held separate discussions with some children when needed, these circumstances affected the dynamic of the rest of the team and their experiences in the group:

> *"It was so annoying and frustrating when R and E were shouting at each other so loud that I couldn't focus for the rest of the time."* (10 years-old-dramatherapy)

Based on children's feedback, both the number of sessions and the number of children in each group should have been different, as described below.

Small Number of Sessions and High Number of Children

Eight sessions of arts therapies was a short amount of time for most children. At the peak of connection between the members of the group, the sessions were approaching the end. Several children expressed during the interviews that they wished to be better prepared for the end of the sessions, with weekly reminders right from the start. As some children expressed:

> *"I felt very sad because the sessions were over. I was crying without reason."* (9 years-old-dance movement therapy)

> *"I felt upset because I didn't want to let it go."* (7 years-old-music therapy)

Some children also expressed that, if each group had less children, they would have taken better advantage of the benefits that each session had to offer. They would have more time to work individually, as well as in a team, and they would potentially have time for more activities.

> *"I would prefer smaller numbers [of children], like five of us in each group."* (8 years-old-dance movement therapy)

Furthermore, the arts therapist's attention would not have to be divided between eight children. Considering the randomization method and the grouping of children who did not get along with each other, smaller groups would have made it more manageable for the arts therapists to contain the group and to facilitate the resolution of any tensions arising.

3.2. Children's Arts Work

3.2.1. Themes of Children's Arts Work

Significant changes were observed in children's emotional expression before and after arts therapies. Children expressed a wider range of emotions, and they appeared to be more comfortable sharing them not only visually through drawings, but also through sounds, movements, or gestures.

Prior to the intervention, the most common emotions and feelings that children shared were: (i) happiness (28 children); (ii) confusion (13 children); (iii) connectedness with people (9 children); and (iii) sadness (4 children). Seven out of 62 children preferred not to say how they felt.

Post-intervention arts-based data were collected by 56 (instead of 62) children because of six dropouts (Table 1). The most common emotions and feelings were: (i) happiness (23 children); (ii) mixed emotions (14 children); (iii) connectedness with people and places (8 children); (iv) excitement (6 children); (v) confidence (4 children); and (vi) calmness (3 children).

It was striking that, pre-intervention, 13 children shared that they felt confused or that they did not know how they felt. Post-intervention, however, this sense of confusion was replaced by an increased acknowledgment by 14 children that people can have mixed emotions and feelings that occur simultaneously. For example, many children mentioned that they felt "happy and tired", "happy and sad", "happy and excited and sleepy", or "so and so". One child added that "There is a little happiness in every anger, and a little anger in every happiness". As such, some children became less reluctant to own emotions that are often considered as negative, such as anger or sadness. For example, while pre-intervention all children who expressed sadness drew someone else (usually the person that makes them feel sad), post-intervention, all children drew themselves instead. Children appeared to have gained confidence in owning different kinds of emotions and accepting all feelings as normal.

Another noticeable difference was in the theme of "connectedness with people"; while pre-intervention most children drew family members, post-intervention they drew members of their arts therapy group. In fact, almost all drawings represented at least one group member, suggesting that some children had developed a sense of belonging, as well as trusting and supportive relationships with other team members.

3.2.2. Aesthetic Qualities of Children's Arts Work

Most children at the pre-intervention stage were very reluctant to use any of the provided musical instruments and materials, apart from the crayons, markers, and papers, potentially because children were more familiar with them. In addition, children did not know the researcher [ZM] at this time; therefore, sharing may have been challenging or even intimidating. In contrast, post-intervention, children used all the materials provided, including musical instruments, scarves, and fabrics. For example, one child wrapped a scarf around her body to express that she felt "calm and comfortable with myself" and that "this is the calmness that comes with satisfaction in life".

While pre-intervention all children chose to remain in the same position without moving around, many children post-intervention made use of the space confidently to communicate their emotions more clearly. Similar trends were observed in drawings; pre-intervention, children drew themselves very small, occupying only a small part of the paper, and usually being surrounded by others. However, post-intervention, they drew themselves bigger and taking most of the space on the paper or being on their own. In most drawings, there were details on faces and facial expressions; in some drawings, for

example, a smile was clearly marked and was sometimes bigger than the whole face. When the full body was illustrated in the drawings, the extension of the hands or other parts of the body were used to show the extent of that specific feeling; for example, long hands widely open were used to communicate the extent of happiness that children experience. These explanations were provided verbally by the children themselves.

Regarding children's drawings, the increased use of colours, the complexity of the characters, as well as the addition of things in the background to allow for a better understanding of the context, were noticeable. The metaphoric use of objects and symbols for self-expression was also observed, particularly in the post-intervention drawings of children who participated in the dramatherapy groups.

In terms of movements and gestures, children put a significant effort in expressing their emotions using their body, projecting less reluctance and more confidence. While pre-intervention children used mostly their facial expressions, post-intervention they used their whole body to show the degree or intensity of each feeling. Post-intervention children displayed higher intensity in their movements. For example, children expressed their confidence through raising their chests out of the rest of their body, extending the chin out of the face, and with their eyes looking up toward the sky. Making use of a strong weight and an increased sense of verticality, children rendered the classic stance of a "superhero" to show that they felt "confident", "strong", and "cool". It was also noticeable as to how children's synchronisation and harmony between emotions and movements had been significantly improved. Pre-intervention, children's movements or gestures lacked flow and were often not aligned to the emotions they were sharing. For example, verbal expressions of "happiness" were not visible or in harmony with their movements and facial expressions. Post-intervention, however, there was a clear flow and rhythm between the movement of the head, the arms, and the entire body, which aligned with the emotions that children were trying to convey. As such, verbal and non-verbal expressions appeared to be in harmony.

Similar changes were observed with children's sounds and musical productions. Children appeared to be moving from limited or unstable rhythmic freedom at the pre-intervention stage, towards a great extent of being or looking confident with this freedom. They moved from producing sounds chaotically toward a rather refined rhythm-making which mirrored their specific emotion. For example, drum beating became more emotional, calm, or cheerful, depending on how each child experienced the emotion of "happiness" and the way they preferred to convey it. Furthermore, children seemed to be moving towards rhythmic freedom as they did not hesitate to experiment with new rhythms and sounds and were not concerned about how the final product might sound.

4. Discussion

4.1. Overview of Findings

Children's interviews and arts work suggested that arts therapies facilitated self-expression, provided a safe space, empowered children, and supported the development of coping mechanisms. Engagement with the arts as a coping mechanism under difficult circumstances was highlighted, particularly in terms of expressing emotions and feelings which are complex and cannot be easily verbalised. These findings echo existing evidence on the importance of engagement with the arts as a non-verbal communication medium and crucial therapeutic element for children's mental health and well-being [22,46–49].

Another significant change was that children started accepting some challenging feelings and emotions as normal, such as anger or fear. This led not only to higher self-acceptance, but also to higher acceptance and understanding of others. The arts-based data also suggested that children became more conscious of the complexity of their emotions, for example that conflicting emotions (e.g., happiness and sadness) can often co-exist. Drawing upon humanistic and person-centred theories, safely accessing and expressing feelings can facilitate self-awareness and have cathartic effects [50,51]. Furthermore, some children were gradually taking more ownership of their emotions, behaviours and actions, and developed

an increased sense of self-control; both of which are key elements of the empowerment theory [52].

Children reflected on the positive feelings that they experienced during the arts therapies. Specifically, they mentioned that the sessions made them feel happier, safer, calmer, and that they enjoyed the sense of togetherness and belonging in the group. This is particularly important considering the distractions and interruptions that most groups faced. This suggests that, even though it might be challenging to ensure privacy in schools, a safe therapeutic environment and relationship can still be achieved with a mutual effort from the arts therapists, the school, and the participants.

The above findings link to the PERMA theory [53], according to which, the elements of Positive emotions, Engagement, Relationships, Meaning and Accomplishment act as enablers of well-being. Based on children's experiences and perspectives, it became explicit that arts therapies can enable all these elements. The findings also link to the self-determination and self-actualisation theory [54] according to which, well-being is dependent on the fulfilment of three core needs: agency, mastery, and relatedness. When these needs are met, children with these attributes can feel confident and assured in their ability to achieve their aspirations and fulfil their own potential (what is known as self-actualisation), whilst also maintaining positive and healthy relationships with others. As children said, arts therapies addressed all of these core needs.

There were, however, aspects that prevented children from getting all benefits that arts therapies have to offer. These aspects were spending too much or too little time on the same activity, lack of group cohesion, the small number of sessions and the high number of children per group. Below we provide some recommendations that could address these limitations in future research and practice.

4.2. Improving the Quality of Group Arts Therapies

Despite the advantages of providing arts therapies in school settings, there are inherent barriers that impede to the therapeutic work. For example, finding a private and safe space proved to be exceptionally difficult. The feasibility of privacy and confidentiality within educational environments has been frequently questioned [55], while also the school calendar is filled with holidays, school trips, ceremonies and activities that interfere with the flow of arts therapies. Most schools could not provide us with rooms appropriate for therapeutic use, an issue that has been commonly reported in other studies [56]. As a result, the sessions took take place in rooms intended for different purposes; for example, the dramatherapy sessions took place in a storeroom. This does not mean that schools are unsuitable spaces for therapeutic work, but the barriers need to be acknowledged and addressed insofar as possible. Although research suggests that there is a positive correlation between the arts therapists' satisfaction with the suitability of the therapeutic environment and the clients' outcome measures, this correlation might not be statistically significant [56], therefore the limitations in the therapeutic space might not significantly affect the therapeutic outcomes. The strategies below enabled us to improve the privacy and safety of the therapeutic environment and are strongly recommended.

The first recommendation is to deliver an arts therapies workshop to the parents or legal guardians and to the school staff prior to the beginning of the sessions. We did not deliver this workshop with the first cohort, but it became clear that the importance of a safe therapeutic environment was not fully understood; as a result, there were frequent interruptions during the sessions that interfered with the therapeutic process. When we delivered this workshop with the second cohort, we noticed a significant change in the school staff's attitudes towards protecting the therapeutic space and not interrupting unless in case of emergency.

The second recommendation is setting clear boundaries between the beginning and end of arts therapies through consistent rituals that provide children with time to transition from an educational to therapeutic environment, and vice versa. All sessions started and ended in the same way; a song, dance, movement or drawing that was a sign of welcoming

children in the group and ended with a similar activity as a closure. This method was also applied when interruptions or distractions occurred, as children needed again time to re-engage with the therapeutic process. Children expressed that this routine was important for their transition in and out of the therapeutic space and to prepare them for going back to class.

The third recommendation is to allow sufficient time for trusting relationships to evolve, particularly between the research team, the arts therapists, and the school staff. At the beginning of the intervention, some arts therapists were concerned that the school staff did not understand the importance of their work and did not protect the therapeutic space. However, even within a couple of weeks, the relationship between the arts therapists and school staff had evolved and made it easier to communicate each other's needs. For this reason, whenever possible, it is recommended that the interventions take place at schools which are already working or have worked in the past with arts therapists. Building longer collaborations may be the key in protecting therapeutic space. Regev et al. [55] also suggested that longer collaboration between arts therapists and teachers is the key for maximum impact of school-based arts therapies. Specifically, they found that arts therapists who collaborate with schools for long periods of time are more likely to have their own therapeutic space, and for the schools to invest in the materials and resources that are needed [55]. Moreover, a synthesis of trials in educational settings [57] found that the establishment of rapport and positive relationships between the research team and the school staff was among the most important retention facilitators that determined the feasibility of trials in schools.

Children recommended that there should be no more than six children per group, so that everyone can receive sufficient attention by the arts therapist, and more time for sharing. They also recommended that two more sessions would have been beneficial, and they would have liked to have weekly reminders about the remaining sessions right from the beginning, so that they can be mentally prepared for the sessions to reach their endpoint.

Most importantly, the randomization process led to shaping groups with members who did not get along well with each other, or their energy level was conflicting. This led to arguments that were challenging to resolve and reluctancy to share personal experiences and thoughts from the whole group. As a result, the group cohesion (or lack thereof) impacted significantly on both the therapeutic process and the therapeutic outcomes. A strategy worth considering in future experimental studies is seeking advice from the teachers as to how children should be clustered into groups following the randomization. This method could help to bring together children who get along with each other, protecting the therapeutic environment for the group as a whole. Alternatively, a pre-intervention group assessment would be crucial to determine whether the group has an adequate level of group cohesion. Finally, another solution could be the delivery of a one-to-one session with each child before their allocation into groups to understand whether some children would find it difficult working in a group, or whether they can handle sharing the arts therapist's attention. Although this strategy is not cost-effective, it could provide valuable insights as to whether groups are an appropriate form of therapy for some children and to minimise the risk of harm for the rest of the group.

4.3. Strenghts and Limitations

This pilot was developed based on two systematic reviews [40,41] which synthesized previous interventions that had been successfully implemented and assessed by children themselves, and it was informed by other evidence-based arts therapies protocols [42,58,59]. The therapeutic protocol and intervention were evaluated by children, arts therapists and the research team [20] and is expected to inform the development of future interventions in school-based arts therapies. The detailed description of the therapeutic protocol and its principles is expected to make this intervention replicable in future studies.

The implementation of quantitative, qualitative, and arts-based data helped to gain an in-depth understanding of the outcomes and process of arts therapies that comes purely from children's perspectives. To reduce power imbalances and misinterpretations of children's views, all tentative interpretations from the qualitative data were made available to children for member cross-checking. This helped to ensure that the findings represented children's viewpoints, contributing to the improvement of credibility and accuracy of the findings [60,61].

Despite the member cross-checking approach, it is possible that some children might have been hesitant to openly share whether they agreed with the initial interpretations and findings, or what they did not enjoy or find helpful about the intervention. In addition, cross-checking the findings from children's arts work was a rather perplexed process and the interpretation stems primarily by the researcher [ZM]. Therefore, there are limitations to the reliability of the arts-based findings. Since the intervention lasted approximately three months, and that the lead researcher [ZM] was present in every session as a participant observer, the relationship with the children became closer over time. This is potentially why we received more feedback on what worked well compared to what did not work well in this intervention.

5. Conclusions

Children verbally and artistically expressed that they experienced positive changes in their mental health and well-being, such as self-expression, safety, empowerment, hope, and optimism for the future. The arts were particularly important for expressing complex emotions and feelings that cannot be easily verbalised. These benefits were linked to humanistic theories [49,50], self-determination and self-actualisation theory [53], PERMA theory [52], and empowerment theory [51]. This study employed a novel approach to working with children, embracing all arts therapies as one research domain and setting children's verbal and non-verbal responses at the heart of outcome evaluation. This study also highlighted areas for improvement based on evidence grounded on children's perspectives. Redirecting the focus of research to encompass children's perspectives may result in better-informed policies and practices, encouraging decisions that are aligned to children's needs. The implementation of the recommendations discussed in this article may increase the benefits for children's health and well-being, as well as the wider recognition and inclusion of arts therapies in national and international health-related guidelines. This may be a crucial step for the survival and thriving of arts therapies in educational and healthcare systems worldwide.

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Article

Ultra-Orthodox Parents' Perceptions of Arts Therapies for Their Children

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Abstract: Studies have underscored the complexity of psychotherapy for Ultra-Orthodox Jews, and cross-cultural therapy in particular, which evokes fear of disruption of basic values. Parents' sense of responsibility for their child's religious education exacerbates these problems in child therapy. However, there is scant research on child therapy for the Ultra-Orthodox, especially in the field of arts therapies. The present study examined the perceptions of 17 Ultra-Orthodox parents whose children were receiving arts therapies (including art therapy, dance/movement therapy, music therapy, psychodrama and bibliotherapy). Semi-structured interviews were conducted with the parents and analyzed based on the principles of Consensual Qualitative Research. The study covered five domains: (1) The parents' experiences in therapy; (2) The parents' perceptions of the child's experiences in therapy; (3) Implications of environmental-social factors on the parents' perceptions and experiences of therapy; (4) Effects of intercultural aspects on therapy; (5) Perceptions of the use of the arts in therapy. The findings show that the experiences of ultra-Orthodox parents in the arts therapies of their children is complex due to the influence of the socio-cultural context, which involves dealing with stigma and tensions in their relationship with the education system. This context also shapes their perceptions of therapy, which can be characterized as purpose-oriented. The findings also highlight the parents' challenges in coping with the intercultural therapeutic relationship, and emphasizes the parents' preference for a therapist from a similar religious/cultural background and for cultural supervision of therapy. However, the results also suggest that there are benefits inherent to intercultural therapy in general and arts therapies in particular, including a sense of security, openness and acceptance of the parents and children.

Keywords: arts therapies; ultra-Orthodox Jews; children; intercultural therapy; parents' perceptions

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1. Introduction

Studies have underscored the effectiveness of arts therapies in treating a variety of difficulties [1,2], and suggest that arts therapies for children promote quality of life, reduce anxiety, and lead to improvement in self-perception, problem-solving skills, and emotional and behavioral problems [3]. In Israel, many arts therapists are employed by the education system [4] and most treatments provided through this system are delivered by arts therapists [5]. The primary reasons for referring children to art therapy in the educational setting are disruptive behavior, trauma, emotional difficulties and anxiety [6].

Despite the greater interest in arts therapies among the Jewish ultra-Orthodox in recent years [7], there is scant research on these therapies in general and in ultra-Orthodox children in particular. The few studies that have examined arts therapies for ultra-Orthodox children [7–9] have all focused on the therapists' perspective. To the best of our knowledge,

there are no studies dealing with the perspectives of ultra-Orthodox parents with respect to arts therapies for ultra-Orthodox children. Therefore, to expand and deepen current understandings of the complex phenomenon of arts therapies in ultra-Orthodox children from another point of view, and given the importance of parental involvement in child therapy [10], the present study examined the perceptions of ultra-Orthodox parents with respect to arts therapies with their children.

1.1. Ultra-Orthodox Jews

Ultra-Orthodox Jews constitute a distinct minority group in Jewish society in Israel and around the world, and are perceived as the most religious-conservative faction in Judaism [11]. As of 2021, the ultra-Orthodox population in Israel numbered about 1,226,000, constituting 12.9% of the total population. The ultra-Orthodox Jewish population in the world is estimated at 2,100,000, which is about 14% of the Jewish population in total. Most ultra-Orthodox Jews live in Israel. The second largest concentration is in the United States followed by the United Kingdom, Canada and other countries [12]. The ultra-Orthodox population is characterized by the fastest growth rate in developed countries, as a result of their young age at marriage and numbers of children. For these reasons, half of the Israeli ultra-Orthodox population are under 16 years old [13]. Ultra-Orthodox society is traditional, collective and patriarchal, and emphasizes faith in God and strict commitment to Jewish law, along with loyalty to the community and obedience to rabbinic authority [11,14]. It consists of three main factions: Hasidim, Lita'im (Lithuanians) and Sephardic Haredim, which differ in terms of their customs, leadership, educational institutions, appearance and other factors [15]. The Hasidim and the Lita'im are the two main factions in the ultra-Orthodox population in Israel, and most are of European descent. The Lita'im emphasize the value of learning the Torah more than the Hasidim, and consider excellence in religious studies to be a central criterion for determining social status. Lita'im are more modern in their lifestyles, clothing and occupations. In contrast, the Hasidic view emphasizes the hidden spiritual dimensions of reality. Unlike the Lita'im, many Hasidim speak Yiddish and start working for a living at an earlier age. Sephardic Haredim trace their origins to the Eastern Mediterranean [16]. Another group is composed of Baalei Teshuva; in other words, people who have shifted from a secular lifestyle to a religious/ultra-Orthodox lifestyle. Despite their opposition to a secular way of life [11], in the last two decades there has been a turning point in the integration of the ultra-Orthodox into Israeli society, which is reflected in the growing presence of ultra-Orthodox men and women in higher education and the labor market [13].

1.2. Ultra-Orthodox Children

Children are perceived as a tremendous blessing in the ultra-Orthodox community, and birth is the main goal of marriage [14]. Due to the rigid division of gender roles in ultra-Orthodox society, there are differences in the relationships between ultra-Orthodox fathers and mothers and their children, such that mothers tend to be responsible for the emotional aspects of raising their children while fathers focus on the intellectual and spiritual aspects [17]. Daughters become partners in child raising, in that they take care of their younger siblings from early childhood, and the entire community provides support to parents [18]. The ideal for ultra-Orthodox boys is to become "Talmidei Chakhamim" (students of sages, who are well-versed in Jewish law), while girls are expected to support and enable them to fulfill their vocation [18,19]. The self-identity of ultra-Orthodox children derives its meaning largely from belonging to the community [20]. Children and adolescents in the ultra-Orthodox community receive clear instructions as to what is allowed and what is forbidden, and they are expected to follow them [21], to constrain confusion, uncertainty, identity crises, search and self-discovery [22]. Compared to secular children, ultra-Orthodox children are required to display more maturity, independence and responsibility [23], and are expected to shape their desires according to God's will and commandments [22]. Norms, values and customs are conveyed to children through everyday

rituals, symbols and ceremonies that do not leave much space for self-expression. Cultural values and norms are woven into children's lives through stories, songs and games, which are a means of educating and socializing ultra-Orthodox children and strengthening their sense of belonging to their community [18,20].

1.3. Challenges in Therapy with Ultra-Orthodox Jews

In most cases, ultra-Orthodox adults and children are treated by arts therapists who are not ultra-Orthodox (a secular therapist or a therapist in another stream of Judaism), because there are few ultra-Orthodox graduates of academic training tracks in therapy. Thus, ultra-Orthodox therapy can be defined as intercultural therapy, where the intercultural differences refer not only to differences in ethnic background, but also to differences in religious affiliation [24]. Thus therapy also involves an epistemological difference between the traditional-collectivist value system that underlies the culture of ultra-Orthodox clients, and the Western value system on which psychotherapy is grounded [25]. Intercultural therapy involves dealing with differences in culture-bound values, socio-economic status and biases related to language and communicative style. Culturally diverse clients do not share most of the values and characteristics rooted in the goals and processes of therapy, and they may differ or be limited in emotional expressiveness, self-disclosure, openness and norms of intimacy [26]. Although there is now greater acceptance of psychotherapy and outside help, especially for children at risk [27], studies show that the intercultural gap still impacts the ultra-Orthodox encounter with psychotherapy and creates significant conflicts [28]. For example, ultra-Orthodox clients may experience a conflict between dealing with difficulties privately and autonomously within the community and seeking help from external sources [11], difficulty opening up about issues that are not culturally acceptable [29], expecting practical solutions that are limited to what is allowed and forbidden according to culture and religion [30], and fear of stigma that may lead to negative consequences for future matchmaking of the individual and other family members, the ability to get a job in the community, social ties, and integration in educational institutions [31,32]. In child therapy, these difficulties can be intensified for the ultra-Orthodox client's parents, who feel a sense of responsibility for the child's religious and spiritual education [33].

The few studies that have examined arts therapies for the ultra-Orthodox have noted other challenges that arise in this form of therapy. For instance, in a qualitative study based on interviews with 14 ultra-Orthodox art therapists and ultra-Orthodox adult clients, the interviewees described the clients' fear of forming a close relationship with the therapist. This was experienced as a childish need, leading to feelings of self-blame and to responses aimed at calming anxiety and blurring closeness, which prevented the development of the therapeutic relationship. The findings also indicated that clients found it difficult to share past experiences, failures, or negative feelings towards the therapist, and repressed negative emotions out of a desire to maintain confidentiality [34]. In another qualitative study which involved interviews with 17 non-Haredi arts therapists, the therapists described the difficulties experienced by ultra-Orthodox children in regulating emotional release, which was manifested in swings from restrained and held conduct to over-ramping resulting from a sense of emotional flooding. This study also highlight the predominant fear of exposure in therapy: children refrained from talking about their families and their parents avoided reporting essential content and sometimes even switched to ultra-Orthodox therapists [7]. In general, the participants emphasized that the encounter between art and religion/culture was complex and raised concerns about violating religious prohibitions. This led to careful avoidance of anything related to sexual content or playfulness [7,34]. In cases where the therapist was secular, there was fear that the treatment outcomes would be inconsistent with the ultra-Orthodox worldview. Thus, clients tended to screen the therapist's lifestyle and perceptions [34], which at times led to hesitation in establishing a therapeutic relationship or simply to dropping out [7]. However, the cultural gap can at times increase clients' sense of comfort and openness given the negligible likelihood of disclosure of complex issues to the ultra-Orthodox community [7,8]. The studies described above also indicate that arts

therapies can provide ultra-Orthodox clients with an indirect and less threatening way to express content that cannot be talked about elsewhere and a means of self-disclosure [7,8,34]. A case study on art therapy for an ultra-Orthodox child provided by a non-Orthodox therapist noted that the potential benefits of art therapy for ultra-Orthodox children include the possibility of expressing negative emotions in an indirect way, which reduces the children's fear of violating cultural norms, religious laws or tarnishing their good name. The author suggested that art therapy can give the ultra-Orthodox child some modicum of freedom of choice, beyond what is authorized in the community [8].

1.4. Parents' Perceptions of Their Children's Therapy

Various studies have focused on examining parents' perceptions of therapy for their children, since child therapy depends on the parents' consent, based on their assessment of the severity of the child's condition and the physical, economic and attitudinal barriers that may prompt parents to reject therapy [10]. A quantitative study that examined perceptions and attitudes toward therapy of 194 African American and Caucasian parents found that parents who perceived fewer barriers and had more positive attitudes toward receiving therapy for themselves also manifested more positive attitudes toward therapy for their children [35]. A quantitative study that examined the perceptions of 122 mothers from different ethnic backgrounds (European-American, African American and Latino) found that mothers' fears of being forced to do or say things against their will and their fear of criticism predicated their intentions to reject therapy for their children [36]. Another quantitative study, in which 405 parents filled out questionnaires as part of an outpatient treatment service for children's aggressive and antisocial behaviors, found that parents' expectations predicted barriers to participation in therapy and dropping out of therapy prematurely, and were influenced by socioeconomic status, belonging to a minority group, and parental stress [37]. A quantitative study on parents of 222 children with increased anxiety symptoms [38], as well as a qualitative study in which six mothers of children with behavioral disorders were interviewed [39], reported that fear of stigma and negative consequences was a significant barrier to the decision to authorize therapy for their children [38,39]. In terms of gender differences, in a quantitative study of 89 Indian parents, mothers reported greater openness to therapy for their children than fathers [40].

Few studies have examined the perceptions of ultra-Orthodox parents, all of which have implemented a qualitative approach and mainly used interviews. These works have focused on examining the perceptions of ultra-Orthodox parents towards child-raising as related to their mental well-being (including parental love and corporal punishment) [41,42], and their perceptions and reactions to situations of risk and harm to children [43], such as a study that examined drawings and the short narratives of 21 ultra-Orthodox mothers on the topic of publicly revealing their children's sexual abuse [44]. Some of these studies suggest that the differences in perceptions between the ultra-Orthodox parents and the non-Orthodox professionals may have affected their relationship and led to parental fear of possible dangers of the intervention and a preference to get help from within the community [42,43]. The study that has come closest to examining ultra-Orthodox parents' perceptions of therapy interviewed 21 ultra-Orthodox mothers and fathers in Antwerp, Belgium on their help-seeking behaviors. The findings showed the importance the parents attributed to the educational system, their preference for non-conventional treatment, and their fear of labeling and spiritual erosion [33]. However, no studies have been conducted on the perceptions of ultra-Orthodox parents towards arts therapies for their children. Since the few studies that have examined arts therapies in ultra-Orthodox children have dealt with the therapists' point of view alone, and in light of the importance of parental engagement in child therapy [10,36,37], the current study explored the following research question: How do ultra-Orthodox parents perceive arts therapies for their children?

2. Materials and Methods

2.1. Participants

Seventeen ultra-Orthodox parents whose children were receiving arts therapies participated in this study (12 mothers and five fathers). The parents ranged in age from 29 to 54; one parent did not provide information on his age (M = 37.5, SD = 7.13). Most lived in northern Israel in the Haifa region (13 parents), and the remainder lived in the center of the country (two parents), the Jerusalem area (one parent), or in the south (one parent). The sample represented all the ultra-Orthodox streams, including Hasidim (seven parents), Lita'im (seven parents), Sephardic Haredim (one parent) and Baalei Teshuva (two parents). The parents had between 1 and 8 children (M = 5, SD = 1.81). Three of the interviewees had more than one child receiving therapy (2–4 children in treatment).

The 13 boys and nine girls in therapy ranged in age from 3 to 14 at the time they started therapy (M = 7.3, SD = 2.74); the age of one child was not indicated. The duration of therapy for each child ranged from 6 to 60 months (M = 24.5, SD = 14.8). They were receiving visual art therapy (10 children), dance/movement therapy (four children), bibliotherapy (four children), music therapy (two children) and psychodrama (two children). Therapy took place in an ultra-Orthodox institution (19 children), a school (one child), a public clinic (one child) and private clinic (one child). Of the therapists who provided arts therapies for the children, 12 were secular, seven were Religious-Zionist and three were ultra-Orthodox (see Table 1 for general data, designed to preserve anonymity).

Table 1. Demographics.

Parent Gender	Parent Age Range	Number of Children in the Family	Faction	Client Gender	Age of the Client When Receiving Therapy (in 5-Year Age Brackets)	Months of Therapy	Type of Therapy	Therapeutic Setting	Religious Affiliation of the Therapist
Male	31–40	8	Hasidim	Girl	6–10	13–24	Bibliotherapy	Public clinic	Religious Zionist
Male	51–60	5	Hasidim	Boy	–	37–48	Visual art	Haredi institution	Secular
Male	31–40	3	Lita'im	Boy	1–5	1–12	Visual art	Haredi institution	Secular
Male	31–40	4	Lita'im	Girl	1–5	1–12	Music	Haredi institution	Ultra-Orthodox
Male	21–30	4	Sephardic Haredim	Boy	1–5	13–24	Visual art	Haredi institution	Secular
Female	21–30	4	Lita'im	Boy	1–5	25–36	Dance/ movement	Haredi institution	Secular
Female	31–40	7	Hasidim	Girl	11–15	13–24	Psychodrama	Haredi institution	Religious Zionist
Female	41–50	5	Baalei Teshuva	Girl	6–10	37–48	Dance/ movement	Haredi institution	Secular
				Boy	6–10	25–36	Psychodrama		Religious Zionist
Female	31–40	1	Lita'im	Boy	6–10	25–36	Visual art	Haredi institution	Religious Zionist
Female	-	7	Hasidim	Boy	11–15	1–12	Visual art	Haredi institution	Religious Zionist
Female	31–40	8	Lita'im	Boy	6–10	13–24	Visual art	Private clinic	Religious Zionist
Female	21–30	4	Lita'im	Girl	6–10	1–12	Dance/ movement	Haredi institution	Secular
Female	41–50	5	Hasidim	Boy	6–10	25–36	Visual art	Haredi institution	Secular
Female	31–40	5	Lita'im	Boy	6–10	13–24	Music	Haredi institution	Ultra-Orthodox
Female	31–40	4	Hasidim	Girl	6–10	49–60	Visual art	School	Ultra-Orthodox
Female	31–40	6	Hasidim	Girl	11–15	1–12	Visual art	Haredi institution	Secular
				Girl	6–10	1–12	Bibliotherapy		Secular
				Boy	6–10	13–24	Bibliotherapy		Secular
				Boy	1–5	13–24	Visual art		Secular
Female	31–40	6	Baalei Teshuva	Boy	1–5	1–12	Dance/ movement	Haredi institution	Religious Zionist
				Girl	1-5	1-12	Bibliotherapy		Secular

According to the parents' reports, the children were referred for one or more of the following problems: emotional problems manifested in frustration, low self-confidence and anxiety (11 children), behavioral problems including outbursts of anger, difficulty in accepting boundaries and violence (10 children), social problems including maladaptive social behavior and loneliness (seven children), learning disabilities (four children), ADHD (three children) and communication disorders (two children). The referrals were made on the parents' personal initiative (eight parents), the educational system (five parents), or professionals such as psychologists, family doctors or social workers (three parents).

2.2. Procedure and Ethics

Arugot is a therapy center for ultra-Orthodox children located in the north of Israel, run by members of the ultra-Orthodox community and rabbinic figures, although most of the arts therapists are not ultra-Orthodox. The Arugot Institute staff contacted parents whose children were receiving arts therapies at the institution. Parents who expressed interest in participating in the study contacted the first author. These parents received explanatory and consent forms via e-mail, in which it was clarified that they were not obligated to participate in the study, and that they could withdraw at any stage, without repercussions on their children's therapy in any way. They were also guaranteed that their identity would remain confidential throughout the stages of the research and the publication of the results. Thirteen parents agreed to be interviewed. Simultaneously, an ad was posted on WhatsApp to specific groups. This led to the recruitment of four more parents who contacted the first author for further details. These parents also received explanatory and consent forms via e-mail. The interviews took place between October 2020 and December 2020. Each interview lasted about an hour. Due to the outbreak of COVID-19, all interviews were conducted over the phone. All parents received the equivalent of $30 as compensation for their time. The interviews were recorded and transcribed after securing the participants' consent. All identifying details were deleted after the interviews were transcribed, and the recordings were destroyed after the transcription. This study was approved by the Ethics Committee of the Faculty of Social Welfare and Health Sciences at the University of Haifa (278/19). The approval was first received on 28 July 2019 and updated on 19 December 2020.

2.3. Data Collection

Semi-structured in-depth interviews with the mothers were conducted by the first author, who is a woman, and with the fathers by the fourth author, who is a man, to foster comfort and openness among the interviewees, and out of sensitivity for the gender division that is the norm among the ultra-Orthodox. The interviewers used an interview guide composed of open-ended questions (see Appendix A). The parents were asked about their perception of the arts therapies their children were receiving. The interviews covered three main foci: (1) The parents' experiences of their child's therapy: the goals of the therapy, core components, central dilemmas, implications for the decision to seek treatment; (2) perception of arts therapies: the role and qualities of the arts in therapy, the relationship between the arts and culture and religion; (3) intercultural therapy: the importance of the cultural/religious background of the therapist, the effect of this background on the therapy, advantages and disadvantages of similarities and differences in culture. The interview guide was formulated based on the literature, as well as our experience of the research context [45]. Drawing on a previous study in which arts therapists working with ultra-Orthodox children were interviewed [7], the interview guide was adapted for interviews with ultra-Orthodox parents. To ensure that the questions were formulated asked in a non-biased and non-leading way, descriptive and comprehensive questions were used. Then, to gain a more in-depth understanding, probes were used, such as requests to give an example and rephrasing of the participants' responses for confirmation.

2.4. Researchers' Lenses and Biases

All four authors are therapists: the first three authors are art therapists and the fourth author is a social worker. The second and third authors are secular. Both interviewers—the first author and the fourth author—identify as Religious-Zionists with no previous personal or professional relationships with the participants. The religious/cultural affiliation of the interviewers was not explicitly stated to the interviewees, but was indicated if asked. Nevertheless, it can be assumed that the religious affiliation of the interviewers had an impact on the exchange, due to the natural use of shared concepts and expressions. The range of observance of the authors provided a balance, where the more observant authors could provide grounding in concepts without a cultural affiliation which could have biased the interpretation, whereas the secular authors could provide a more external perspective on the findings. All the authors were thus cognizant of the possible impact of their own lived experiences, which helped ensure results that were not biased. Although the authors' cultural/religious backgrounds were different, they approached the interviewees and the data analysis process with an awareness of intercultural differences, with the excitement that accompanies such an encounter, curiosity to hear and learn, and with the desire to understand the participants' experiences while striving for cultural humility [46].

2.5. Data Analysis

The research method and data analysis adhered to the principles of Consensual Qualitative Research (CQR), which is based on phenomenological elements whose purpose is an in-depth observation of the experiences and subjective perceptions of the participants, while striving for a consensus by a team of researchers [47]. The method was developed in the field of psychotherapy research [48], and is therefore common in research on counseling and therapy processes [49,50]. This method is considered very effective in researching topics that have not yet been studied or that are not sufficiently theoretically based [36]. Therefore, this method is used in relatively new research fields such as arts therapies [51], and in particular in the study of arts therapies for the ultra-Orthodox [7].

In the first stage of data analysis, three interviews were analyzed separately by the first three authors, who are researchers and art therapists, to identify the central domains that emerged from the data in each of the interviews. Then, the three authors met to reach a consensus on the definition of the central domains of the three interviews (cross-analysis). Subsequently, the first author analyzed the rest of the interviews, by dividing them into the agreed domains and making adjustments for new material if necessary. In the next stage, the researchers went through the material associated with each domain separately, defined the core ideas in each domain, and then they met for a discussion to reach a consensus. The prevalence of the core ideas in the Results section is characterized as follows: the term "most parents" is used to describe a phenomenon that was identified in over 75% of all interviews, that is, in 13 or more parents; the term "some parents" describes a prevalence in 25–75% of all interviews, that is, between five to 12 parents; and the term "a few parents" describes a prevalence of less than 25% of the cases, that is, four parents or less [47].

2.6. Trustworthiness of the Study

Since transparency is a significant aspect of trustworthiness, the research process is reported in detail, so that the process can be replicated in other studies [52]. The relevant background on the authors was provided above. Because ensuring credibility is particularly important for establishing trustworthiness, the authors furthered their prior acquaintance with the culture of the participants and, as mentioned, an established research method was chosen, that is appropriate for the study of the phenomenon and has been used previously in studies of a similar nature [53]. In order to increase credibility, investigator triangulation was also carried out, in the form of data analysis in a team [52]. For an honest response from the participants, it was made clear to them that their sincere position was important and that there were no right or wrong answers in the study. As mentioned, there was a gender match between the interviewer and the interviewee to contribute to feelings of

comfort and openness. The interviewees were given the right to refuse participation and withdraw at any stage, and it was made clear to them that their privacy would be fully preserved so that they should not feel afraid to express themselves, and that the information they provided would be as reliable as possible [53]. Conducting the interviews over the phone helped increase reliability, as this technique enabled the participation of individuals belonging to different factions in ultra-Orthodox society, who most likely would not have participated if it had been a face-to-face interview, which would have resulted in narrowing the population participating in the study [54]. The questions asked were open-ended while avoiding the expression of attitude, opinion or presupposition, so that the interviewees would tell their story in a way that was not biased or dictated [55]. However, we decided against member checks to avoid bothering the participants, whose access and recruitment were complex.

3. Results

3.1. The Parents' Experiences in Therapy

3.1.1. The Parents' Relationship with the Therapist Was Seen by Them as Important

The findings indicated that most parents understood the importance of their relationship with the therapist and perceived it as a key to the success and continuation of therapy: "You cannot separate yourself from it. It will not work. Must cooperate". As for their expectations from their relationship with the therapist, some of the parents emphasized that their main goal was to understand the therapeutic process and the child who was receiving therapy. These parents hoped to better understand how the therapist sees and understands what is happening in therapy and its continuation, as well as the reasons for the child's challenging behaviors and inner world: "A little explanation of mental activity, I'm very interested in what causes what, and why it happens". In addition, a few parents said they wanted practical tools from the therapist on ways to cope, especially in difficult situations: "How to deal with conflicts that arise all the time, how to manage them".

The descriptions of some of the parents suggested that although both spouses were involved to some extent in the relationship, the mothers were more so. Some parents received parental guidance, and a few called the therapist on the phone in times of crisis, and took part in dyadic therapy. Most parents' expectations concerning their relationship with the therapist appear to have been met. Some parents talked about the guidance they received from the therapist about their conduct at home and with the child, which included instructions and concrete tools for coping. They also described the explanations the therapist gave them about their child's behavior and the therapy process. Some parents emphasized that rather than getting advice, the sessions with the therapist often involved providing more information about the child's life: "She devoted a lot of time to the things I feel because I am with him most of the time, and sometimes we know what is good for the child and what is not".

3.1.2. Along with the Parents' Positive Feelings towards the Therapist, Ruptures Sometimes Appeared in the Parents' Relationship with Her

Some parents brought up things that impeded their ability to be involved in the relationship with the therapist, including the burden of raising children and having to work, the financial strain caused by the cost of the meetings and COVID-related social distancing measures. Despite their positive perception of the therapist, including a strong sense of trust, the therapist's professionalism and empathy, containment, devotion and avoidance of judgment, at times there were conflicts. For example, even in cases where a good relationship had developed between the parents and the therapist, they sometimes found it difficult to follow the steps that had been suggested in parental guidance: "It was something that was between me and her all the time, she told me to loosen up and I was constantly stressed". Some of the parents criticized the therapist. They felt they were being disrespected as parents, that they were being watched, or pushed too much: "I felt really bad there. I felt I have no connection, I don't understand her, she asks about things that are

difficult to talk about and she doesn't understand that". These same parents criticized the therapist's approach and avoidance of in-depth work that could include a painful reflection for the child: "I wanted to tell her—deal with it, like, you're the therapist. I think she gave up to him". A few parents requested termination and referral to a different therapist, which they considered a trivial move: "I asked for a replacement. Nothing happened".

3.1.3. The Parents Expected Perceptible Results but Some Understood That This Is a Complex Process

Some parents attached considerable importance to the success of therapy, and wanted the therapy to lead to concrete results, including targeted behavioral improvement (such as better discipline and respect of boundaries, the ability to delay gratification and less anxiety), as well as more self-confidence, self-expression and flexibility. These parents wanted quick results and explained that simply having their child enjoy therapy was not enough; rather, significant work should be done and that the sessions should be well-utilized: "It's important to me that they don't waste their time. It's important to me that the therapy be exhaustive". These parents expressed frustration when they felt that the therapy had stalled and was not leading to noticeable progress, and at times terminated therapy if there were no tangible results after a plateau period: "Of course you don't expect 100% success at first. You go to the five or six next sessions. If there is an improvement then you say—Okay, it's worth continuing. If not, no". At the same time, some parents stated that although they aimed for results, they came to realize that this process would not necessarily lead to "correction" of the difficulty: "It's a process. It's something you understand more and more over time. On the one hand, you want results in the here and now, but it doesn't work. It doesn't make sense either".

To make therapy a success, some parents said that they encouraged their children to share their worlds and feelings, out of the understanding that this is the only way therapeutic work can be done: "If you don't really come to work and share, then why are you here? It's a waste of time. There won't really be work on the essential needs". Some parents explained that for therapy to be a success, they avoided interfering in the therapy process, and did not impose restrictions on content allowed in therapy, even if this was not to their liking. Only one mother described a significant intervention in therapy, including restrictions on conversation and a requirement that the therapist's suggestions be approved by the parents: "I told her what she could talk about and what not".

3.1.4. Parents Felt That Therapy Enhanced Their Understanding of the Child and Their Parenting, and Led to an Improvement in Family Relations

Some parents described how the therapy contributed to their understanding of the child, the reasons underlying behaviors and the best ways to deal with this child. In their view, this made their dealings with the child easier and improved their relationship: "Thanks to therapy I began understand my son. I saw him differently. And then I had a much easier time with him". A few parents stated that the change in their conduct as parents and the advice they had been given led to an improvement in their lifestyle at home and had a positive effect on the relationship between all family members: "It contributes a lot to the building of the bond between the brothers, to the bonds between the parents and the children. Our perspective as parents is different". A few parents discussed the realization that they were contributing to their child's challenging behavior, and the need to go through a process of change themselves: "You first need to address the root of the problem. When the tree is sick, if you treat the branches and the root is still diseased it will not help". However, despite understanding their effect, and even in cases where the therapist recommended that the parents consider therapy themselves, a few parents admitted that they did not intend to do so: "They wanted us to go to therapy as parents. But we already have too much to do, we don't have the energy".

3.1.5. Most Parents Perceived the Therapy as Effective, although Some Were Dissatisfied

Most parents stated that there had been improvement after therapy. Some parents only described a partial improvement—"really small, minor benefits", whereas others reported an improvement which only emerged gradually over time: "Sometimes it doesn't seem that impactful, but over time you realize that it works". Certain parents described a substantial improvement: "She saved the girl. She supported her in an unusual way". However, a few parents stated that despite the improvement, the initial reason for consulting was only partially resolved or at times remained unresolved: "Shall I say there is no problem? Has this been fixed? Is it behind us? Certainly not". Similarly, a few parents were unsure why the improvement had taken place and did not necessarily ascribe it to therapy: "I don't know if I can attribute it to the therapy or if he just got older". A few parents stated that they could not point to any change that occurred in their child as a result of therapy.

Mixed perceptions also appeared in the parents' satisfaction with arts therapies. A few parents stated that they were satisfied with their choice of this type of therapy, even when they initially hesitated about its effectiveness: "I had doubts about whether it was enough. I saw it worked". A few other parents criticized the type of therapy their child received: "I think more is possible" and argued that more was needed beyond the child's enjoyment of the sessions and that no in-depth work had been done on content and issues significant to the child: "I was frustrated when I saw that things weren't moving, it made me wonder whether art therapy really is something that works".

3.2. Parents' Perceptions of the Child's Experiences in Therapy

3.2.1. The Therapy Was Significant for the Child and Provided a Sense of Success and Enjoyment

Some parents considered that their child had a very positive experience in therapy. These parents described the bond between the child and the therapist as characterized by trust. They also highlighted the importance their child attached to therapy, which was reflected in the children's high attendance rate, taking public transportation on their own to go to therapy, sadness if a session was cancelled, and the children's attempts to contact the therapist even after the end of therapy. These parents also mentioned the satisfaction, the feeling of success and the enjoyment that the children derived from art making: "She felt comfortable there so that's what made her continue. If she wasn't enjoying herself, she wouldn't want to continue".

3.2.2. At Times Therapy Elicited Conflict and Resistance in the Child

Some parents stated that their child initially did not want to engage in therapy, which they ascribed to suspicion of the therapist as a result of a history saturated with diagnoses and treatments. This resistance was expressed in refusals to go to therapy: "She just voted with her feet. She did not cooperate. She did not want any treatment". Some parents noted that even during therapy their child had to deal with difficulties, including the stigma considering that therapy is intended for crazy and problematic children. This caused the children to hide the therapy from their friends, try not to be seen going to therapy, and to resent the mutual transfer of information between the therapist and the educational system: "She really hid it, she didn't want anyone to know. She took it as something that is only for people who have problems, not for ordinary people". Some children had trouble sharing content from their world or feelings during therapy: "He was not ready to talk about what he was going through".

3.2.3. Establishing the Therapeutic Relationship Emerged as a Complex Process, Whose Success Depended on the Therapist's Professionalism and Positive Character Traits

Some parents described the building of the relationship between the therapist and the child as a long, gradual, complex process: "There were many ups and downs, there were crises". Some parents explained that to build the relationship, the therapist gave the client control and the right to choose: "She didn't decide for her. She didn't tell her come

on this day at this time [but] 'I'm waiting for you and if you choose I'm here for you". These parents also emphasized the therapist's strictness about the setting and the rules of therapy: "Consistency. Stability. She gave him the feeling that the sessions were very important and time is very valuable". These parents primarily described the therapist's qualities and characteristics which they believed helped establish the relationship with the child, such as empathy, eliciting enthusiasm from the child and focusing on strengths and positive actions.

3.3. Implications of Environmental-Social Factors on the Parents' Perceptions and Experiences of Therapy

3.3.1. Dealing with Stigma

Some parents stated explicitly that among the ultra-Orthodox, anything that deviates from the norm is stigmatized, including therapy. These parents explained that the fear of stigma leads to concealment: "Trying to sweep under the rug or embellish things", so that severe and complex issues, such as sexual abuse, are not disclosed outside the community or even outside the family. These parents noted that among the ultra-Orthodox there is a widespread perception that therapy is for people with problems and for the insane. In their view, the concealment stems from a fear of tarnishing the good name of the child and the family, and damaging matchmaking—which is of crucial importance for the ultra-Orthodox: "People are afraid of matchmaking. Life is driven by matchmaking. What others will say, what they will see". A few parents insisted however that there has been a change in the ultra-Orthodox perception of therapy and stated that alongside changes in the relationship between parents and children, getting professional therapy for children has also become more acceptable in the ultra-Orthodox community and is often perceived positively: "Most people today prefer to open things up. Our parents were a little distant from us. We are closer. The world is changing".

Some parents said that stigma prompted them to hide therapy from their community: "It was very important to me that no one would know". A few parents even sided with the view that therapy indicates problematic behavior and oddness. By contrast, some other parents emphasized that they strongly opposed social stigma: "When I can, I refute this injustice that is done to children for the sake of phony respect and because of the stigma". These parents supported therapy and explained that their position stemmed from making the child's well-being a priority: "First of all, I want the best for my children, I don't look at what others think of me". Nevertheless, even parents who opposed the stigma believed that they do not represent the majority in the ultra-Orthodox community, since most of them described what set them apart from mainstream ultra-Orthodoxy, for example, working in the fields of aid and welfare, their Anglo-Saxon backgrounds, or being Baalei Teshuva, which helped explain "maybe that's why it seems different to me".

Parental attitudes towards social stigma affected their conduct with their children toward therapy and the explanation they gave to their children for going to therapy. For instance, some parents whose attitude was characterized by criticism of stigma and concealment clearly explained the therapeutic process to their child (even without explicit use of the word "therapy"), by describing the therapy as a place where the child would work on feelings and difficulties, for a better future: "We gave her the feeling that it was the right thing for her". The few parents whose attitude was characterized by concealment and fear of stigma were reluctant to be transparent and did not tell their child about the role of therapy, fearing that this would lead to a negative self-concept: "We never talked about it with him, I'm afraid to say something that would sound bad to him. You cannot give the child the feeling that something is damaged". Instead, these parents chose to emphasize the enjoyment of therapy, calling the sessions "classes": "He goes to class, it's not therapy—which is problematic". These parents noted the importance of getting therapy at an early age, before the child understands and absorbs the stigma: "We took him at an early age because later it is more difficult, the child understands that he is actually problematic, he is undergoing therapy, which makes him strange".

3.3.2. The Relationship between the Parents and the Therapist with the Ultra-Orthodox Education System Emerged as Complex but Very Meaningful for the Parents

Some parents claimed that the ultra-Orthodox education system, which in their opinion has a significant impact on therapy, is not adapted to contain emotional difficulties. They explained that most teachers concentrate on learning, and if a student has problems the teachers usually expect medical treatment or parental guidance in an external setting: "'I don't know what to do, he jitters all the time, give him some Ritalin'. That's how rabbis talk". These teachers tend to take a behavioral approach—"They use practical language. They want results", and cooperation between teachers and parents or therapists is rare. According to these parents, the help that the school offers in the case of emotional difficulties usually includes referral to an educational counselor, the school psychologist or remedial teaching. Parents tend to request arts therapies: "This was not the school's suggestion. I came up with the idea of art therapy and they were a little shocked".

A few parents emphasized that there is a connection between academic success and the child's emotional state. These parents explained that educational gaps lead to frustration and damage to self-concept, and therefore affect the child's behavior, as well as conduct in interpersonal relationships and can account for somatic reactions. In their opinion, therapy can promote academic success by strengthening the child's self-confidence. One parent noted that academic proficiency is crucially important among the ultra-Orthodox, since it shapes and influences the child's future in terms of the family (a "good" marriage) and socially: "In good a yeshiva [i.e., school for higher religious education for boys] there are good guys, in the less good Yeshivas the students are kids who dropped out. It's terribly dangerous".

The tension between the importance of academic success and the system's attitude towards emotional difficulties and therapy places parents in a complex situation. A few parents described feeling disappointed, hurt and exhausted, and a few other parents stated that they avoided disclosing the therapy to the educational system: "I was mainly worried about the school. You don't want him to be labeled as problematic now". While a few parents described explicit communication with the school system, a few other parents described how the therapist helped them be in contact with the school, including a briefing from the therapist to lay the groundwork for dialogue with the educational staff or a direct, defensive stance on the part of the therapist: "She stood by us throughout this process and talked to the principal and the educational counselor". However, it is important to note that these parents were referring to an ultra-Orthodox therapist, since in their view they are the only ones who can understand the conflict and the steps required to deal with the education system: "When you know the material, you know how to give good advice, who to talk to".

Nonetheless, some parents said that even in cases where the therapist was not ultra-Orthodox, she contacted the educational staff, sometimes in a routine and regular manner and sometimes when a problem came to the surface in therapy or in the classroom. A few parents stated that this was the only way the therapist can see the child as a whole and understand social functioning, and explained that ongoing contact between the therapist and the educational system optimizes the therapeutic process: "I think the secret of success is real cooperation between the parties who take care of the child, the school and the parents". According to a few parents, in their cases the therapist's attempts to contact the system failed. In a few rare cases the teacher initiated and maintained the relationship with the therapist.

3.4. Effects of Intercultural Aspects on Therapy

3.4.1. Cultural/Religious Differences between the Therapist and the Client Elicited Reactions Related to Dealing with the Difference, but Was Accepted for the Benefit of the Client

Some parents described their children's reactions in cases where the therapist was not ultra-Orthodox. These included the children asking the therapist or the parents about the therapist's dress code or the child explaining to the therapist about key cultural and

religious elements. At the same time, most parents stated that the cultural difference did not bother them, and emphasized the importance of the therapist's professionalism. These parents explained that the child's welfare was prioritized over cultural differences: "For me, it was a price I was willing to pay, so that my son would have a little easier time".

Some parents stated that the best way to deal with the differences in religious observance between them and the therapist was to explain the difficulties that derive from the disparity. Most of these parents stated that they went about explaining politely, but a few took a more interventionist approach which was manifested by their presence during the sessions to monitor and warn the therapist when what was happening did not conform to the family's norms. A few parents mediated the issue of religious difference with their children, for example by explaining that the main thing is that the therapist was good, while clarifying the difference: "It's them and it's not us. We are different and that's okay".

3.4.2. Most Parents Preferred an Ultra-Orthodox or Religious Therapist, but Some Compromised on Therapy from a Secular Therapist in an Ultra-Orthodox Setting

Most parents stated that if they had a choice, they would prefer a therapist from an ultra-Orthodox/religious background: "If not ultra-Orthodox, at least religious". They explained that they compromised when agreeing to therapy from a secular therapist since the sessions took place in an ultra-Orthodox institution: "It was important to me that the environment be ultra-Orthodox".

Some parents explained that they needed to be sure that the therapist would respect the cultural norms and the content that may come up in the therapy, and would not express overt or covert criticism of the parents: "I feel safer in terms of the attitude, the content, taking a more guarded approach". A few parents explained that an ultra-Orthodox/religious therapist is able to understand life in the ultra-Orthodox world and the meanings, consequences and nuances which require appropriate consideration in therapy: "There is a difference between a secular child who is in therapy and an ultra-Orthodox child, in terms of needs, difficulties or certain things at home that a therapist with a religious lifestyle can understand better". A few parents mentioned that children bond better with a therapist with a similar religious/cultural background, since the similarity of speech, dress code and set of values increases their sense of security and closeness: "It is easier for our daughter to connect with people like us". A few parents stated that an ultra-Orthodox/religious therapist can be a significant figure in their child's life, since the therapist corresponds to the values they want to impart to their child. Nevertheless, one mother said that a secular therapist was preferable to a non-Orthodox but religious therapist, because sometimes the similarity in religious beliefs (without similarities in cultural affiliation) may lead to complacence, arrogance or wrangling on the part of the therapist.

Some parents explained that if there is no ultra-Orthodox/religious therapist available, therapy should still take place under an ultra-Orthodox setting (such as an institution managed by ultra-Orthodox staff), since the ultra-Orthodox staff can provide guidance to secular therapists on the nuances and terminology, explain what is permitted and prohibited among the ultra-Orthodox, and provide guidance in terms of conduct and content. A few parents mentioned that an ultra-Orthodox setting is advantageous because it can supervise the conduct of secular therapists (including requirements for appropriate clothing and language) and the content that arises in therapy, so that there will be no exposure to content that does not fit with the spirit and values of ultra-Orthodox society: "There is some kind of filter and explanatory system so that there will be no offensive content". A few parents stated that therapy in an ultra-Orthodox setting increases their sense of belonging and reduces their feeling of being criticized: "It feels like a safer place to put the child, a place that accepts us".

3.4.3. The Parents Feared a Lack of Understanding by Secular Therapists That Could Undermine Their Children's Religious Education, and Therefore Requested Restrictions Adapted to the Cultural Norms

Some parents expressed concerns that a secular therapist would show a lack of understanding of their world, including customs, concepts and nuances, the educational system, the lifestyle of ultra-Orthodox society, and the set of values and cultural norms that underlie them. They felt that a lack of understanding on the part of the therapist could make therapy less effective: "If she doesn't understand all the nuances, it's less effective". These parents added that the therapist's lack of understanding could impede the child's ability to bond and benefit from the therapist: "This raises many questions for the child. It can undermine trust". Some parents feared that a secular therapist would have negative attitudes towards the ultra-Orthodox, such as disrespect, arrogance and criticism towards their behavior as parents, their way of life and their way of thinking: "I don't want anything unwelcoming to infiltrate therapy. Criticism can be suppressed". Some parents also expressed the fear of exposing their children to prohibited or unacceptable content, which would endanger their children's Torah and moral education after therapy: "I don't want the children to hear things that we would not want them to hear, that there will be no harm in the therapy". These parents emphasized that ultra-Orthodox children are under guidance and supervision: "The ultra-Orthodox child has explicit rules about what is permitted and what is not. The therapists need to be careful not to touch on these topics, not to discuss topics s/he is not familiar with". These parents explained that their child's education is at greater risk in therapy, since a close relationship develops with a significant figure: "You develop trust in the therapist. You open your heart. You basically become exposed, so everything the therapist tells you, you accept. This is a very big risk for me". A few parents did not want their children or themselves to have to interact with a therapist wearing immodest clothing.

Some parents stated that they expected the therapist to stick to "ultra-Orthodox language": "A more refined, cleaner language. Without slang, without cheap phrases". In particular, these parents made it clear that the therapist must avoid using explicit words to describe body parts and body secretions. These parents added that the therapist should also adopt appropriate and restrained body language as much as possible: "Calm body language, restrained, not overly physical ". A few parents talked about the importance of adhering to a modest dress code as regards the therapist and the characters used in the therapeutic material. A few parents also referred to the importance of getting guidance from people who belong to the ultra-Orthodox community in general, and from the parents themselves in particular. In their view, the therapist should check whether the techniques used in the therapy are appropriate, and learn from the parents about the unique world of the ultra-Orthodox child and important aspects of life. A few parents stated that boys over the age of 11 should not be treated by a female therapist, or at the very least a rabbi should be consulted: "A teenager and a female therapist is a problem. I wouldn't do anything without asking a rabbi about this". A few parents said that computers or cell phone should not be used during therapy.

3.4.4. A Non-Orthodox Therapist Was Seen by Some Parents in a Positive Light: As a Professional Who Enabled Openness and Sharing of Sensitive Content

Some parents stated that despite their concerns, their experience with a non-Orthodox therapist was actually positive. These parents said that they experienced the therapist as professional, culturally sensitive and willing to understand where the family comes from: "She really accepted us, with our opinions, religion, style and conduct". These parents explained that the therapist respected their lifestyle out of her understanding that it was in the best interest of the client: "She realized that she had to be sensitive to our daughter's lifestyle, to where she grew up and to the way she was brought up. Not to expose her to things that would confuse her too much".

Some parents stated that they felt free and open in intercultural therapy precisely because the therapist did not belong to the ultra-Orthodox community: "I'm much more

comfortable sharing with someone I don't know and shouldn't know". Some parents suggested that a non-Orthodox therapist has an advantage in handling sensitive and complex cases (such as trauma), since they feel that only a non-Orthodox therapist can understand and contain the complexity, without prejudice or criticism: "I'm not sure that I would feel free enough to go to an ultra-Orthodox therapist and share this with her, because I'm not sure she would understand these things". A few parents added that the client can also feel more liberated with a non-Orthodox therapist: "He felt more liberated. I did not want my son to feel like he had to hide something". A few parents felt that in many cases a secular therapist was more professional than an ultra-Orthodox therapist: "It is difficult to find someone in our sector who is a really good, responsible and professional therapist". These parents added that a secular therapist may have greater openness and flexibility of thought than an ultra-Orthodox therapist: "She doesn't see things as rigidly as in the ultra-Orthodox sector".

3.5. Perceptions of the Use of the Arts in Therapy

3.5.1. The Parents Recognized the Benefits of Integrating the Arts in Therapy

Some parents explained that the arts are particularly suitable for therapeutic work with children, because psychotherapy that is only verbal is tedious and too abstract for children: "When you sit down to talk with a child, it is very boring. It's something that should be more experiential". These parents added that they chose arts therapies based on their child's interests: "My child really likes creating, really likes to mess with materials, so we came here". Some parents explained that the arts provided a significant tool for self-expression and noted that their child used the arts to express his loves and desires, as well as to release negative emotions in times of difficulty, in a free and authentic way: "It is a way to express herself without judgment or rules". They noted that the arts allowed for the expression of content that could not be expressed verbally: "It allowed the expression of places in the soul where there was no speech, there was perhaps not even an awareness or there was no emotional, verbal ability to say them". Some parents felt that art-making made their child calmer and more open, and as a result, the therapist and the parents were able to establish a relationship with the child and have a meaningful and in-depth conversation: "When engaged in artwork, the child is more liberated, more open, more sharing". Some parents emphasized that the artwork itself allows others to see what preoccupies the child and reflects the inner world, including processes the child goes through and unconscious content: "It's an amazing thing, this power of really reading a child's mind. You can go down very deep with art therapies. It's like you came to the soul through the back door". Another advantage was the strengthening of self-confidence through experiences of success: "It gave him a lot of confidence, because he experienced success. He really made very beautiful things". These parents noted the possibility of empowering the child by presenting his/her works to others. A few parents stated that through engaging in the arts, practical therapeutic goals can be achieved, such as working on playing skills, understanding social situations and problem solving, anger management, flexibility and boundaries.

3.5.2. The Integration of the Arts in Therapy Was Seen as Legitimate and Did Not Conflict with the Religious Views and Cultural Affiliation of the Parents

Some parents considered that the connection between the arts and therapy is natural and desirable, and that engaging in the arts has become very acceptable in their community. Some emphasized that engaging in the arts is an integral and inherent part of their spiritual views, since the arts connect and bring the individual closer to God: "I think this is a way to worship God. It doesn't conflict. This is the thing that most causes closeness. The most connecting". A few parents stated that there was no problem with the use of arts in therapy since it is not real art. These parents explained that in arts therapies the child is involved in simple arts, at their level. However, if they were being instructed in classical and professional artistic work, they would see it as a problem: "It's not masterpieces, it's

simple things. If, for example, it reached the level of sculpting people or talking to him about all kinds of artists, that would be something else". Another parent explained that there is no problem with the integration of the arts in the therapy simply because it is child therapy, but if it was art therapy with an adult there would be a problem, because it might lead to expressing forbidden drives: "In child therapy there shouldn't be a problem. In the treatment of an adult, this can get to inner cravings that are expressed in the artwork and this is a problem". A few other parents did not understand why there would be a problem in integrating arts in therapy, since there is no connection between the arts and religion: "It's two different levels". A summary of the central domains and core ideas appears in Figure 1.

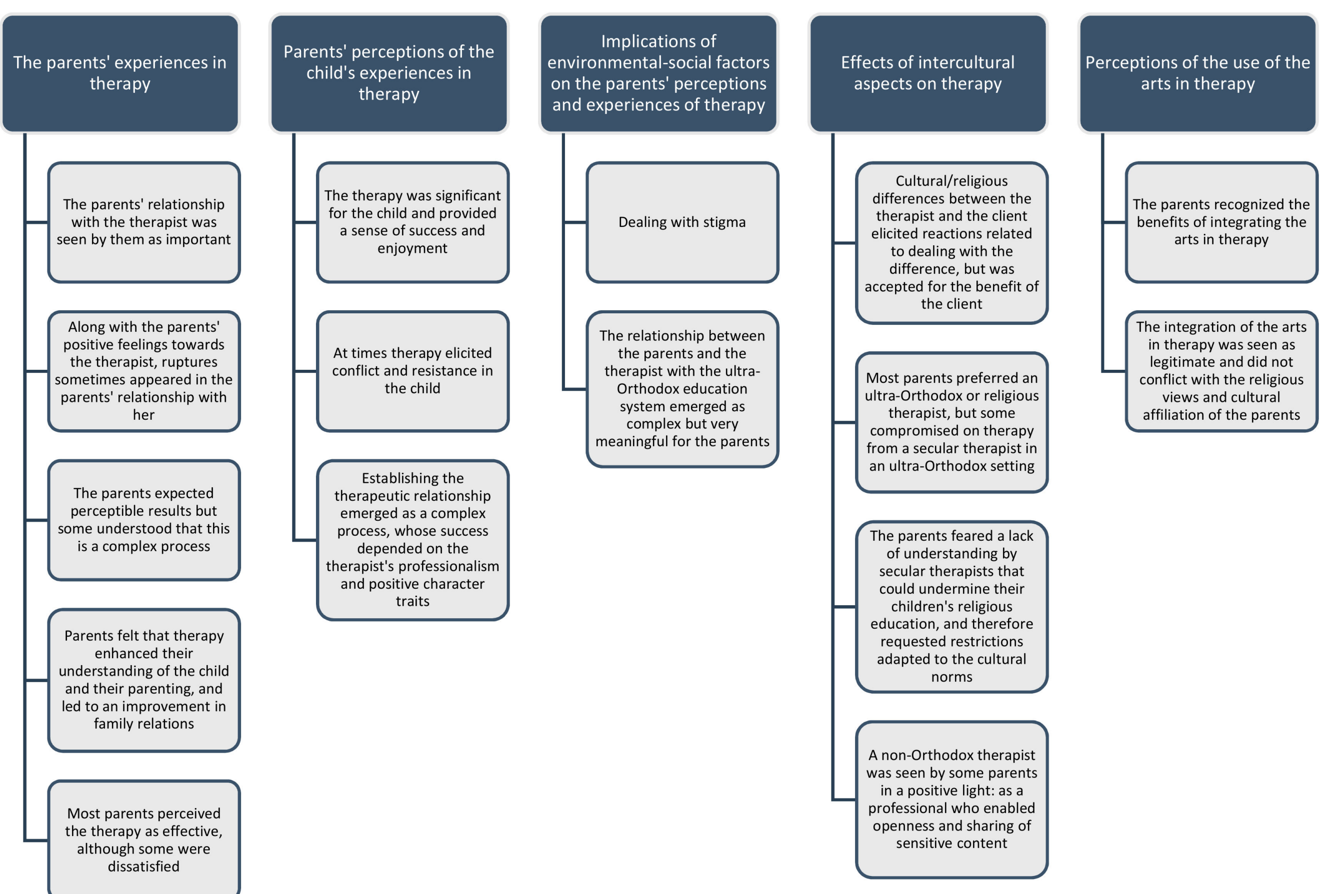

Figure 1. Central domains and core ideas.

4. Discussion

The current study examined the perceptions of ultra-Orthodox parents towards their children's ongoing arts therapies. This study complements a previous work that examined art therapy for ultra-Orthodox adults [34] and publications that have examined arts therapies for ultra-Orthodox children from the therapists' points of view [7–9].

4.1. Understanding the Parents' Experiences and Perceptions of Therapy from a Socio-Cultural Context

The findings suggest that the participating parents' experiences were influenced by the ultra-Orthodox view of therapy. The participating parents did differ in their opinions as to the stigma associated with therapy in the ultra-Orthodox, but they were all apparently activated by it and had different ways of dealing with it. For example, some of the participating parents tended to hide the fact that their children were in therapy out of fear of negative repercussions. This finding is consistent with the literature that describes the fear in ultra-Orthodox individuals of having to admit a disability or difficulty, which may

create a negative stigma and negatively affect areas of the individual's life and that of the family [31,32]. It can be assumed that the complexity emerging from the findings as to the experience of ultra-orthodox parents who send their child for arts therapies is related to the characteristics of the ultra-Orthodox community, which is described in the literature as a collective culture in which the community plays a central role in the individual's life [12]. The social context apparently added further complexity to the parents' already complex experience, since significant difficulties in a child may overwhelm parents with difficult emotions such as anger, frustration, shame and guilt, such that parents may perceive seeking out therapy as an indication that they are 'bad parents' or unable to cope [39]. Nonetheless, some other parents who participated in the current study resisted this stigma and expressed acceptance of therapy. These attitudes may reflect the changes taking place in ultra-Orthodox society, that are multifaceted and characterized by shifts alongside the maintenance of past perceptions of therapy [7,27].

The ultra-Orthodox education system also emerged as another social factor that contributes to the complexity of the experience. The parents who were interviewed in the current study often stated that they were torn between the importance they ascribed to academic success, which in their view plays a decisive role in shaping their child's family and social future, and the attitude of the ultra-Orthodox education system towards emotional difficulties and therapy, which the participating parents described as non-containing and stigmatizing. Emphasizing the importance of the educational factors in the process from the perspective of the parents who participated in this study, and the impact of the educational system's perception of the therapy on the parents, contributes to findings from a previous study that described the helplessness of ultra-Orthodox parents in terms of the therapy options offered through the educational system, as well as their preference to send their children for therapy within the school or to outside non-conventional services [33]. Examining the perspective of the educational staff with respect to the therapy that children receive is essential, given their influence on children and the need for cooperation with them to optimize therapy [56]. In light of the centrality of the educational factors in the process according to the parents, and given the lack of research examining the perception of these factors on the arts therapies of ultra-Orthodox children, their point of view should be examined in a follow-up study.

The participating parents also described a technical complexity which is cultural in origin, in the form of barriers that made it difficult for the parents to be present during therapy related to child raising and job obligations, and the financial cost of the sessions. This is probably related to the large numbers of children in the family, high poverty rates and low income characterizing the ultra-Orthodox despite the growing number of men and women in the labor market [13]. This helps shed light on the impact of culture on the ability to engage in therapy, and suggests that intercultural therapy not only involves differences in values and perceptions, but also concrete cultural obstacles that require attention.

Many of the participating parents took a purpose-oriented attitude towards therapy. This attitude is also found in the general population, and it is expressed, for example, in wanting therapy to provide a quick-fix solution to their children's problem once and for all [39]. However, in the present case this purpose-oriented position tended to dominate. The participating parents focused on the success of the therapy and expected that it would lead to targeted and practical immediate results. Some parents emphasized that the progress should be visible and wondered whether the therapy worked when the change was not noticeable. Most of the participating parents described therapy as effective, but stated that the "problem" that initiated the referral was not completely resolved. Similar to previous descriptions by arts therapists who treat ultra-Orthodox children of many decisions to abridge therapy [7], the participating parents indicated that they did not consider halting treatment to be problematic. A position similar to the participating parents' perception was also reported in a study on ultra-Orthodox therapists and clients, who described the purpose of art therapy as aimed at correcting failures and improving functioning through the acquisition of tools [34]. It is possible that the purpose-oriented attitude, which also

exists among parents in general and is apparently widespread among the ultra-Orthodox, implies a lack of awareness of the meaning of psychotherapy, which may be due to the fact that openness and involvement in psychotherapy in ultra-Orthodox society is a relatively new phenomenon [27], intertwined with other processes of change occurring in this society in the last two decades [13]. This attitude may be related to the characteristics of ultra-Orthodox culture, since according to a widespread claim in the literature, culture also affects self-perception and the individual's perception of what therapy is [57,58]. These findings may emphasize the importance of the collective in the individual's experience in ultra-Orthodox society, in terms of the parents' experience and perception of therapy. As shown in the literature, in ultra-Orthodox society, the self derives its meaning from its belonging to the community and its identification with its goals [59]. Self-fulfillment is expressed, to a large extent, in the realization of the individual's social vocation [20], and mental well-being. Optimal functioning is linked to a strong sense of relatedness of the individual to the community [60]. As a result, individuals in collective societies may perceive the goals of therapy in a completely different way than therapists endorsing Western concepts, as focusing on solving practical problems without reference to internal change [61]. However, while some participating parents stressed quick results, other parents came to appreciate the processual nature of the therapy and the therapeutic relationship. This may be further evidence of the process of change taking place in the ultra-Orthodox society's perception of therapy.

The current study also points to the importance of the therapist's relationship with the parents as a means of developing and strengthening the parents' understanding of what therapy is and what can be expected from it. Most participating parents said that they understood the importance of their involvement in therapy and their relationship with the therapist, and that they would not interfere or limit the process even if it was not to their liking. A few parents who were interviewed even expressed a willingness to go through a process of change themselves. Furthermore, the participating parents emphasized the progress the therapy brought about in their understanding of their child. The feeling of a greater ability to understand their children and the impact of the parents' conduct on them after art therapy also emerged from another study in which the perceptions of a non-Orthodox mother were presented [62]. It can be assumed that this is the result of the therapists' work with the parents. For example, a study on arts therapists who treat ultra-Orthodox children reported that they explain what therapy is, highlight the gradual process, and work to strengthen the parents' ability to observe and understand their child [7].

4.2. Intercultural Aspects in the Relationship between the Parents and the Therapist and in the Therapeutic Relationship

The interviewed parents noted the challenge of dealing with differences in religious affiliation between the therapists, the children and their families, since most arts therapists are not ultra-Orthodox. The parents in the current study talked about their concerns about engaging their children in therapy with a secular therapist, which involves a close relationship with a significant figure who does not share their worldview. The participating parents also emphasized the fear of exposing their children to forbidden or unacceptable content, which they felt could undermine their children's religious and moral education. A previous study also noted the fear of ultra-Orthodox parents that a non-religious therapist would challenge their spiritual and cultural outlook [33] and lead to 'spiritual harm', consisting of a decrease in adherence to the commandments, a violation of social/cultural rules and norms, and deterioration in spiritual faith and the sense of connection with God [63]. These findings are consistent with the literature on the complexity that characterizes intercultural therapies [24] and shows the complexity of the intercultural and value encounter that also exists at the social level.

Even though most of the participating parents said that they accepted the cultural differences between themselves and the therapist because they focused on professional-

ism and the well-being of their children, they emphasized their preference for an ultra-Orthodox/religious therapist by explaining that their acceptance of a secular therapist was predicated on the fact that the therapy would take place in an ultra-Orthodox setting. Studies have described the tendency of ultra-Orthodox society to rely on internal systems as a way to deal with distress, as well as the preference of certain rabbinic leaders for therapy provided by ultra-Orthodox professionals who acquired their training in secular academic systems [59] and of ultra-Orthodox parents to get assistance from within the community [43]. The participating parents indicated their fear of criticism and negative perceptions from a secular therapist, the fear that a secular therapist would not understand the repercussions and that it would be easier for their child to bond with a therapist from a similar religious/cultural background. It is interesting to note that a previous study that examined the perspective of non-Orthodox therapists on arts therapies of ultra-Orthodox children presented a similar experience to that of the parents who participated in the current study. For instance, that study found that the non-Orthodox therapists who were interviewed indeed acknowledged their criticism of certain aspects and characteristics of ultra-Orthodox society, and stated that their lack of familiarity with concepts and shades of meaning created gaps in the therapeutic relationship, which sometimes made it difficult for the child clients to develop trust [7]. The parents here mentioned the need for an ultra-Orthodox setting, under the guidance of ultra-Orthodox staff and supervision of the therapist and the content in the therapy. These feelings about the ultra-Orthodox setting correspond with the experiences of non-Orthodox therapists, who stated that they benefitted from guidance from the parents and the ultra-Orthodox staff, and were supervised by the institute's management concerning their dress, the content, and the tools used in therapy [7]. However, in another study, non-Orthodox therapists noted that the guidance they received mainly concerned their outward appearance and not how best to deal with the characteristics of the ultra-Orthodox culture, which led to misjudgments on their part in therapy [9].

The participating parents noted the adjustments that should be made in intercultural therapies. These include adapting the therapist's language to the ultra-Orthodox code (clean and refined language, without the use of slang or explicit words to describe body parts and bodily secretions), adopting a restrained body language, adhering to a modest dress code, receiving guidance from members of the ultra-Orthodox community, avoiding the use of modern technology during therapy, and avoiding assigning adolescent boys to a female therapist. These concrete guidelines may be meaningful and valuable, since clear strategies for overcoming the difficulties that arise in intercultural therapy are rarely presented in the literature, or are vague and difficult to implement [64].

Nevertheless, the participating parents also referred to the benefits inherent to intercultural therapy. Some parents stated that they and their children felt more open and freer to share, precisely because the therapist did not belong to the ultra-Orthodox community. Some parents perceived the non-Orthodox therapist as more able to understand and contain particularly sensitive and complex cases because there was no judgmentalism towards the content being revealed. Previous studies have reported the positive effects of receiving therapy in a neutral and external environment on the increased sense of security and willingness to disclose on the part of ultra-Orthodox parents and clients [7,8,27]. The literature dealing with intercultural therapies also shows that among clients from other traditional and closed societies, such as Arab-Muslims, there may be a preference for receiving therapy from a therapist who comes from a different cultural or religious background, out of a desire for secrecy and in order to avoid revealing personal secrets in the community to which the clients belong, as well as fear of being judged [65]. In addition, a few parents who were interviewed also stated that a secular therapist would be more professional and have greater openness and flexibility of thought than an ultra-Orthodox therapist.

4.3. The Perception of the Meanings of the Use of the Arts in Therapy

The participating parents did not experience conflicts with the use of the arts in therapy. These parents listed various benefits, including adaptation to child therapy, the possibility of authentic non-verbal self-expression, the possibility of creating a relationship and conversation through artistic work, observing the child's inner world through creation, and strengthening self-confidence through experiences of success. The parents made it clear that the nature of the arts integrated into therapy did not pose a threat to them, and some emphasized that the connection between the arts and the therapy is natural and desirable. These findings run counter other studies that have examined arts therapies in ultra-Orthodox society, in which it was suggested that the encounter between the arts, religion and culture may involve the fear of violating the religious prohibitions on idol making, a fear of creative expression that is not modest, as well as difficulty in playfulness that evokes feelings of anxiety and guilt [7,34]. This may be related to the difference between therapy for children and therapy for adults. As explained by the participating parents, the arts in which the children engage in therapy are simple arts appropriate to their level and therefore do not pose a risk of forbidden inclinational expression. Alternatively, the differences may stem from observing a cultural phenomenon from the point of view of individuals who do not belong to the culture and observing the phenomenon from the point of view of the members of the culture themselves, in this case the ultra-Orthodox parents. Perceptions on the part of outsiders may be influenced by their views of society and a set of values they do not share. On the other hand, social desirability biases may lead members of the culture to present themselves in a positive light, which does not necessarily correspond to their true feelings [66].

However, the participating parents' comments suggested that some of them did not understand the connection between artistic activity and an improvement in their children's behavior. For example, some parents felt that the therapy focused on enjoyment, but that significant and in-depth therapeutic work did not take place, since they felt that this must also include a verbal reflection of the unspoken content that arises in the artistic work. This showed a lack of familiarity or understanding of the meaning and power of artistic work in therapy. As described in the literature, the arts can be a language for complex content which is forbidden or prevented from reaching verbal consciousness, or content that cannot be communicated through words [67]. Furthermore, symbolic artistic work, which is not necessarily verbal, is essential to the healing process. It provides a safe, distant and non-verbal medium for expressing a difficulty, observing it and discovering alternatives for a solution, thus enabling the clients to carry out internal integration and make changes in their own lives [68]. It is worth noting that criticism of arts therapies and the parents' lack of understanding of the basis and essence of arts therapies is also true for the general population, such as parents of children with autism [69].

4.4. Implications for Clinical Practice

The findings suggest that in intercultural therapy in general, and in therapy for ultra-Orthodox children in particular, the therapist's relationship with the parents is of utmost importance, because this relationship is essential to the parents' understanding of therapy and their child. The therapist must be aware of the social pressure that some parents and children face as a result of being in therapy, the gaps in understanding of therapy and its goals among ultra-Orthodox individuals, and take steps to make the therapy more accessible. The ultra-Orthodox parents who participated in this study tended to perceive therapy in a purposeful way. This suggests that therapists' work with parents should also deal with practical and focused goals and expectations, and provide a psycho-educational explanation of the ways in which arts therapies can affect the achievement of these goals. Special attention should be paid to the therapist-teacher relationship, with an emphasis on careful communication that promotes understanding of therapy and empowering the parent in this relationship. The findings show that the therapist in intercultural therapy, especially for ultra-Orthodox children, must receive guidance from members of the culture

and adapt to the culture's characteristics and priorities. Consideration must be given to intersectionality and transferences originating from intercultural differences. The findings also show the importance of training ultra-Orthodox therapists, and establishing dedicated professional therapy centers for the community through cooperation with members of the culture.

4.5. Limitations of the Study

The current study sought to examine the arts therapies of ultra-Orthodox children from the perspective of the parents of the children in treatment. Since the few studies that have examined arts therapies in ultra-Orthodox children have focused solely on the perspective of the therapists, the current study enables an initial observation of the experience of fathers and mothers who belong to all factions of ultra-Orthodox society with respect to arts therapies for their children. However, there are several limitations to this study. All the interviews were conducted over the phone. Telephone interviews had substantial advantages for the participants including the convenience of providing sensitive information and extended access to participants, especially individuals who are difficult to contact such as mothers of small children or members of closed religious communities. However, one disadvantage of this technique is the reduction of social cues, and in particular the inability to use information from the interviewee's body language. Another disadvantage is that the interviewers had fewer opportunities to create a good interview climate because they could not see the interviewee's context. Unlike face-to-face interviews, the interviewee may be in the presence of others during the interview and be interrupted [54]. In addition, the children of the parents interviewed in this study received various types of arts therapies (including visual art therapy, dance/movement therapy, bibliotherapy, music therapy and psychodrama). It is possible that focusing on examining one type of therapy would have enabled a deeper understanding of the specificity of different modalities of arts therapies and the differences in their possible impact on the therapy of ultra-Orthodox children. Another limitation is related to the fact that the interviewed parents referred to therapies provided in different settings (including an ultra-Orthodox institution, a school, a public clinic and private clinic). This diversity may have influenced and shaped the experience, and raises questions about the influence of other untested variables on therapy.

4.6. Suggestions for Future Research

This study complements a previous study which examined therapy from the perspective of non-Orthodox arts therapists. However, to achieve a broader and more comprehensive understanding, further research is needed which should examine the perspective of the educational staff and the perception of the children themselves. In order to understand specificity and possible variations in the influence of the different types of arts on the therapy of ultra-Orthodox children, further research should focus on modality. Similarly, future research should examine the therapy delivered to ultra-Orthodox children in one single setting (for example in one ultra-Orthodox institution or in the educational system). Further research could also delve into possible differences between the various factions in ultra-Orthodox society in terms child arts therapies. In addition, a follow-up study involving the collection of quantitative data through an attitude survey tapping the perceptions and experiences of the parents could provide a clearer picture of the prevalence of the experiences described in this study and help evaluate development and changes over time.

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Appendix A. Interview Guide for Parents of Ultra-Orthodox Clients

1. **The encounter between ultra-Orthodox parents and children and psychotherapy**
   - 1.1 Tell me what prompted you to seek therapy for your child.
   - 1.2 What brought you to therapy and what made you stay in therapy?
   - 1.3 What are the most important things you expect from therapy for your child?
   - 1.4 What, in your opinion, are the goals of arts therapies?
   - 1.5 Are there differences between the way you see the goals of therapy and the way the therapist sees them?
   - 1.6 What are the main dilemmas you face as a parent of a child receiving therapy?
   - 1.7 What content would you like to be included in the therapy? What content should be avoided in therapy?
   - 1.8 Are there consequences to your decision to seek therapy for your child? If so, which ones?
   - 1.9 Does your community know that your child is receiving therapy? How do you feel about that?
2. **Arts therapies in ultra-Orthodox society**
   - 2.1 What is art (or drama/music/movement) for you?
   - 2.2 What do you think should be the role of art (or drama/music/movement) in therapy?
   - 2.3 Do you think art (or drama/music/movement) promotes therapy? How?
   - 2.4 How do you see the relationship between therapy, art, culture and religion.
   - 2.5 Arts therapies can stimulate emotional expressions, playfulness and release. What is your attitude towards this?
3. **The intercultural encounter**
   - 3.1 Is the cultural/religious background of the therapist important to you?
   - 3.2 If you could choose, would you prefer your child's therapist to be from a similar or different cultural background to yours? Why?
   - 3.3 Do you feel that the cultural difference between therapist and client has an effect on therapy?
   - 3.4 Do you think cultural similarity between therapist and client has an effect on the therapy? In what ways?
   - 3.5 What do you think could help bridge the cultural gap between a non-Orthodox therapist and an Orthodox client?
   - 3.6 What, in your opinion, are the advantages and disadvantages of working with a therapist who comes from a cultural background similar to the client?
   - 3.7 What, in your opinion, are the advantages and disadvantages of having a therapist who comes from a different cultural background than the client?

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