

Development of a manual for dyadic parent-child art therapy

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Abstract

This thesis explores the development of a treatment manual focused on a dyadic approach to art therapy that involves both children and their caregivers. The research took place in four phases: a survey of 85 British art therapists to establish the prevalence of, rationale for, and influences on dyadic art therapy; a Delphi study involving a panel of eight experts to gain consensus on core principles, practices and competences; a qualitative study involving six practising dyadic art therapists and four service users; and finally the construction of a web-based draft manual based on the empirical research findings and feedback from stakeholders on the first draft.

The survey demonstrated that in the United Kingdom the use of dyadic art therapy is common, that few art therapists have received any specialist training in this approach, and that there is a desire amongst art therapist to develop their knowledge and skills further. The Delphi and the qualitative studies were used to develop content for a draft manual. A web based manual was constructed which stakeholders were invited to review. Feedback from the stakeholders indicated that the manual was seen as a refreshing, aesthetically pleasing resource with potential applications in training, practice and research and also as charting new territory for the art therapy profession as a whole.

The expert-informed research-based manual developed here seeks to present a developing and evolving description of dyadic art therapy rather than a definitive one. The content of the manual is based on therapists' and service users' accounts of dyadic art therapy. The research which led to the development of the manual did not focus on mechanisms of change. The manual is a resource which can be used to train art therapists and specify the intervention for future research into dyadic art therapy.

CHAPTER I: Introduction

1.1 Art Therapy

The British Association of Art Therapists (BAAT) website gives the following definition of art therapy:

‘Art therapy is a form of psychotherapy that uses art media as its primary mode of expression and communication. Within this context, art is not used as diagnostic tool but as a medium to address emotional issues which may be confusing and distressing.’ (BAAT, No date).

The terms ‘art therapist’ and ‘art psychotherapist’ can be used interchangeably. BAAT has sought to shed light on the dual use of the term ‘art therapist’ and ‘art psychotherapist’:

‘All the Arts Therapies professional bodies are currently seeking to include ‘psychotherapy’ in their professional titles in order to clarify the level at which they practice and in recognition of their qualifying standards... Art Therapist and Art Psychotherapist are both used although they refer to the same level of professional competency’ (BAAT & AMICUS, 2005)

In line with this, the terms art therapy and art psychotherapy, and art therapist and art psychotherapist are used interchangeably throughout this thesis

1.1.1 Dyadic Parent-Child Art Therapy

Dyadic art psychotherapy is an art therapy intervention ‘which routinely involves parents and carers together with the child in sessions’ (Taylor Buck et al 2012 p.20). As a clinician I have developed an interest in opening up children’s art therapy sessions to involve caregivers, encouraging them to actively participate in the therapeutic process. Developing this ‘dyadic’ way of working directly with the children and their caregivers has been hampered by the sparse body of literature documenting this approach, particularly with school age children. In the early days I sought greater clarity on what to do and how to do it and looked in vain for research into service user views and outcomes of dyadic art therapy. After a few years of developing my clinical practice, I began to wonder if I could use empirical research to develop a manual for dyadic art therapy which might serve both as a resource for other art therapists and as a tool for future outcome research.

1.2 Manuals

'Psychological treatment research is not informative to the field if one does not know what treatment was tested; nor can researchers replicate an undefined treatment intervention. For this reason, research projects for which a treatment manual was not written and followed are of limited utility in terms of assessment of treatment efficacy' (Chambless & Hollon, 1998, p. 11)

The idea of defining and specifying interventions is controversial for some psychological therapists. Art therapists have traditionally favoured heuristic and ethnographic research methods that are 'sympathetic to the art at the heart of the discipline' and it has been suggested that 'art therapists like to diss [sic] the traditions of psychiatric orthodoxy' (Gilroy, 2006, p. 91). So it seemed likely that some art therapists might be wary of a manual which they might fear could be like a 'cookbook' or a set of instructions to 'paint by numbers' (Silverman, 1996), and which would represent a concession to a reductive modernist agenda.

This thesis presents empirical research which has been designed to develop content for a manual of dyadic parent-child art therapy. I have also reflected on how a manual might be constructed and presented to make it acceptable and useful to art therapists. The main output of this thesis is an online manual and a link to this is provided in Chapter 9. The version of the manual accessed via this link is in the fourth stage of iteration, and stands ready for future iteration as art therapists begin to use it in training, practice and possible research.

1.3 My starting point as a clinician and researcher

I have worked as an art psychotherapist since 1996, initially for the National Society for the Prevention of Cruelty to Children (NSPCC) but, for the last 16 years, in a National Health Service Child and Adolescent Mental Health Service (CAMHS). As well as my art therapy training, I have a diploma in observational studies, which comprised modules in infant and young child observations, recent research in child development, psychoanalytic theories and work discussion seminars. I have also completed introductory training in systemic family therapy and in various specific interventions. Throughout my career I have offered art therapy in different formats, including individual child art therapy, groups for children, family art therapy, art therapy with single dyads and parent-child art therapy groups.

This thesis grew out of my clinical interest in dyadic parent-child art therapy. I wanted to discover more about this way of working and to gather my findings into something that could be used in practice, training and future outcome research. I was keenly aware that there was a lack of robust evidence for art therapy, and that one of the limiting factors in this respect was the paucity of clear specifications of the nature and process of the intervention.

I decided to apply for an NIHR fellowship to fund my research. Although I was immersed in the subject clinically, I began with little or no research training. However, I was helped by a number of people to design a project that withstood the rigours of the NIHR selection process.

1.4 Types of framework considered

I wanted to describe the dyadic art therapy treatment model and techniques in a way that would be potentially useful for treatment and research purposes. There are a number of different types of documents used to specify how psychological therapies are delivered in treatment and research, including clinical guidelines, competence frameworks, and manuals.

Clinical guidelines are systematically developed statements used to assist clinical decision making (DH, 1994), ideally they are based on evidence derived from rigorously conducted empirical studies (Murphy, et al., 1998). However, I did not find any outcome-based studies of dyadic art therapy that I could draw on to develop evidence-based clinical guidelines.

Competence frameworks describe the activities needed to carry out an intervention effectively, according to best practice. They do not prescribe practice, but are ‘intended to support the work of therapists by articulating the knowledge and skills they need to deploy when working using [a given] model’ (CORE). University College London have developed a number of competence frameworks. The development of the competence frameworks involved identifying approaches ‘with the strongest claims for evidence of efficacy, based on the outcome in clinical controlled trials’ and these were ‘almost invariably’ based on a manual describing the treatment model and techniques (Lemma, Roth, & Pilling, No date, p. 7).

I wanted my description to include competences, but also have other components. I therefore decided that a manual, which would include competences, would be the most appropriate format.

1.5 Approaches to developing manuals

Manuals in current use do not have a standardised content or structure (Lambert et al., 2004), and there is a paucity of research into their construction (Duncan, Nicol, & Ager, 2004). Manuals may be based on reviews of the relevant literature, adaptations of existing material, expert self-report, or empirical research. I wanted to use empirical research because I wanted the manual to represent a consensus of views from a range of art therapists and to be firmly grounded in current clinical practice.

1.6 The potential utility of a manual

One of my aims was to produce a manual that could inform clinical practice and training. From my own clinical experience I knew that a clearer understanding of what dyadic art therapy entailed would have been helpful to me when I had started working this way and I thought that art therapy colleagues might feel the same.

My other aim was to produce a manual that would be helpful for evaluation and research. Increasingly commissioners of services are basing decisions on research evidence, particularly that generated by randomised controlled trials of treatments. If art therapists want to use outcome-based research to demonstrate the effectiveness of their interventions they will need to be clear about the content of the treatment being investigated.

1.7 Focus of the manual

I wanted the focus of the manual to be dyadic parent-child art therapy with school aged children. This was the age of the children I was seeing in my clinical practice, yet a review of the literature found little information about dyadic art therapy for this age-range. Clinically, I was finding the intervention useful with children and their caregivers when there were relational and attachment difficulties. So this client group was initially the focus of my research. However, the survey and the therapists' interviews highlighted the utility of dyadic art therapy for a variety of problems so I decided that initially the manual would not be tightly focused on a single diagnosis or difficulty. Of

course for any future clinical trials greater specificity about the applications would be needed.

1.8 Epistemology

In seeking to develop content for a dyadic art therapy manual, I adopted a pragmatic approach, selecting methods which I thought were the most relevant and useful for each study. My pragmatic approach is underpinned by a 'subtle realist' (Hammersley, 1992) belief that although physical and social phenomena exist independently of me and my own perception of them, I can only view and make sense of these phenomena through the lens of my own subjectivity. An explanation of the approach I adopted is given in Chapter 3.

1.9 Methodology

My aim was to try to understand what might usefully be included in a dyadic art therapy manual. I wanted to address questions I had identified through my clinical practice and I sought the most appropriate methods to address these questions.

1.9.1 Mixed methods

First, I wanted to find out whether my own interest in the approach was shared by my fellow practitioners, and I wanted to gather views from people within the profession but beyond those proximal to me both professionally and geographically. The most pragmatic way of doing this seemed to be a national survey of art therapists.

Next, I wanted to find out more about the core components of dyadic art therapy. I considered a number of methodologies, but in the end it struck me that possibly the simplest and most effective way was to ask a group of experts to agree on the core components. From this starting point the Delphi process was designed to elicit consensus on the key principles, practices and competences for the work.

The Delphi provided comprehensive principles and competences, but was rather thin on the practices. The results were also quite abstract, not linked to clinical examples or case material. I wanted to get an understanding of what was happening in real-life dyadic art therapy sessions, and I wanted to hear from service users about what it was like to be on the receiving end of the therapy. So the third phase of my research was interviews with key stakeholders: therapists, caregivers and children. I also decided to

use a post-session questionnaire for parents and caregivers to capture week by week impressions of what they had found helpful or hindering in the sessions.

Finally I set about constructing the manual. The first draft was based on the empirical findings. I had researched the content of the manual but not its format. I selected a web-based format for ease of dissemination and access and for sufficient flexibility that the content could evolve to reflect clinical practice. A number of iterations of the first draft then took place. First I compared the content I had derived from the empirical studies with suggested content for psychological therapy manuals, this identified a number of gaps so I reviewed the data I had collected to see if it provided any of the information that was missing. Next, following a training session I delivered in dyadic art therapy I added in some clinical vignettes and role-plays that participants had identified as helpful illustrations. Finally I incorporated feedback from the Delphi experts and the therapists I had interviewed.

Thus the design was mixed methods, combining qualitative and quantitative methods in the same study, with integration focusing on the production of the manual. See Figure 3.1 in Chapter 3 for a flowchart of the mixed methods design.

1.10 Aim of the thesis

The primary aim of my research was to use empirical research to develop content appropriate for inclusion in a manual of dyadic art therapy for children with relational difficulties. Potential uses for the manual include offering a description of dyadic art therapy for use in future outcome research as well as the sharing and development of clinical practice and therapist training. The potential for tension between these different uses is discussed in Chapter 9.

1.11 Thesis structure

A review of the relevant literature is described in Chapter 2. This is followed by an outline of the research design used for the empirical research in Chapter 3. The methods and findings of each of the three empirical studies are then reported separately in Chapters 4 to 7. Chapter 8 provides an account of the construction of the manual and the way in which it has been further developed. Finally there is a discussion of the thesis in Chapter 9.

At the end of the thesis there are appendices with additional information. The manual is web-based so only key pages of the manual are shown in the appendices (8.1-8.8) and a link to the complete online manual is given in Chapter 9.

Appendix 1.1 provides links to three peer reviewed journal articles emanating from this research.

CHAPTER 2: Literature Review

2.1 Introduction

The focus of this thesis is development of content for a manual for dyadic art therapy. The research question is: *What would be suitable content for a dyadic art therapy manual?* To begin to address this question, I reviewed existing literature on art therapy (see Section 2.2), dyadic parent-child psychotherapy (see Section 2.3), and manualisation of treatments (see Section 2.4).

2.2 Art therapy

The aim of this section is to offer an overview of art therapy rather than a systematic review of the effectiveness of art therapy. The latter has been undertaken by other researchers, the most recent being a review of art therapy for non-psychotic disorders (Uttley et al., In Press).

2.2.1 Historical background

Art therapy as a professional practice can be found in many countries around the world. The historical development of art therapy has been described by practitioners in the United Kingdom (UK) (Waller, 1984, 1991; Wood, 2011), the United States of America (US) (Junge & Asawa, 1994), Europe (Waller, 1998), Australia (Westwood & Linnell, 2011), and more recently Asia (Potash, Chan, Kalmanowitz, Fan, & McNiff, 2012). Parallel but distinct histories can be traced in the US and the UK, with each country having recognised pioneers and influences, which in turn have exerted influences on the global development of art therapy.

In the US, Vick (2012) has identified four early pioneers noted for their contributions to the development of the profession of art therapy: Naumberg, Kramer, Kwiatkowska, and Ulman. Naumberg, who has been described as the Mother of art therapy, (Junge & Asawa, 1994) conceived a model of ‘dynamically oriented art therapy’ in the 1940s, drawing on influences from psychoanalytic practice. Kramer, who had a pioneering role as an art therapist from the end of the 1940s, was more interested in the intrinsic therapeutic potential of art making (Vick, 2012). Ulman pioneered the first dedicated journals and books on art therapy in the US, synthesising ideas and outlining models, while Kwiatkowska pioneered research and family art therapy (Vick, 2012). Vick outlines three phases of growth in the profession of art therapy in the US. The Classical

Period (1940s to 1970s), during which these four pioneers were active; the Middle Years (1970s to mid-1980s), during which the field broadened and the role and identity of art therapists became more established; and the Contemporary Period (mid-1980s to present).

In the UK, Waller (1984, 1991) identifies the artist Adrian Hill as a pioneer. Hill was influenced by his own experience of convalescing in a sanatorium during the second world war when he witnessed at first hand how some patients had made horrifying war images and used these images as a way to begin talking about their pain and fear (Waller, 1984). Seeing the enormous value of hospital patients having access to art and artists, Hill began his 'long campaign to promote the availability of art and artists' (Waller, 1984, p. 6). Another UK pioneer identified by Waller (1984) was Adamson who, at the end of the 1940s, was the first appointed art therapist in the UK. The doctors who originally championed this appointment in a psychiatric hospital were primarily interested in the paintings produced by patients for diagnostic purposes and, although they recognised that the creative activity might be helpful for their patients, they stressed to Adamson that he 'was not to attempt to interpret pictures or show any special interest in the psychological problems of the patients' (Waller, 1984, p. 6). As more artists and art teachers began working in hospitals, Waller describes an on-going lack of clarity about the role of art therapist which led to the formation of 'a central association in 1964 with a view to clarifying the role of the would-be art therapists in hospitals in order to arrive at a suitable training and a structure for employment.' (Waller, 1984, p. 7).

An overview of the development of the professional identity of art therapists in the UK is given by Wood (2010) who identifies 'three overlapping twenty-year periods of the last century' (p.16) and a fourth contemporary period. In the first of these, from the late 1930s to the end of the 1950s, pioneering art therapists such as Hill and Adamson 'proposed and upheld the healing power of expression' (p.16). During the second period, which Wood identifies as the 1960s and 1970s, art therapists 'worked to consolidate the profession of art therapy' (p.16). The way in which art therapists felt able to work during this period was influenced by the discourses emerging from social psychiatry, humanistic therapies and existentialism (Wood, 2011, p. 211). During the third period of British art therapy, Wood (2011) suggests that 'there was an increased focus on particular approaches being offered to clients with particular difficulties' (p.

241), and points to special interest groups developing within the profession. Also, Wood (2010) describes how during this period art therapists sought more rigorous explanations of the therapeutic relationship which many found in the psychoanalytic psychodynamic tradition: ‘psychodynamic understanding of the therapeutic relationship appeals to many of them because it theorises the unconscious in ways that other models (e.g. from humanistic and cognitive traditions) do not.’ (p.16).

During the contemporary period in the UK, Wood asserts that art therapists are weaving together three main strands of the profession’s earlier history: a ‘belief in the power of expression; a social psychiatry (and social inclusion) understanding of context; and clarity about psychotherapeutic principles. This is all in conjunction with efforts to produce research and evidence of effectiveness. There is a surprisingly long list of different therapeutic approaches and adaptations being used’ (Wood, 2011, p.53).

2.2.2 Contemporary settings and applications in the UK

In the UK, there is no definitive pathway for adults or children to be referred for art therapy and the only standardised guidelines are in relation to schizophrenia (NICE, 2009). However, art therapy is delivered to a number of ‘discernable clusters’ (Uttley et al., In Press) including ‘people who have been abused and traumatised, are on the autistic spectrum, who have addictions, have dementia, have eating disorders, have learning difficulties, are offenders, are in palliative care, have depression, personality disorders or people displaced as a result of political violence.’ Referral is not necessarily diagnostically determined and decisions may also take into account service users’ personal circumstances or difficulties (Uttley et al., In Press).

2.2.3 Art therapy with children

The general literature on art therapy does not always make an explicit distinction between work with adults and work with children. For example, Hogan reflects on the diversity of art therapy practice and proposes a continuum of theory as ‘a fluid way of conceptualising art therapy practice’ (2009, p. 29), but she does not differentiate between therapy with adults and therapy with children or young people. However, there is a body of literature focussing specifically on art therapy with children and young people. This literature includes accounts of how it has evolved and descriptions and reflections of current practice. Case and Dalley (1990) describe the significant but ‘largely undocumented’ influence of ‘early practitioners and eminent teachers such as

Michael Edwards and Diana Halliday' on the development of the practice of art therapy with children and young people and also the significant influence of 'child psychoanalytic theories such as those of Donald Winnicott and Melanie Klein' (Case & Dalley, 1990, p. 2).

The literature focussing on art therapy with children and young people is predominantly descriptive studies and expert opinion, which is recognised as lower level evidence in many common conceptualisations of evidence hierarchies (e.g. Daly et al., 2007; U.S. Preventive Services Task Force, 1989). Significant contributions have been made in the UK to this body of descriptive studies by Caroline Case who, as an art therapist and child and adolescent psychotherapist, takes an analytic or psychodynamic approach to art therapy with children. Recent articles by Case have focussed in particular on trauma and the processing of traumatic memory (Case, 2005, 2010).

The psychodynamic approach to art therapy with children and young people is predominant in the existing literature. However other influences such as systemic approaches and attachment-based approaches are becoming more evident:

'Increasingly art therapists are turning to attachment theory to explore early childhood relationships and their impact on subsequent behaviour; and to family systems theory which seeks to make a change in the way that members interact rather than focusing on the child or children with 'the problem'.' (Waller, 2006)

These influences challenge the more traditional emphasis on the relationship between therapist and client. The focus shifts from the therapeutic relationships with therapist and image privileged in the traditional adult art therapy model, to intra-familial relationships.

2.2.4 Art therapy and evidence-based practice

The art therapy literature is rich with accounts of single case studies but these rate poorly on generally accepted hierarchies of evidence. Although some art therapists have argued that case studies enable art therapists to rigorously examine their clinical practice (D. Edwards, 1999), the context in which art therapy is delivered has changed dramatically in recent years, with an increasing emphasis on delivering evidence-based interventions and demonstrating effectiveness to the people who commission services.

In 1996 Roth and Fonagy published their first edition of *What works for whom?* a critical review of psychotherapy research, examining the available evidence pertaining to the treatment of a range of psychological difficulties. At the same time in the field of art therapy, the discussion began about ‘the new discipline’ of evidence based practice (Gilroy, 1996, p. 52). Andrea Gilroy argued that whilst it was important to be aware of the available evidence, and to base art therapy practice on research, art therapists should also be aware of their ‘own kind of evidence’ and make sure that it did not get lost, or overlooked, in favour of quantitative research.

Wood (1999) advocated ‘the importance of evidence of effectiveness couched in the language of a particular evidence-based discourse’ (p. 51), and reflected on why there might be some resistance within the profession: ‘I suspect that some of the resistance to evidence-based research arises from the fear that it could mean that the approach to the work will become homogenised and lose its more vital connections with the art-making process’ (p. 59). Gilroy’s subsequent book *Art Therapy, Research and Evidence-based Practice* (2006) highlights the exponential expansion of evidence-based practice, and the pressing ‘demands for evidence of the effectiveness of every treatment and practice across the public sector’ (p1). There is evidence that art therapists are now beginning to engage with this agenda on a wider scale than previously. The role that the professional research practice network has played in this will be now be discussed, followed by discussions of existing systematic reviews of art therapy, the extent to which the service users’ voices have been represented, and hypothesised mechanisms of change.

The Art Therapy Practice Research Network

Practice research networks provide an infrastructure to meet ‘the dual agenda of evidence-based practice (EBP) and practice-based evidence’ (Margison et al., 2000, p. 128). The Art Therapy Practice Research Network (ATPRN) was instigated at the turn of the century in the context of increased awareness of the value of evidence-based practice and fiercer commissioning pressures that have been outlined earlier. Huet, Springham and Evans (2014) note that the ATPRN created a professional culture change. They reflect that although formal research outcomes might have been developed more rapidly if a top-down centralised approach to art therapy research had been adopted, this could have resulted in practitioners adopting a passive role in the process. Instead the practitioner-driven structure of the network produced a ‘hugely increased number of research sympathetic practitioners’ (Huet et al., 2014, p.179) and

the old research-adverse culture has largely subsided leaving in its wake a recognition that art therapists need to define their practice more rigorously.

Systematic reviews of art therapy

Since the turn of this century there has been an increase in the number of randomised controlled trials of the effectiveness of art therapy in Europe, America and Asia. A review of art therapy outcome studies from 1999-2007 was conducted by Slayton et al (2010). They looked at 35 studies, 14 of which included children under the age of 12, and 12 of which included adolescents between 13 and 18 years of age. They concluded that there was ‘some evidence that art therapy can lead to positive treatment outcomes for these populations’. However, the authors found that within the body of studies reviewed:

‘several of the complications that historically have been found in art therapy research continue to exist. There is a lack of standardized reporting and utilization of control groups, and a tendency to use anecdotal case material to demonstrate treatment outcomes rather than measure results. Often poor or only vague descriptions of the treatment interventions are provided, which makes it difficult or impossible to determine the study procedures. Finally, studies that mix interventions prevent an examination of which intervention led to the changes reported’ (p.116).

They recommend that in the future art therapy researchers: ‘be more standardized and more precise, to do more fully experimental designs, and to replicate studies’ (p.116) and hope that larger scale effectiveness studies will be conducted in the future.

In 2014 I was part of an NIHR Health Technology Assessment looking at the use of art therapy for non-psychotic disorders which will be published shortly (Uttley et al., In Press). This included art therapy with children and young people. The systematic review concluded that art therapy appeared to be clinically effective in a number of studies with samples from different clinical profiles. The most relevant symptoms effectively targeted were depression; anxiety; mood; trauma; distress; quality of life; coping; and self-esteem. Art therapy was seen to have significant positive effects compared to the control groups in a number of the studies. Art therapy was reported to be an acceptable treatment associated with a number of benefits and also appeared to be cost effective compared to patients on the waiting-list. However the authors recommended that

confirmatory studies were needed and that in general their conclusions should be viewed with caution due to ‘the paucity and quality of the evidence retrieved’ (Uttley et al., In Press).

2.2.5 The service users’ perspective

There is a small body of literature describing the experiences of art therapy service users. Some of these are accounts by individuals of their experience of art therapy. For example in 1993 two art therapists and an art therapy client co-authored a book giving detailed accounts of their personal perspectives on a two-year therapeutic relationship (Dalley, Rifkind, & Terry, 1993). Each chapter begins with one of the client’s images representing the stages of his therapeutic process and describing his journey from emotional ‘autism’ to emotional ‘literacy’ (p.1).

There has also been qualitative research into service users’ views of art therapy. A qualitative enquiry into service users’ perceptions of helpfulness of art therapy during chemotherapy sessions identified that of 54 randomly selected participants, 51 found their art therapy experience helpful. Three groups of these patients were identified: those who found the experience generally helpful; those who found the relationship with the therapist particularly helpful; those who found the three-way relationship between client, therapist and image helpful. The systematic review mentioned earlier (Uttley et al., In Press) had a qualitative component which reviewed 12 cohort studies of art therapy. The themes relating to benefits of art therapy for service users included: the importance of the relationship with the therapist; increased understanding of self; distraction from own illness; personal achievement; self-expression; relaxation; empowerment; and expression of feelings. The potential harms identified related to situations which might arise in which emotions were activated but left unresolved, a lack of skill of the art therapist, and the sudden ending of therapy.

In the UK a number of art therapists have shown an interest in using the Reflect Interview (RI) (Springham, No date) to evaluate the outcomes of art therapy in routine practice. The Reflect Interview is combined with images produced by the clients into an Audio-Image Recording (AIR). Springham and Brooker (2013) ran a feasibility study to establish whether these tools could be used to build data sets across multiple sites and populations of art therapy users. The age of the service users participating in the feasibility study ranged from 12 – 80. The authors concluded that the tools had high

respondent validity and were unobtrusive to administer. The authors also reported findings from a thematic analysis of six RIs which were administered during the feasibility study. They found that service users thought that during art therapy: distressing thoughts become more manageable; the capacity to hope increased; social anxiety was reduced; confidence in making and looking at art increased; the children interviewed reported they felt happier. The service users thought these changes had come about because: they were externalizing their thoughts and feelings into the art work; they felt a link between the art and themselves; art making in a group enriched the connection to others; the creative process in the art; the art objects helped recall positive events; and the art objects became a concrete record to reflect on.

2.2.6 Hypothesised mechanisms of change in art therapy

Mechanisms are ‘those processes or events that lead to and cause therapeutic change’ (Kazdin & Nock, 2003, p. 1117). The literature on art therapy includes clinicians’ and service users’ reflections on what leads to change in art therapy, a brief review of which is given below.

Art making

Art making is seen as having the potential to bridge internal and external worlds and process traumatic events. Images are seen by art therapists as ‘vessels of containment’ and ‘channels for communication’ (Meyerowitz-Katz, 2003, p.68) which can offer a ‘means to connection’ (Patterson et al., 2011, p.77). Nowell Hall (1987) describes how for some people ‘making an image can create a bridge and a way of ‘speaking’ out of states that might be described as the depth of despair’ (p.171).

Art making is also seen as a way of processing memories (Lusebrink 2004). Hanney & Kozlowska (2002, p.41) suggest that drawing enables children to express non-declarative memories, rescuing them from a wordless form by ‘creating visible and palpable illustrations of experiences’. Art-making may function as a ‘useful exposure and desensitization tool in the treatment of young children with PTSD’ allowing intolerable feelings to be externalized in a concrete form that can then be manipulated and reworked in the therapeutic process, enhancing a sense of mastery (Kozlowska & Hanney, 2001, p.73). Lobban (2012) suggests that the creative process ‘stimulates new ways of articulating and thinking about experiences that break away from rigid thought patterns [which] suggests that new neural pathways are being formed’ (p.10). She

quotes an interview with Dr Lukasz Konopka who hypothesises that art therapy ‘taps into primitive brain networks and helps to establish new neural pathways that could alter function and be long-lasting’ (p. 11).

Art making in the context of a therapeutic relationship

Art therapy offers the possibility of making images within the context of one or more relationships. The three-way relationship between the image, the artist and the therapist has often been conceptualised as a triangular relationship: ‘Painting in the presence of the therapist alters the intention and the dynamic balance [...] This may be described as a triangulation around the potential space’ (Wood, 1984, p.68). Greenwood hypothesises that: ‘Showing the art work and looking and talking about the pictures together provide additional opportunities for development of self in relation to others and sharing and modifying anxieties [...] facilitates mentalisation’ (Greenwood 2012, p.10). Service user derived mechanisms outlined by Springham et al (2012) include four suggestions of what is helpful about sharing art making with others. They are: responses from other service users and the therapist to their images; joint attention enhanced by a homogenous group; help understanding and reflecting on own mind and contrast with mind of others; accepting multiple perspectives.

2.2.7 Summary

Art therapy is a form of psychotherapy that uses art media as its primary mode of expression and communication. Art therapy as a professional practice can be found in many countries around the world with parallel but distinct histories in the US and the UK with each having recognised pioneers and influences, which in turn have exerted influences on the global development of art therapy. Art therapy literature is rich with accounts of single case studies which rate poorly on generally accepted hierarchies of evidence. In the UK, there is no definitive pathway for children to be referred for art therapy and the literature on art therapy does not always make an explicit distinction between work with adults and work with children. The psychodynamic approach to art therapy with children and young people is predominant in the existing literature. However other influences such as systemic approaches and attachment-based approaches are becoming more evident.

2.3 Dyadic parent-child therapies

A review of literature on dyadic parent–child therapy was undertaken at the beginning of the study and updated in May 2014. The search was conducted using three databases: Medline; PsycINFO; and AMED. The hyphenated words *parent-child* were searched for in the title, combined using the operative AND with *therapy* (also in the title). The term dyadic was not used, as initial searches indicated it was not sufficiently specific as it is also used to describe couple counselling. The search went from 2004 to 2014 to give a degree of historical perspective while also ensuring that articles retrieved had contemporary relevance to current practice.

The search retrieved 203 results; with duplicates removed this left 196 unique results. Of the items retrieved 162 referred to Parent-Child Interaction Therapy (PCIT), with 97 of these appearing since 2009 indicating a burgeoning new interest in this approach. Lyon and Budd (2010) describe PCIT as an evidence-based practice for the treatment of externalizing behaviour in preschool children and write that there has been considerable research to establish efficacy. PCIT is described as drawing heavily on ‘parenting, social learning, and attachment theories’ (Lyon & Budd, 2010, p. 3) and having two successive phases which are Child Directed Interaction and Parent-Directed Interaction. The websites for PCIT do not indicate any research or clinical work currently taking place in the UK.

Other than PCIT, the remaining 34 items discuss parent-child approaches embedded within a number of existing therapeutic approaches or disciplines such as music therapy (n=4), filial play therapy (n=4), cognitive behavioural therapy (CBT) (n=3), Lucille Proulx’s (2003) parent-child-dyad art therapy (n=2) (which is discussed in detail later) and supportive expressive therapy (n=1).

This literature is described in two themes covering the theoretical influences underlying dyadic therapies and hypothesised mechanisms of change.

2.3.1 Theoretical influences underlying dyadic therapies

PCIT was the intervention which featured most significantly in the search results. As has been discussed, it draws on a number of key theories, which are: Parenting Theories, Social Learning Theory; and Attachment Theory. These theories, in different

combinations and with different emphases, underlie many of the other therapies elicited by the literature search and so a brief review of these theories will be given.

Theories about parenting

In the late 1960s Diana Baumrind (1966) outlined three parenting configurations or styles: *authoritarian*, *permissive*, and *authoritative*. Baumrind and others then expanded on the theory by adding in the dimensions of responsiveness and demandingness. Responsiveness refers to ‘the extent to which parents intentionally foster individuality, self-regulation, and self-assertion by being attuned, supportive, and acquiescent to children's special needs and demands’ (Baumrind, 1991, p. 62) and demandingness refers to ‘the claims parents make on children to become integrated into the family whole, by their maturity demands, supervision, disciplinary efforts and willingness to confront the child who disobeys’ (p.61-62). These two dimensions indicated a distinction between two different permissive styles: neglectful and indulgent. The relationships between these four configurations and two dimensions is illustrated in Figure 2.1.

Figure 2.1: Parenting styles diagram after Rhee et al (2006)

		Demandingness (expectations for self-control)	
		High	Low
Responsiveness (attunement and support)	High	Authoritative Parenting Respects the child’s opinion while maintaining clear boundaries	Permissive Indulgent Parenting Indulgent without boundaries
	Low	Authoritarian Parenting Strict disciplinarian	Permissive Neglectful Parenting Emotionally uninvolved and does not set rules

Authoritative parenting has been found to have positive outcomes in terms of child obesogenic behaviours and body weight (Johnson, Welk, Saint-Maurice, & Ihmels, 2012; Vollmer & Mobley, 2013), adolescent persistence (Padilla-Walker, Day, Dyer, & Black, 2013), peer problems (Yamagata et al., 2013) emotional autonomy (Kudo, Longhofer, & Floersch, 2012), and long term mental health (Uji, Sakamoto, Adachi, & Kitamura, 2014). However, recent studies have indicated that the influence of parenting styles is complex, culturally dependant and part of a reciprocal bidirectional transaction between parent and child. As such, the impact of parenting style cannot be seen as independent of the child or young person (M. Kerr, Stattin, & Ozdemir, 2012) and should be understood within the cultural context (Slone, Shechner, & Farah, 2012).

Social learning theory

Another key theory which informs PCIT and other evidence-based parenting programmes such as The Incredible Years (Webster-Stratton, 1998) is Social Learning Theory. In the 1960s, psychologist Albert Bandura began describing how new behaviours are adopted by children and how these behaviours are directly or indirectly shaped either by the children's experiences or through modelling: 'Although behaviours can be shaped into new patterns to some extent by rewarding and punishing consequences, learning would be exceedingly laborious and hazardous if it proceeded solely on this basis [...] Most of the behaviours that people display are learned, either deliberately or inadvertently, through the influence of example' (Bandura, 1971, p. 5).

Social Learning Theory therefore posits that children learn in a social context by observing actions, attitudes and outcomes which they then imitate (or avoid imitating). The theory is that learning begins with an observation from which information is gathered, followed by a decision making process about the potential utility of the observed behavior, with positive outcomes potentially acting as reinforcements. This observational learning is based on three types of model: live models in which the behaviour is witnessed at first hand; verbal instruction in which a detailed description is given; and symbolic in which the information is gathered from a book, a television programme, video game or similar.

Learners' own characteristics, including their physical and cognitive abilities and their previous experience, impact on the quality of the attention given to the modeled behaviour as well as the ability to retain and reproduce the learnt behaviour (or if a

negative consequence has been modeled to refrain from reproducing the behaviour). Learners' motivations are also important in this respect and may include anticipated consequences and personal beliefs and values. The concept of reciprocal determinism describes how an individual's behaviour has an impact on the environment, just as the environment has an impact on the individual's behaviour.

Learnt behavioural strategies for interacting with others and managing emotions are based on this kind of experience and then reproduced with a degree of consistency across settings. For young children, formative experiences usually occur in the family environment within intra-familial relationships. For this reason, parenting interventions based on Social Learning Theory focus on parenting strategies such as positive attention; praising desirable behaviour; clear instructions; limit setting and boundaries. Clinical trials have shown that parenting interventions which focus on these dimensions can reduce children's negative behaviour (Scott et al., 2010; Webster-Stratton, Reid, & Hammond, 2004)

Attachment theory

The final key theory underlying many of the dyadic interventions found in the search is Attachment Theory. 'Attachment', now a common developmental and psychological term, was first coined by psychiatrist and psychoanalyst John Bowlby (1958, 1969) to capture the unique tie between a young child and the mother. Bowlby saw the infant's attachment to the mother as an instinctive bond evolved for the protection and survival of the species. Characteristic of the child's attachment bond is the desire for proximity to the primary attachment figure, including returning to the attachment figure when afraid and feeling anxious. These characteristics led to the conceptualisation of the attachment figure as the child's 'safe haven' and 'secure base'.

Similarly Bowlby (1969) posited an affectional caregiving bond which parents have to the child, and suggested that within these closely bonded relationships infants and children develop mental representations or working models of themselves and others which they use to predict and understand the environment. These working models, formed in the context of the infant-caregiver relationship, continue to exert an influence throughout life and have an impact on future caregiving and parenting.

Although the first tenets of attachment theory were set out by Bowlby, much of the subsequent development of attachment theory was influenced by the American-Canadian psychologist Mary Ainsworth who reinforced basic concepts and introduced other key concepts and classifications. One of these concepts was maternal sensitivity, which she and her team of researchers devised a scale to measure (Ainsworth, Bell, & Stayton, 1974). Sensitivity was defined as the mother's "ability to perceive and to interpret accurately the signals and communications implicit in her infant's behaviour, and given this understanding, to respond to them appropriately" (Ainsworth et al., 1974, p. 127). Ainsworth described four essential components to sensitivity: awareness of signal; accurate interpretation of them; appropriate responses to them; prompt responses to them. Ainsworth's research indicated that 'Without exception, the infants whose mothers rated low in sensitivity displayed one or another of the behaviour patterns... which reflects a disturbed attachment-exploration balance' (p. 107).

2.3.2 Hypothesised mechanisms of change in dyadic therapies

Social reinforcement strategies

Mechanisms of change that have been hypothesised for PCIT focus on behaviour modification strategies (Kennedy, Kim, Tripodi, Brown, & Gowdy, 2014), including social reinforcement from parent to child and from therapist to both the parent and the child: 'Therapists who conduct parent-child therapy may use social reinforcement to change behaviours in both parents and children' (Borrego & Urquiza, 1998).

One type of social reinforcement is differential attention, which is giving positive attention to appropriate child behaviours and ignoring inappropriate behaviours. Recent research (Pemberton, Borrego, & Sherman, 2013) suggests that differential attention is a mechanism of change in PCIT, but not necessarily in an entirely straight forward way:

'This study indicates the importance of determining what family factors are associated with different change patterns, and therefore different mechanisms of change [...] Parental use of contingent responses toward the child appears likely to function as a mechanism of change, but does not appear to be the only such mechanism. Furthermore, parent and child change across treatment may not occur in the manner expected, and may vary widely across contexts' (p.43).

Enhancing caregiving

Attachment-based interventions tend to focus on providing children with a stable environment and sensitive, non-intrusive, non-threatening, predictable, and nurturing parenting. A review of interventions in the parent-child relationship informed by attachment theory (Broberg, 2000) indicates that the interventions ‘can be grouped under two headings: preventative and therapeutic’ (p.38). While most of the preventative interventions tend to focus on enhancing maternal sensitivity (Broberg, 2000, p. 38), the therapeutic interventions focus more commonly on the representational level, looking at the parent or caregiver’s own attachment experiences and how these are impacting on their current parenting styles. However, Broberg points out that they are not exclusively focussed on the parents’ internal representations and many include behavioural components as well (Broberg, 2000, p. 39). These are discussed below.

Addressing caregivers’ internal representations

Focusing on the internal working models of carers is seen as central to some attachment-based therapies. For example, Amos et al (2007) describe an intervention called parent and child therapy (PACT) which was ‘designed for children aged 4 to 12 years who were experiencing emotional and behavioural problems that had not responded to conventional treatments’. They say that, ‘Central to PACT is the view that to change behaviour, the intervention must address simultaneously (i.e. in parallel) the internal working models’ of both mother and child’ (Amos et al., 2007, p. 61).

Enhancing caregiver sensitivity

More recent research, building on Ainsworth’s concept of sensitivity, has demonstrated a causal link between caregiver sensitivity and the child’s attachment security: ‘when an intervention is rather successful in enhancing maternal sensitivity, this change appears to be accompanied by a parallel positive change in infant attachment security’ (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2003, p. 211). The authors also noted the possibility of an undetected sleeper effect on attachment security and recommended that further research into the possibility of a time lag between changes in sensitivity and attachment security.

Watch Wait and Wonder (WWW) (Cohen et al., 1999) and SET-PC (Cummings & Wittenberg, 2008) both focus on enhancing and developing the parent or caregiver’s observational capacities and reflective functioning. In WWW and SET-PC, parents

observe themselves and their infants playing together and then reflect on what they have witnessed in discussions with the therapist. A study of WWW showed the development of more organized or secure attachment relationships; an improvement in the infant's cognitive development and emotion regulation; an increase in parenting satisfaction and competence; a decrease in depression and parenting stress; and a reduction in maternal intrusiveness and mother–infant conflict (Cohen et al., 1999). A randomised controlled study of SET-PC found decreases in the children's externalising behavior and improvements in the quality of observed parent-child interactions and the parents' psychological functioning with treatment gains maintained at 1-year follow-up.

2.3.3 Dyadic art therapy

In the field of art therapy, the joint involvement of caregiver and child within the art therapy sessions is seen by art therapists as helpful in some instances (Taylor Buck, Dent-Brown, & Parry, 2012). A review of literature discussing dyadic parent–child art therapy was undertaken at the beginning of the study and updated in May 2014. The databases searched were Medline; PsycINFO; and AMED. Articles published at any time were included and the search terms which were used with the operative AND were: dyad OR dyadic OR “parent-child”; “art psychotherapy” OR “art therapy”. The search retrieved 28 items but on closer examination many were excluded as not pertinent because they did not refer to direct work with an adult-child dyad. Many papers were using the term dyadic in a different context, for example: dyadic art therapy is used on occasion to refer to couple or marital art therapy; the term ‘dyad’ was sometimes used to refer to the client-therapist pairing or the supervisor-supervisee dyad; in another paper a dyadic peer consultation process was focussed on.

Articles that have been published from this thesis were excluded from the review. This left four relevant items including: an article by Lucille Proulx (Proulx, 2002) called ‘Strengthening Emotional Ties Through Parent–Child-Dyad Art Therapy’; a review of Proulx's book of the same name; an article by Plante and Berneche (2008) which takes a phenomenological approach to investigating how dyadic art therapy groups as described by Proulx serves to reinforce emotional ties; and a new item which had not been present in earlier searches describing a joint painting assessment procedure (Gavron, 2013). Of the four items found in the search, three related directly to the dyad art therapy developed by Lucille Proulx. This highlighted the significant contribution from Canadian Art Therapist Lucille Proulx (2003) whose book *Strengthening*

Emotional Ties through Parent–Child-Dyad Art Therapy is a theoretical and practical guide to dyadic art therapy interventions primarily with infants and pre-schoolers.

Other references to dyadic art therapy were also found through internet searches and other leads. This secondary search uncovered book sections or single chapters by: Rubin (2005); Ambridge (2001); Schur (2001); and Hall (2008). Additional articles were found by: Landgarten (1975); Lachman et al (1975); Henley (2005, 2007); and Hosea (2006). This relatively small body of literature will now be discussed with reference to the following themes: age of clients; client groups; group and individual formats; assessment and treatment; the make-up of the dyad; the content of sessions; the therapist's stance or approach; challenges of dyadic art therapy; benefits of dyadic art therapy; and gaps in the literature.

Age ranges

In terms of the ages of the children discussed, writers such as Proulx, Hall, and Hosea focused on work with children from birth to three. Proulx made the point that although her approach focuses on the younger client group, she has also used it with older children and adolescents. Others, such as Henley, Gavron, Plante & Berneche and Ambridge, also describe work with older children and adolescents.

Applications and client groups

There was a range of difficulties presented by dyadic art therapy clients. Proulx (2003) states that there are 'as many reasons as there are dyads', but pulls out a 'common denominator' which is 'that communication and interaction between parent and child have been disrupted' (p.100). Similarly Gavron describes an assessment procedure with no specified client group, but the case studies given suggest it is for use with children who display a range of social and emotional difficulties. The book chapter by Ambridge (2001) on the other hand discusses a very specific client group which is mothers and young survivors of sexual abuse. Similarly, Henley's (2005) dyadic sessions are with a specific group of children with attachment disorders. Some therapists such as Hall (2008) and Hosea (2006) focus on the parents' difficulties rather than the child's, with the group seen 'as a resource which can help get parents off to a good start in face of environmental difficulties, mental health problems or troubling experiences' (Hosea, 2006, p. 69)

Although it was not always specified, some of the publications described working predominantly with dyads of birth parents and children (Hall, 2008; Hosea, 2006). On the other hand Henley (2005) specified that the dyadic work he described was with post-institutionalised adopted children. Other authors such as Proulx (2003) described work with both birth families and adoptive families.

Settings

There was a wide variety of settings in which the dyadic art therapy took place, including: a preschool day treatment centre; a family infant team; a kindergarten class; a community group; a child sexual abuse project; and a child and adolescent mental health teams. The authors were working in the UK, the US, Canada and Israel.

Group and individual formats

Sessions with individual dyads and groups of dyads were discussed. Much of the work with infants and pre-schoolers was in a group format. There were also groups for parents and older children such as those described by Landgarten (1975), Rubin (2005) and Plante and Berneche (2008). Rubin wrote that in her experience, parent-child groups would typically involve some time with the dyads together 'followed by separate activities – usually a 45 minute discussion time for parents and snack and activity for children' (p. 214). Work with individual dyads was described with children who tended to be in middle childhood rather than infants or pre-schoolers. Individual dyadic work was offered by Proulx (2003) (despite her work largely focusing on groups), Henley (2005), Ambridge (2001), Rubin (2005), Schur (2001) and Gavron (2013).

Assessment and treatment

At the start of any therapeutic intervention there may be a number of assessment sessions. Assessment models vary but are likely to include questions about suitability and feasibility of treatment as well as formulations about issues such as therapeutic need or diagnostic criteria. While most of the publications discussed treatment strategies, one focussed solely on an assessment procedure (Gavron, 2013) and other authors discussed the use of dyadic sessions in the assessment process. Rubin (2005) said that dyadic sessions could have value for both 'diagnostic and treatment purposes', serving to complement a range of art therapy interventions such as family and group art therapy (p.188).

Proulx (2003) described the assessment procedure used for her parent-child interaction group: 'the team assesses the dyads participating in the treatment, and the Crowell relationship procedure is applied, then the psychiatrist who heads the team formulates a diagnosis' (p.45). The Crowell procedure is an observational assessment in which the dyad is asked to perform a sequence of nine events or episodes 'consisting of free play, clean-up, bubbles, four teaching tasks, separation, and reunion' (DelCarmen-Wiggins & Carter, 2004, p.47). Proulx provided an appendix with references to this and other assessment tools in which she stated that it is important for the art therapist to get as much information as possible when working with the infant and preschool population, including a family history, a pregnancy and birth history.

In terms of treatment, Proulx (2003) wrote that individual dyadic sessions can be 'the primary therapy mode' (p.99) but it can also be an adjunct to other approaches such as group or family work. Rubin (2005) unpacked this idea: 'Although family art therapy can and usually does involve the entire nuclear family. . . it is also helpful to work with smaller components of the larger unit' and that because, in her experience, the 'most important and influential person in a child's life is usually the mother' it may be 'useful to have occasional mother-child sessions both early and late in treatment, for a variety of purposes' (p. 188).

The make-up of the dyad

The majority of the literature described mother-child sessions although some mention was given to involvement of fathers. Hosea (2006) wrote that the presence of fathers in her parent-infant groups was welcomed: 'We have found that fathers can be valuable, nurturing figures within the group, providing support for their infant alone or for both mother and child' (p 69-70). Proulx (2003) described a specific father and child group which resulted in 'positive changes in the interactions' between the dyads (p.43).

The content and structure of sessions

Some of the group interventions appeared to have formal session structures with separate times assigned to different activities and in some groups separate adult and child time (L. Proulx, 2003; Rubin, 2005). Proulx (2003) outlined session content and the layout of the room. Key features were child-height tables for the dyad to sit at, and appropriately chosen materials and activities (for which she provides detailed descriptions). She described how parents are encouraged to follow the child's actions

and not intrude or teach, and the dyad share the making of the image which in the group format is then displayed on a wall.

Proulx made a distinction in the format of group dyad work and individual dyad work, allowing the latter to be more fluid and client-led: 'One of the main differences between individual dyad art therapy and group dyad art therapy is the format. In individual dyad art therapy, the mother and child can choose to do art, play with the toys or sandbox. There is a wide variety of choices for them. The dyad activities are introduced when the therapist sees the parent and child are unable to arrive at a mutually acceptable decision. The therapist is then able to offer an intervention that will engage them.' (p102).

The therapist's stance or approach

Some of the clinical descriptions indicate that the therapists adopt a flexible needs-led approach. Proulx's (2003) gave a list of activities which in a group setting the therapist can suggest the dyads complete together. However, she described tailoring this approach when working with individual dyads, allowing more client-led activities and only suggesting a task if the dyad appears stuck. Henley (2005) discussed one girl who struggled with a non-directive approach, preferring activities to be 'structured with concrete themes and techniques rather than those which emphasized open-ended or spontaneous expression' (p.39).

Some writers described a practical helping or facilitating stance. In the group described by Plante and Berneche (2008) the therapist does not focus on interpretation of unconscious processes, but instead promotes and encourages creative activity and exploration, becoming an ally to the dyad. Emphasis is placed on offering help with technical issues and with dyadic interactions.

The therapists' stance may reflect the theoretical underpinnings of the work. Proulx (2003) stated that her work is based on 'principles from the fields of child psychiatry, psychology and art therapy' including attachment theory. Henley (2005) cited attachment theory. Hosea (2006) referenced the work of Stern and Winnicott.

Challenges of dyadic art therapy

Henley (2005) discussed the complexities of negotiating the tricky three-way relationship between an adopted child with an attachment disorder, the child's carer and

therapist. He described the importance of being able to build an empathic therapeutic relationship with the caregivers and of understanding the stress that they have experienced caring for a traumatised child. He highlighted how the caregiver may feel undermined if the therapist establishes a strong therapeutic relationship with the child: ‘the establishing of a therapeutic alliance with the therapist became unwittingly a competition with the mother, who became uneasy at her child’s newfound intimate friend’ (p.44). Proulx (2003) also discussed transference and countertransference issues, highlighting that the dynamics may be overwhelming for the beginner and she stressed the importance of personal therapy and supervision.

2.3.4 Hypothesised mechanisms of change in dyadic art therapy

Art as the instrument of change

Landgarten (1975) suggested that her mother-daughter art therapy groups offered an opportunity to both mother and child for self-expression catharsis and awareness of feelings. Proulx described how her work aimed to address unresolved attachment conflicts through expressive art: ‘The spontaneous art expression and playful use of the media in dyad art therapy allow both parent and child to project onto the artwork their primitive unresolved conflicts.’ (p.27). Proulx provided suggestions for the symbolic and developmental potential of various art materials.

Hall (2008) also described the therapeutic process, elucidating that she sees the images as the instrument of change: ‘we evolved a way of working with art materials in our clients’ homes, using brief video recordings of the parents’ and children’s interaction. The art images produced became instruments for change’ (p.23).

Facilitating communication and connection between the dyad

Proulx stated that dyad-parent-child art therapy ‘is designed to promote reciprocal non-verbal and verbal communication between the child and the parent’ (p.73). Hosea’s (2006) analysis of the parent-infant painting group indicated that: ‘Painting affects the relationship of mother and child and brings them “close together”, both literally in physical proximity and metaphorically in an emotional sense. They are brought into intimacy and share time and space, reaching out and engaging with each other’. Plante and Berneche’s (2008) phenomenological evaluation indicated that dyadic art therapy groups with school age children provided an opportunity to step outside established patterns of relating to find new more harmonious ways of interacting. They also

reported that following the groups the participants were able to deal more positively with conflict and be more empathic to the other person's perspective.

Enhancing caregivers' reflective function

Hosea (2006) actively involved the group members in her research and was able to see that 'watching their video and doing the research interview gave the mothers a reflective space for themselves. They showed that they valued being an observer of their child' (p.76). Although the provision of reflective space does not necessarily lead to enhanced reflective function, offering the opportunity for reflection may have helped to facilitate and give value to the process of reflection.

2.3.5 Comparison of dyadic art therapy to other approaches

Dyadic art therapy as described in the literature shares commonalities with other art therapy approaches and other dyadic approaches. Individual art therapy for children offers the child the chance to make images which bridge internal and external worlds and to share these with the therapist. Dyadic art therapy also offers children the chance to do this, but not just in the presence of the therapist, they can also do so in the presence of their most significant other: their primary caregiver. This sharing can have a bidirectional quality as the caregiver gains insight, perspective and understanding about the child's internal world. Although in individual work with children, review sessions involving caregivers offer the possibility of activating this feedback loop, in dyadic sessions it becomes a core component of the work. In individual child art therapy, unless the caregiver is in therapy themselves, change is largely expected to come from the child. In dyadic art therapy there is potential to promote change in both the child and in the caregiving system.

The possibility of working with the child and the system is present in family art therapy, and dyadic art therapy has been described as an option within family art therapy (Rubin, 2005). Indeed dyadic art therapy could be seen as a branch of family art therapy.

However the theoretical influences and the hypothesised mechanisms of change may be different between family art therapy and dyadic art therapy. Kerr (2008) wrote that using art-making in family treatment can allow the therapist the opportunity to analyse communication patterns, systems and boundaries. This systemic approach differs to the emphasis Proulx, Henley and Hosea placed on attachment theory, psychoanalysis and

object relations (Henley, 2007). Clearer articulation of theoretical mechanisms for each approach may also highlight further differences.

Other dyadic approaches are informed by some of the same theories as dyadic art therapy, so the key difference to approaches such as WWW or PCIT seems to be the centrality of the art and the art making.

2.3.6 Summary

Dyadic parent-child therapies tend to be influenced by parenting theories, social learning theory, attachment theory, or a combination of these theories. Hypothesised mechanisms of change include: social reinforcement strategies and enhancing caregiving by addressing caregivers' internal representations and enhancing caregiver sensitivity.

The most comprehensive accounts of dyadic art therapy focus on work involving infants and pre-school children. There are a variety of reasons for offering dyadic art therapy but often it is to address disruptions in communication and interaction between parent and child. There are a variety of national and international settings and much of the literature focuses on group delivery. Dyadic sessions may be seen as part of a wider art therapy assessment. The dyad may comprise mothers or fathers with their birth children or adopted children. Potential mechanisms for change include facilitating communication and connection between the dyad and enhancing caregivers' reflective function.

2.4 Psychological therapy manuals

2.4.1 Background

Psychological therapy treatment manuals are documents which specify the particulars of a given therapy:

‘Treatments manuals are, at base, a cogent and extensive description of the treatment approach therapists are to follow [...] they may contain careful session-by-session outlines of interventions, or they may describe broad principles and phases of treatment [...] they should provide a clear and explicit description of the kinds of techniques and strategies that constitute the intervention.’ (Chambless & Hollon, 1998, p. 11)

Psychological therapy manuals first appeared in the 1960s with behavioural manuals such as Wolpe's (1969) deconditioning procedures which were relatively simple to manualise (Luborsky & DeRubeis, 1984). Manuals of non-behavioural therapeutic interventions soon began to emerge as well, but these were harder to manualise as 'the manual writer must allow for flexibility of approach by the therapist' (Luborsky & DeRubeis, 1984, p. 7). However, despite the challenges, the drive to manualise a wide variety of therapeutic interventions has continued.

2.4.2 The case for manuals

Manuals are seen as useful for clinical training and monitoring purposes as they provide theoretical frameworks, descriptions of techniques and examples of appropriate applications (Lambert et al., 2004). It is argued that manuals lead to purer, more consistent delivery of interventions (Waltz, Addis, Koerner, & Jacobson, 1993) and facilitate the training of therapists, and dissemination of the intervention (Kendall, Chu, Gifford, Hayes, & Nauta, 1998).

Particular interest has also been shown in manuals by clinicians and researchers engaged in outcome based research when clarity about the treatment being tested is paramount. Indeed some consider manuals to be essential prior to evaluation of any therapy: 'research projects for which a treatment manual was not written and followed are of limited utility' (Chambless & Hollon, 1998, p. 11)

2.4.3 Controversy, concerns and compromises

Not all researchers or clinicians are positive about manuals. Silverman (1996) wrote a scathing article describing 'manualisation as methodolatry', pointing out that it does not necessarily lead to effectiveness and may even have negative impacts on the therapeutic process. There is some evidence that these concerns may be valid. Adherence to prescribed techniques when there are problems in the therapeutic alliance may worsen alliance strain (Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996) and some researchers have noted that therapists adhering to manuals appear 'less approving and supportive, less optimistic, and more authoritative and defensive' and patients can 'sometimes feel "subjected" to a treatment in a manner that overlooks their individual needs' (Henry, Strupp, Butler, Schacht, & Binder, 1993, pp. 438-439). Pote et al (2003), in describing the process of manualising systemic family therapy, highlight therapists' concerns about oversimplifying a complex process:

‘Preliminary discussions with colleagues, who were both familiar and unfamiliar with manual use, revealed considerable doubt that manualisation could be achieved without oversimplifying systemic therapist practice, restricting creativity and provoking resistance from therapists’ (p.241).

Music Therapists (Rolvsjord, Gold, & Stige, 2005) have echoed similar concerns about the negative connotations manualisation might have within the profession: ‘associated with fixed sequences of techniques that should be applied in a rigid and inflexible manner’ incompatible with ‘the most basic principles of any therapeutic perspective that tries to understand the individual patient before trying to induce change’ (p. 23).

Efforts have been made to address concerns that manuals might be overly prescriptive or rigid. Pote et al. (2003) evaluated the manual they developed in light of possible objections, the first being that systemic practice was ‘too unique’ (p.254) to capture. The researchers acknowledged the unique nature of each therapeutic conversation, but said they felt they were able to identify some ‘common patterns’ which ‘could contribute helpfully to a manual, and form a prescriptive base, from which therapists could develop their own creative components’ (p.256). They highlighted ‘two important elements of the manual that guarded against it becoming prescriptive and overly goal orientated’. These were the inclusion of ‘guiding principles’ and ‘broad and flexible goals’, both of which allowed for flexibility in the sessions. The authors clarify that they have ‘striven for clinical richness’ and have ‘enriched the manual by discussions of theoretical principles and models of change, and developed any techniques described through the use of multiple clinical examples’ (p.258). They conclude that:

‘[A] manual should be a clinically rich guide, not a total prescription, and adherence is not required to be one hundred per cent, allowing room for therapists’ creativity’ (p. 259).

Similar efforts to maintain therapeutic flexibility in a manual have been made by music therapists (Rolvsjord et al., 2005). The authors conclude that a manual should balance ‘flexibility with structure, therapist creativity with treatment fidelity, therapist control with generalisability’, and move from techniques to principles as described by Beutler (2002), with the focus ‘on broad definitions ... to provide guidance about the underlying conceptualisation’ (Rolvsjord et al., 2005 p.23).

The advantages and disadvantages of manualisation may be dependent on the way in which the manual is used: ‘Manuals can be used in a narrow, rigid fashion by people with little training and experience, but to do so would be to lose the best of what an empirically supported, manualized treatment has to offer’ (Kendall et al., 1998, p. 178).

Instead a middle ground is sought:

‘between the complete freedom of an unstructured treatment and the strict adherence to every detail of a treatment manual. This middle ground uses a well-conceived manual as a guide. When used this way, a manual can be flexible, vibrant and alive, requiring creativity and clinical skill to be optimally successful. When used correctly, manuals are responsive to a client's individual characteristics and needs. It is only when utilized improperly that manuals become the flat, routinized procedures that critics are correct in reviling.’
(Kendall, et al., 1998, p. 179)

2.4.4 Existing manuals

A compendium of psychotherapy treatment manuals (Lambert et al., 2004) includes over 100 manuals with a wide range of applications including anxiety disorders, affective disorders, childhood disorders, eating disorders, outpatient treatments, and partner relational problems. Theoretical orientations included amongst others: cognitive behavioural therapy; dynamic therapies; interpersonal; and family therapies. One of the authors noted in a separate paper that the manuals are not equivalent in form or substance, some were as long as a book while others were barely 30 pages. Also the content varied: ‘some have rating scales for adherence and competence; others do not. Some provide explicit session-by-session guidelines and homework forms while others do not. Some are relatively easy to master; others depend heavily on supervision and other training procedures.’(Lambert, 1998).

The compendium of psychotherapy treatment manuals (Lambert et al., 2004) provides a snap-shot of the manuals which were available ten years ago. To get an idea of the types of manuals that have been produced since then, a literature search was conducted in September 2014 using Medline and PsychInfo, limited to English language and publication years 2004-2014. The terms manual OR manualization OR manualisation were searched for in the title, combined using the operative AND with psychotherapy OR “psychological therapy” (also in the title), and 40 results were found. Not all of these were psychotherapy manuals, for example, some referred to training manuals or

manuals for rating scales, and many were reviews of manuals, with some manuals being reviewed multiple times. No manuals on dyadic art therapy were found in this search.

The papers presented or reviewed a number of psychotherapy manuals, including manuals of: Metacognitive Narrative Psychotherapy for people diagnosed with Schizophrenia (Bargenquast & Schweitzer, 2014); Psychodynamic Psychotherapy with various specific client groups (Leichsenring, Beutel, & Leibing, 2007; Possick, 2012; Woeller, Leichsenring, Leweke, & Kruse, 2012); Panic focused psychodynamic therapy (Busch, Milrod, Singer, & Aronson, 2012); Trauma-Centered Group Psychotherapy for Women (Bryant-Davis, 2013); Equine-Assisted Psychotherapy (Cepeda, 2011); Group Psychotherapy for Children and Families Experiencing Traumatic Grief (Welt, 2007); Mentalisation-based psychotherapy for Anorexia Nervosa (Skarderud, 2007); Integrative Group Psychotherapy for psychosis (Ruiz-Parra et al., 2010).

It was not possible to access all the manuals found in the search because articles reviewing the manuals or describing trials of the interventions do not necessarily provide access to the manuals. Authors and developers of manuals sometimes specify that they are only available to people who have completed the appropriate training. However some manuals are open access.

2.4.5 Manuals, competence frameworks and clinical guidelines

For research purposes a treatment manual is a document explaining how the therapy is to be conducted. Researchers also make assessments of treatment integrity, rating ‘the extent that therapists adhere to the treatment manual during therapy and perform the interventions in a competent manner’ (Waltz et al., 1993, p. 620). Ratings of therapist competence assess the skill with which the therapist conceptualises their clients’ difficulties and applies the appropriate techniques, and they differ from ratings of therapist adherence in which raters record the occurrence of certain events consistent with the treatment protocol (Shaw et al., 1999). If adherence is about what is being done, competence is about how well it is done (Parry, Roth, & Kerr, 2007). Competence in delivery has been found to be associated with patient-rated change (Omalley et al., 1988).

Therapists’ competences are also important in clinical practice. Competence frameworks provide detailed information about the skills needed to deliver and

supervise various modalities of therapy. They may focus on the groups of interventions, such as those developed for humanistic therapy, (Roth, Hill, & Pilling, No date) or on client groups such as the competence framework for Child and Adolescent Mental Health Services (Roth, Calder, & Pilling, No date).

There are other documents and frameworks used to inform clinical practice, for example the Health and Care Professions Council (HCPC) specify Standards of Proficiency for members and have a framework of proficiency which apply to all arts therapists. Additionally, clinical practice guidelines are used to inform the selection and delivery of particular interventions or procedures. Clinical guidelines are systematically developed statements used to assist practitioners and patient decision making and recommendations are based on reliable evidence (DH, 1994). In an ideal world, 'clinical guidelines would be based on evidence derived from rigorously conducted empirical studies. However, in practice there are few areas of health research where sufficient research-based evidence exists' (Murphy, et al., 1998, p.1), and so consensus methods 'are increasingly being used to develop clinical guidelines which define key aspects of the quality of health care, particularly appropriate indications for interventions' (Murphy et al., 1998, p. iii).

2.4.6 Methods of development

Some manuals are based on reviews of the relevant literature. Bargenquast and Schweitzer (2014) describe the development of a principle-based treatment manual of Metacognitive Narrative Psychotherapy for people diagnosed with Schizophrenia. The authors state that the development of the manual was largely informed by an in-depth literature review which established specific principles and broad therapy process for a number of phases of treatment. Proscribed practices were also identified. The manual was then reviewed by an expert panel whose feedback was used to revise and finalise the manual.

Other manuals are adaptations of existing clinically based material. Leichsenring, Beutel and Leibing (2007) describe a treatment manual for social phobia which is based on supportive-expressive therapy. The authors describe how they based the manual on an existing manualised treatment (supportive-expressive therapy) complemented by treatment elements specific to social phobia. Possick describes using an existing teaching syllabus as the basis for a manual (2012).

Another approach to developing manuals highlighted by the search is to draw on the clinical expertise of people working in the field (Bryant-Davis, 2013; Woeller et al., 2012). However Pote et al (2003) argue that basing manuals on experts' self-report limits their validity and applicability to standard clinical practice.

Pote et al. (2003) are sceptical about manuals developed by reflection rather than a research process and propose systematic analysis of the therapeutic process as a better method of manual development. With this in mind they designed a research process to see if they could produce a usable manual of systemic family therapy. The research included semi-structured interviews with five experts; observations and ratings of expert sessions; development of the manual; and feedback from therapists testing the manual.

The manual developed by Pote et al. integrated the views and practice of experts, creating a consensus of sorts about best practice. To see if other people developing manuals had sought consensus a search of Medline and PsychInfo was made searching for the terms manual OR manualization OR manualisation in the title combined using the operative AND with a search for Delphi OR consensus in the title. There were no limits applied. This produced 11 results only two of which pertained to psychological therapies. These were Delphi Studies which sought consensus on appropriate content for manualised treatment programmes (Duncan et al., 2004; McCulloch & McMurrin, 2007) and these will be discussed in more detail below.

To follow up further on the critique from Pote et al. that there was a lack of systematic research involved in development of manuals a final search was made using the search terms therapy AND (manualization OR manualisation) AND systematic (in either the title or abstract) with no limits applied. This search identified the paper by Pote et al. and four others. The only one of these four that was relevant was a paper by Fonagy and Target (1996) about whether or not research should determine clinical practice. The authors argued that close collaboration between researchers and clinicians enriches the work of both, and the field of psychotherapy in general.

It can be seen then that although traditionally manuals have evolved from clinicians' self-report or syntheses of clinical writing, this has been challenged more recently by the idea that a more systematic approach to manual development could increase validity

and relevance. Pote et al. used a systematic approach which included interviews and observations of clinical practice. However, the searches did not retrieve psychotherapy manuals that have been developed using either consensus methods or involved service users.

2.4.7 Guidance on content and characteristics

Manuals in current use do not have a standardised content or structure (Lambert et al., 2004), and although ‘there has been extensive discussion of the role and place of treatment manuals, little study of their construction has taken place’ (Duncan et al., 2004, p. 201). However there is some guidance available about what content is appropriate as well as about appropriate characteristics.

Content

Two Delphi studies have looked at appropriate content of manualised treatment programmes (Duncan et al., 2004; McCulloch & McMurrin, 2007) and other clinical researchers have given overviews or suggestions of appropriate content (Carroll & Nuro, 2002; Luborsky & J. Barber, 1993). McCulloch and McMurrin (2007) and Duncan et al (2004) concur that manuals should specify what the intervention aims to do. Luborsky and Barber (1993) suggest that a description of the technique and an outline of the underlying principles and models of change are essential, and Carroll and Nuro (2002) suggest that this description should include the treatment frame, and guidelines for the conduct and goals of sessions. Detailed instructions and advice on delivery are seen as important by McCulloch and McMurrin (2007) and Duncan et al (2004) recommend specification of the aims and objectives of each session.

Carroll and Nuro also suggest that manuals should outline the defining elements of the treatment, including unique and essential elements of the treatment, essential but not unique elements, recommended elements and proscribed elements. However proscribed elements did not reach consensus in one of the Delphi studies (Duncan et al., 2004) as either essential or desirable (it was not seen as inappropriate either). Adherence scales were seen as essential by some but were not generated in the Delphi on content for a cognitive behavioural treatment manual (Duncan et al., 2004)

Iteration and evolution of content

Carroll and Nuro (2002) also assert that content of manuals should evolve alongside the respective treatment. They propose a model of manual development comprising a series of progressive stages and suggest guidelines for the content of manuals at each stage of development. They clarify that manuals may be needed to serve a number of different functions. A Stage I manual defines the treatment in broad strokes and is useful for preliminary evaluation of feasibility and efficacy. A Stage II manual has additional content and specificity which means it can be used to reduce the impact of therapist effects in clinical efficacy trials, as well as highlighting the distinction between therapies and linking process to outcome. A Stage III manual is one which is suitable for effectiveness testing and broad dissemination to the clinical community.

These are useful distinctions for this thesis. It is clear that much of the scope of this project lies within the preliminary stage outlined by Carroll and Nuro. However, this manual is not being designed for immediate use in a pilot as Carroll and Nuro's Stage I manuals appear to be. Instead, it is designed to be used first in clinical settings and training by members of the broader community who will help to shape and hone further iterations of the manual which may then be used in outcome research. So it may be that while the manual will share many characteristics of a Stage I manual it will also require some of the flexibility and detail of a Stage III manual.

According to Carroll and Nuro a Stage I manual should include: an overview, description, and rationale of approach; a conception of the disorder or problem; theoretical mechanisms of change; an outline of treatment goals; a discussion contrasting the approach to other related approaches; specification of defining interventions; outline of session content; outline of general format for delivery. This is a useful summary, although it is perhaps not a definitive summary as, for example, it does not mention contraindications or appropriate settings.

Characteristics

McCulloch and McMurrin (2007) emphasised the importance of 'readable presentation, jargon-free language, and user-friendly format of materials' (p.265) and Duncan et al (2004) found clarity in terms of language and presentation to be important. As discussed earlier many manual developers have highlighted the importance of

flexible manuals (Pote et al., 2003; Rolvsjord et al., 2005), an issue endorsed as desirable in the Delphi study by Duncan et al (2004).

2.4.8 Art therapy manuals

Manuals may cause conflict for art therapists who value the creativity and flexibility of their intervention. Creativity tends to be thought about in terms of ‘flow’ (Csikszentmihalyi, 1997) or ‘potential space’ (Winnicott, 1971) but it is seldom seen as something for which a recipe can be given, and many art therapists may feel wary about overly prescriptive specifications of an intrinsically creative and interpersonal intervention (Taylor Buck & Dent-Brown, 2014). Attempts at manualisation may be seen as likely to produce a ‘cookbook’ or set of instructions to ‘paint by numbers’ (Silverman, 1996). Art therapists potentially face a dilemma then, torn between the recognition that developing art therapy manuals may be helpful for the development of the evidence-base for art therapy and the fear that using a manual might be too reductive and prescriptive.

A literature search of three databases (Medline AMED and PsychInfo) took place early on in the research process and then was updated in September 2014. Search terms used were “art therapy” OR “art psychotherapy” combined using the operative AND with manual OR manualised OR manualized. No time limits were applied and the search was made for words present in the title or abstract. This search identified 29 items, only six of which referred to art therapy treatment manuals. Three of these manuals covered art therapy with specific client groups, i.e. obese patients (Sudres et al., 2013), patients with acute cancer (Hopf, 2011) and patients with eating disorders (Hinz, 2006; Sepulveda, 2007). Two were more general manuals, one being Liebmann’s classic manual of art therapy for groups (Levin, 2006; Liebmann, 2006) and the other covered the whole gamut of creative therapies (Brooke, 2006; Wolf-Schein, 2012). The remaining paper reviewed a ‘studio-manual’ of a hermeneutic phenomenological approach to art therapy (Carpendale, 2009; Zwaagstra, 2010). Of the papers identified, only one referred to an evaluation of effectiveness (Sudres et al., 2013). This manual was the most specific in terms of delivery of intervention and client group, indicating perhaps that the more specific a manual is the more readily it can be used in evaluation and research.

The search identified a review of Liebmann’s manual which was first published in 1986. The reviewer states that the book ‘remains one of the key manual-based guides

for the art therapist working with groups today' (Levin, 2006, p. 128). The book is a generalised description of art therapy with groups with no specification of applications or suggested client groups. Although in the most recent edition Liebmann herself recognises some of the limitations of the book, including the lack of information about different client groups, her work can be seen as blazing a trail. There is little evidence that in 1986 many other British art therapists were thinking about manualising their practice.

More recently within the profession there appears to be a growing recognition of the need for clarity and specificity around the practice of art therapy. Cornish (2013) argues that a lack of clarity about the role of art therapy may lead to art therapy being decommissioned in Child and Adolescent Mental Health Services (CAMHS), stating: 'in addition to increasing the research evidence-base, the role of art therapy, its unique (and generic) processes and practices within specialist CAMHS urgently requires both verbal and conceptual clarity for effective articulation'. In a discussion of what can be learnt from the recent Matisse randomized control trial, Wood (2013) highlights a 'lack of clarity' (p.92) about the approach which was being offered in the trial, which 'must have led to variations in what was provided for clients at the different trial sites' (p.92). She argues that the art therapy approach used in the trial was not specifically adapted to the needs of people with a diagnosis of schizophrenia and that this did not reflect UK practice over several decades. She urges that: 'Trial protocols need careful preparation and hypothetical clarity about what is being tested' (p.95).

In the UK, art therapists working with specific client groups have developed best practice guidelines and accounts of this process have been published (ATCAF, 2013; Springham, Dunne, Noyse, & Swearingen, 2012). Springham et al (2012) state that, 'Clinical guidelines are an important part of evidence-based practice. They operationalise research for practice and they define practice for research'. Some of the guidelines are comprehensive and cover some of the material suggested by Carroll and Nuro (2002). For example Brooker et al (2007) developed evidence-based clinical practice guidelines for the use of art work in art psychotherapy with people who are prone to psychotic states, which includes information about: the aims of the work; the context and setting the role of the art work; referrals; assessments; formats; and therapeutic approaches. The authors describe the guidelines as based on the best available evidence pertaining to art psychotherapy with people prone to psychotic

states. Comprehensive guidelines such as this could provide a good starting point for a range of manuals focussing on specific conditions or client groups.

2.4.9 Summary

There is currently no manual for dyadic art therapy with school age children. However there are an increasing number of psychological therapy manuals that can serve as illustrations and models for the construction of other manuals. This construction necessitates decisions about the level of prescription and flexibility. Flexible, broadly descriptive manuals may help to counter concerns within the art therapy profession about manualisation.

2.5 Research gaps

2.5.1 Dyadic art therapy

Most of the literature on parent-child art therapy focuses on work with infants or pre-school children. There are few descriptions of dyadic art therapy with school age children in middle childhood. Some of the literature which does cover this age range refers only to occasional dyadic sessions within a family art therapy package (Rubin, 2005), or to group approach (Plante & Berneche, 2008). The most comprehensive account of dyadic art therapy is given by Proulx (2003) who documents her own clinical practice with a particular focus on preventative group work with ‘the early childhood population’ (p. 19). The book is not based on empirical research and only briefly describes work with individual dyads and older children. The emphasis of Proulx’s book is on theoretical orientation and prescribed activities rather than broad principles and goals. There is a need for manual for dyadic art therapy for all ages of children but particularly school age.

2.5.2 Children’s perspectives

Some research has taken place looking at what service users find helpful about art therapy. However the majority of this work focuses on art therapy with adults. There is a paucity of systematic research into what children think about art therapy, or of what the parents of children involved in art therapy (either individual or dyadic) see as helpful, or hindering, about the process.

2.5.3 Research-based art therapy manuals

There are not many art therapy manuals to be found. The search reported found only a handful of manuals, some of which were not specific about the client groups. There are some books which can be used as manuals (Liebmann, 2006) but they often rely on expert self-report and may therefore not represent a consensus of best practice, and may also lack specificity. There are a number of much more specific clinical guidelines for using art therapy with particular client groups which might be able to be used in the same way as a manual, such as those developed by Brooker et al (2007) for the use with people who are prone to psychotic states. However for dyadic art therapy there are no consensus led, research-based guidelines.

2.5.4 Summary

The literature searches uncovered sparse literature relating to individual dyadic art therapy treatment with children in middle childhood. A handful of case studies and vignettes make up the available literature, and while these vignettes give a flavour of the work, there is as yet no comprehensive or systematic description of dyadic art therapy with children in middle childhood. The literature also lacks comprehensive accounts of service users views' of art therapy with children and families, and more specifically, of dyadic art therapy. There is also an apparent lack of research-based art therapy manuals which focus on the overarching principles and goals of the intervention and have a format that is sufficiently flexible to allow room for the therapists' individuality and creativity.

The literature searches shaped my thinking about how to set about developing the content for a manual of dyadic art therapy. I wanted to develop a manual that was flexible enough to counter concerns in the profession about a loss of creativity, but at the same time I wanted the manual to be sufficiently precise that it could be used in outcome-based research. I wanted the content to be developed using empirical research rather than personal experience alone, and I wanted it to be grounded in clinical practice, including the views of service users as well as therapists.

CHAPTER 3: Methods

3.1 Introduction

In this chapter I outline the objectives of the research and describe the research paradigm I worked within. The research falls into four sequential phases and I will outline each of these. Details of data collection and analysis of each phase are presented in Chapters 4-7.

3.2 Objectives

This thesis seeks to develop content for a dyadic art therapy manual for clinical practice and research purposes through empirical research. The objectives of the thesis are:

- To identify the relevance, prevalence, reasons and influences for delivering dyadic parent-child art therapy in the UK (reported in Chapter 4).
- To identify expert opinion on the principles, practices and competences for dyadic art therapy (reported in Chapter 5).
- To gain insight into how dyadic art therapy is experienced by people who are delivering it and receiving it (reported in Chapters 6 and 7).
- To use the findings from the empirical research to construct a draft manual and begin an iterative process of developing the manual further by incorporating feedback from research participants and other dyadic art therapists (reported in Chapter 8).

3.3 Research Paradigm

Within social sciences research there has been a tradition of researchers explicating their ontological and epistemological position and how these beliefs influence the methodology they use. However, my research design was not ontologically driven. Instead I took a pragmatic approach, with the research questions as the starting point. The top-down ontology-driven approach has been described as just one possible paradigm (Morgan, 2007). Morgan calls the hierarchy of ontology, epistemology and methodology, which has dominated social sciences research since the 1980s, the 'Metaphysical Paradigm'. He describes this paradigm as an 'epistemological stance' which emphasises 'metaphysical issues related to the nature of reality and truth' (p.49). He suggests an alternative paradigm, explaining that he is not using the term to denote an 'epistemological stance' but 'a system of beliefs and practices'. To mark this

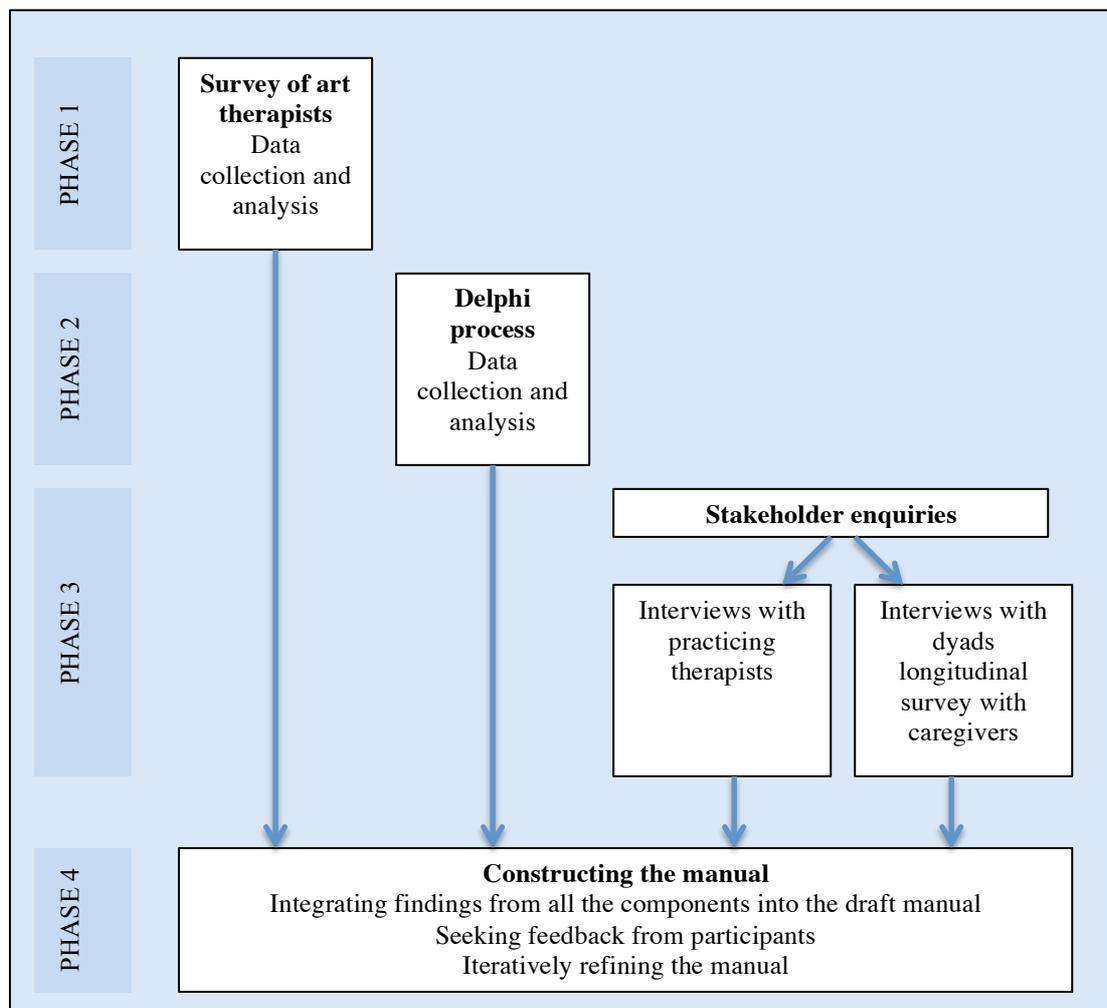
difference he does not use the word paradigm, instead he calls the alternative paradigm he proposes *The Pragmatic Approach*.

Pragmatism is a worldview that draws on the work of theorists such as William James and John Dewey (Creswell & Clark, 2011; Morgan, 2007) and is typically associated with mixed methods research. The focus is primarily on the research question and the use of multiple methods to inform the inquiry (Creswell & Clark, 2011). The pragmatic approach does not ignore the relevance of ontological and epistemological assumptions, but rejects the ‘top-down privileging of ontological assumptions in the metaphysical paradigm as simply too narrow an approach’ (Morgan, 2007, p. 68). Within my pragmatic approach I adopted a ‘subtle realist’ position (Hammersley, 1992), based on an awareness of how my own internal world impacts on my perception and understanding of the external world. In practice this meant that reflexivity was important to my whole study to understand how my background and beliefs shaped the questions I asked, how I addressed them, and how I collected, analysed and interpreted findings.

3.4 Mixed methods design

Mixed methods were chosen to extend the range and breadth of the inquiry (Greene, Caracelli, & Graham, 1989) with the aim of developing a more comprehensive account of the issue under study (Bryman, 2006). A convergent parallel mixed methods design (Creswell & Clark, 2011) was used with three empirical components - a survey of qualified British art therapists working with children and families, a Delphi study, and a qualitative enquiry with stakeholders. The results of each component were analysed separately before being integrated into the first draft of the manual which was then refined iteratively using feedback from research participants. The components were completed sequentially, primarily because I was a single researcher, as opposed to having a rationale for an explanatory or exploratory sequential design (Creswell & Clark, 2011). However due to the sequential nature of the design, later studies were informed to some degree by findings from the earlier studies.

Figure 3.1: Flowchart of the convergent parallel mixed methods design



3.5 Ethical issues

3.5.1 Ethical Approval

Ethical approval was sought at three separate points during the progression of the study. The first application was for the survey. At that time, NHS ethics approval was required through the National Research Ethics Service (NRES). Currently the situation has changed and were I applying now, University ethics approval would be sufficient. The second application was for the Delphi exercise and, again, NHS ethical approval was required. However, because of the relatively low ethical risk represented by the study, proportional ethical review was sought and gained. The third application was sought for the qualitative enquires which comprised: the therapist’s semi-structured interviews; the child’s semi-structured interviews; and the Helpful Aspect’s of Therapy (HAT) questionnaire for parents and carers. Ethical permission was granted by NRES for these enquiries to take place and NHS local governance approvals gained.

3.5.2 Involving children

Within research ethics, children are often seen as vulnerable because they have a reduced ability to protect their own interests (Singh & Keenan, 2010). This may particularly be an issue when obtaining informed consent for their involvement.

Children who are too young to give legal consent to participate in research still need to assent to participation. It is essential that children feel they have a free choice, and that this is, as far as possible, an informed choice.

Children who were identified by their therapists as potential participants in Phase 3 of the research were given an age-appropriate (or developmentally appropriate) version of the participants' information sheet to read through with their parents or carers (See Appendix 7.3 and 7.4). A meeting was then arranged between carer, child, therapist and researcher at which the child was invited to ask any questions they might have.

Caregivers were asked to give legal consent for their own participation and that of their child, but they were also asked to discuss this with the child and to let the therapist or researcher know if the child had any reservations or did not wish to participate. The child's informed assent was vital given the child-centred element of this research project.

There was a possibility that issues of child protection could arise, so the participants' information clarified that, if information was given that indicated someone was at risk, then this information would be shared with the appropriate people. The interviews with the children and carers were arranged to take place in the clinical setting with appropriate people available should any such disclosures arise.

CHAPTER 4: Survey of art therapists

4.1 Introduction

This thesis focuses on parent-child dyadic art therapy. My own interest in this came from my clinical work. Discussions with colleagues suggested that a number of other art therapists were also working in this way and there was a growing interest in this approach within the profession as a whole. However, this was purely anecdotal and so I decided to search for evidence of the prevalence of use of this approach amongst art therapists in the UK.

Initial literature searches demonstrated that although there were some descriptions of dyadic work with mothers and toddlers or infants (Hall, 2008; Hosea, 2006; Proulx, 2002), there was less literature describing the approach beyond early childhood. There was no literature indicating whether this way of working had filtered through to art therapists in the UK, whether they were developing their own ways of working with children in middle childhood, or the reasons they might have for adopting this approach. In addition I was aware of further anecdotal evidence that art therapists working with children and families might, to some degree, be shifting from the traditional art therapy focus on the therapeutic relationship between client, therapist and image, to a wider focus on significant intra-familial relationships. This shift of focus has been outlined by Waller (2006):

‘Increasingly art therapists are turning to attachment theory to explore early childhood relationships and their impact on subsequent behaviour; and to family systems theory which seeks to make a change in the way that members interact rather than focusing on the child or children with ‘the problem’ (p.281).

I found an earlier survey of art therapists carried out in 1998 (Karkou, 1999) which asked art therapists about their theoretical influences. This offered the opportunity to track any marked changes or shifts since 1998. I was also interested to find out whether, in the absence of any training in dyadic art therapy, art therapists were drawing on training or experience in some of the other relationship based interventions identified in the literature review such as Filial therapy or Watch Wait and Wonder.

My aim was to undertake a survey of art therapists in the UK to measure prevalence of dyadic art therapy, to understand why art therapists adopt this approach, and to understand their theoretical influences.

4.2 Methods

A survey is a method of collecting information ‘from and about people to describe, compare, or explain their knowledge, feelings, values, and behavior’ (Fink, 2006, p. 1). Surveys can take the form of a self-administered questionnaire (paper-based or electronic), or an interview with a researcher (face to face or remote such as a telephone interview). Surveys may be conducted for a wide range of reasons including: as market research; to help design and inform public services; to evaluate products or services; or for academic research purposes. Whatever the format or reason for the survey, it should be fit for purpose and should be able to demonstrate reliability and validity: ‘A reliable survey results in consistent information’ whilst ‘a valid survey produces accurate information’ (Fink, 2006, p. 7).

4.2.1 Mode of administration

The purpose of this survey was to find out about the behavior of UK art therapists working with children and families in regards to dyadic art therapy. By surveying a wide range of art therapists, working in diverse settings with children and young people, I hoped to explore the emerging practice of dyadic art therapy. The aim required a large sample and, since face to face or telephone interviews would have posed restrictions in terms of numbers, a self-administered questionnaire was designed that could be completed either on paper or online using a survey website.

4.2.2 Sampling frame

The British Association of Art Therapists (BAAT) is the professional organisation for art therapists in the UK. It maintains a directory of qualified art therapists and works to promote art therapy in the UK. Full members must be qualified Art Therapists holding a PG Dip/MA/MSc in Art Therapy from a validated course in the UK and must also be registered with the Health and Care Professions Council (HCPC) (BAAT, No date). Only a sub-set of therapists in this directory work with children and families and this was the target population. The population size of qualified and active members of BAAT working with children and families when the survey was undertaken in November 2010 was 878 (figure supplied by BAAT office).

When selecting a sample of the target population to survey, random sampling guards against bias because it ‘gives everyone who is eligible to participate in the survey a fair chance of selection’ (Fink, 2006, p. 45). However, in this case, I needed to survey the whole of the target population (i.e. all members of BAAT currently working with children and families) rather than a representative sample of the population. This was because I was concerned about a low response rate given that unsolicited surveys typically have low rates of response (Fink, 2003, p. 43). A sample size calculation indicated that to achieve 95% confidence of estimating a 50:50 split response to any given question within 10%, 87 questionnaires would need to be returned.

Ideally the questionnaire would have been sent to the subset of BAAT members working with children and families. Unfortunately this database of names and contact details was not available to me. Therefore I had to take a pragmatic approach. First, I sent the questionnaire to all members of BAAT, via the profession’s news-briefing service. Second, further awareness raising took place at a BAAT special interest group for art psychotherapists specialising in work with children and families (ATCAF). Finally, snowballing techniques were also employed with members of ATCAF being asked to raise awareness with other art psychotherapists whom they thought might be interested in participating, and an invitation sent by the coordinator of the SIG for art therapists in education to all the group members. Of the estimated population of 878 art therapists working with children and families in Britain, those who chose to respond would of course be a self-selecting group perhaps more likely to have an interest in dyadic art therapy than those who chose not to respond. However, although this bias is important and should be acknowledged, it would also have occurred if a randomly selected sample of the population had been approached.

4.2.3 The questionnaire

Fink recommends that the definitions and models used to select questions for a survey are grounded in theory or experience (Fink, 2006, p. 7). Since I wanted to find out about my peers’ ‘knowledge, feelings, values, and behavior’ (Fink, 2006, p. 1) about dyadic work, one of the starting points was my own clinical practice, and the clinical practice of art therapists I had a personal relationship with, e.g. my supervisor and my supervisees. I drew on this experience, asking written questions of my peers to see if they involved parents and carers to the same extent that I did and for the same reasons that I did. Using free text boxes, I also left space for them to tell me about different

motivations and ways of working that might be outside my own experience. The questions were also grounded in theory. Proulx's book (2003) gives the most comprehensive account of dyadic work and some of the questions drew on her descriptions. Other questions drew on literature outlining other interventions focused on the primary attachment relationship and on increasing caregiver sensitivity and reflective functioning (Chambers, Amos, Allison, & Roeger, 2006; Landreth & Lobaugh, 1998; Marvin, Cooper, Hoffman, & Powell, 2002; Slade et al., 2005; Wan, Moulton, & Abel, 2008).

The majority of the questions were closed questions which are considered more efficient and more reliable than open questions due to the uniform data they provide (Fink, 2006). However, alongside the fixed-choice answers, space was included for respondents to describe their own motivations, approaches and theoretical influences (if they were not included in the choices given). A free text comment box was also added to every section (see appendix for a copy of the questionnaire). This was because closed questions can represent the researchers' agenda, even if they have been developed through listening to people's views in focus groups and depth interviews. The use of "any other comments" may redress the power balance between researchers and research participants (O'Cathain & Thomas, 2004). The intention was not to generate in-depth qualitative data, but rather to create a 'safety net' to capture important issues that could have been missed by the closed questions.

4.2.4 Piloting

Fink (2006, p.6) states that: 'All types of questionnaires and interviews must be pilot tested', to help iron out any difficulties with the instructions and highlight where greater clarity might be helpful. Piloting a questionnaire can increase the validity and reliability 'because it can help you see that all topics are included and that sufficient variety in the responses is available' (Fink, 2006, p. 32). This questionnaire was piloted on a group of six experienced art psychotherapists, all of whom worked in Child and Adolescent Mental Health Services (CAMHS). During the pilot test the completion time was monitored and a mean time of 14.2 minutes (12 minutes median) recorded. After completion a discussion was held and feedback was sought from the participants, some of whom also wrote comments on their questionnaire. The participants highlighted some areas where greater clarity was required in the wording, or where additional

options could be given. Table 4.1 shows the feedback comments and the changes made in response.

Table 4.1: Changes implemented after pilot

Points raised by testers	Changes implemented
In questions about work settings, fixed choice answer ‘CAMHS’ could be broken down to reflect tiers or inpatient/outpatient setting	Option changed from ‘CAMHS’ to ‘CAMHS Inpatient’ and ‘CAMHS Outpatient’
The question ‘If parent/carers are included in art therapy sessions do you also arrange separate meetings with them?’ was insufficiently clear and needed unpacking	Wording changed to ‘If parent/carers are included in art therapy sessions do you also arrange separate meetings just with the parents/carers?’
The question ‘Please specify any other interventions you offer to children/young people with attachment difficulties and rate how frequently you use this approach’ needed clarification in terms of whether this was about interventions offered by the individual therapist by the wider team.	Wording changed to ‘Please specify any other interventions you personally offer to children/young people with attachment difficulties and rate how frequently you use this approach’
The question ‘When referred a child or young person with attachment difficulties, how frequently do you offer the following interventions?’, had the fixed choice options of: ‘Never’; ‘Occasionally’; ‘About half the time’; ‘Often’; ‘Almost always’; ‘N/A’. However, feedback was that whilst they personally might not offer some of the given interventions, if they were part of a team there might be someone else able to offer the intervention.	The wording of the question was changed to ‘When referred a child or young person with attachment difficulties, how frequently do you <i>personally</i> offer the following interventions?’ (italics given here but not in questionnaire), and the fixed choice options were expanded to include ‘I do not offer this – but it is available in my team’.

Points raised by testers	Changes implemented
<p>The statement ‘My work with children/young people and families is informed by:’ was followed by a list of suggested theories (e.g. Psychoanalytic theory) and some blank boxes for respondents to add in other influences. The fixed choice responses were originally ‘Not at all’; ‘Moderately’; ‘To a great degree’. Testers asked for an increased range of choices</p>	<p>The option ‘Slightly’ was added to fixed choice options</p>
<p>The fixed choice responses to questions about specialist knowledge and interest were originally given as: ‘True’; ‘False’; ‘Don’t know’. Testers thought this needed more range.</p>	<p>Questions slightly reworded so that fixed choice responses could be: ‘No; ‘A little’; ‘Yes’; ‘Don’t know’.</p>
<p>In the section enquiring about reasons for involving parents and carers in sessions, one of the testers who was a very experienced art therapist, commented that she worked dyadically to enable the parent and child to share a playful and creative experience which might lead to greater attunement and fun, as such forging new neural pathways.</p>	<p>As there was no question reflecting this important intention, the following question was added: To offer the child/young person and the parent/carer a shared creative/playful experience.’</p>
<p>The group discussion following completion highlighted the importance of giving respondents space to add in comments and thoughts based on their own working practice</p>	<p>Free text comment boxes were added in at the end of every page and the following instruction was added in to the start of the questionnaire: ‘If you have any additional comments please write them in the box at the bottom of each page.</p>

Overall the participants found the survey relatively quick and easy to complete. Written feedback also included positive comments, for example: ‘Really well laid out, user friendly format’.

4.2.5 Data collection

Following the pilot study, an electronic on-line version of the questionnaire was launched (using Survey Monkey which is a web-based survey platform) with an invitation included in the BAAT electronic news briefing service. Although this bulletin goes out to all members of BAAT, it was specified that only those working with children or young people and families were being asked to complete the questionnaire. Inclusion criteria were: being a qualified art psychotherapist; a current member of BAAT; and working with children or young people. At the same time an invitation to complete the questionnaire was issued in person at a BAAT special interest group (SIG) for art psychotherapists specialising in work with children and families (ATCAF). There were approximately 20 art therapists at the meeting, all of whom had experience of offering art therapy to children and young people. As such this seemed like a good place to raise awareness of the survey. Awareness was also raised by asking the ATCAF members present at the meeting to encourage their colleagues to participate. This included the chair of a second relevant SIG (for art psychotherapists working in education), who was present at the launch meeting and sent an email out to all her members to invite them to answer the questionnaire on line.

4.2.6 Analysis

Data were analysed using the statistical computer program SPSS (Statistical Package for the Social Sciences). The chi-square test was used to compare categorical variables and t-tests were used for continuous variables. Means were calculated with 95% confidence intervals for prevalence variables. A p-value of .05 was used to indicate a statistically significant difference.

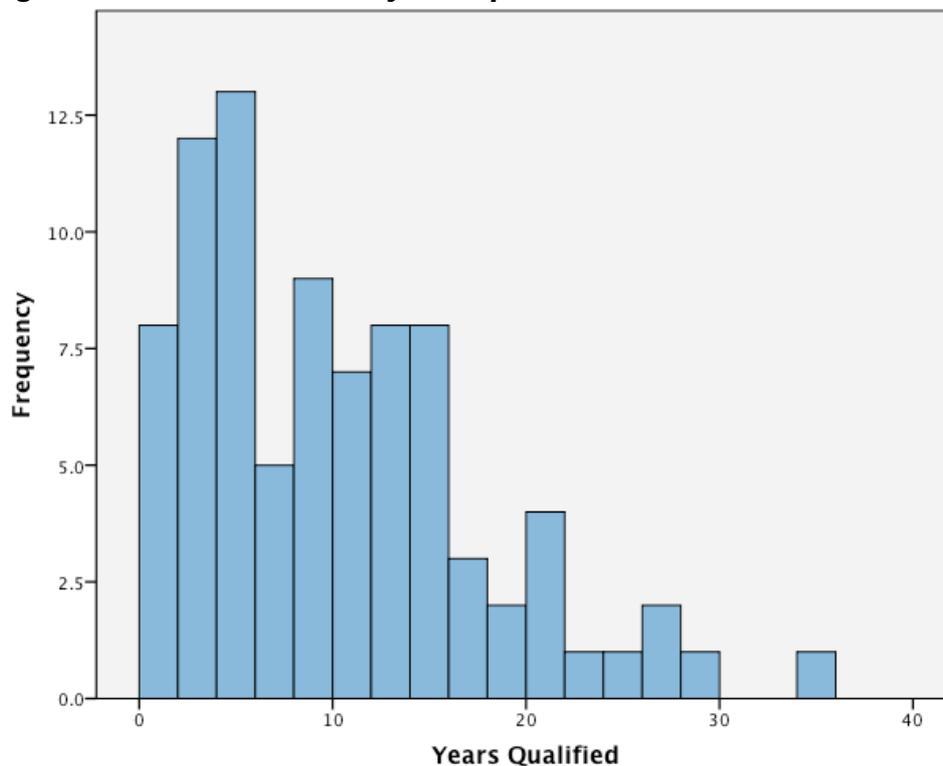
4.3 Results

4.3.1 Response rate and participant characteristics

There were 106 questionnaires completed between 1st June and 1st October 2010, with 85 of those respondents identified as meeting the inclusion criteria. This represents 9.7% (85/878) of the total population of art therapists working with this client group. All further analysis is based on these 85 eligible respondents, although for some questions a few respondents did not enter a response and so they have been excluded from the denominator.

Respondents were all qualified art psychotherapists who had been qualified for between one and thirty-four years. The mean number of years qualified was 9.7 (Standard Deviation (Std dev.) = 7.4) as shown in Figure 4.1.

Figure 4.1: Distribution of years qualified



Respondents worked in a variety of settings but mainly CAMHS and education (Table 4.2).

Table 4.2: Work Setting

Setting	Number of respondents (%)
CAMHS out-patient	32 (37.6%)
Education	18 (21.2%)
Other	16 (18.8%)
Multiple settings (including CAMHS)	7 (8.2%)
Multiple settings (not including CAMHS)	5 (5.9%)
CAMHS in-patient	3 (3.5%)
Private practice	3 (3.5%)
No setting recorded	1 (1.2%)
Total	85

Respondents were asked to report the lower and upper age limits for their clients. The lower limit was, on average, 6 years old (although there were some extreme outliers) and the upper age limit was, on average, 16 years old. However, there were some therapists with much narrower age ranges: one therapist's range was very specifically from age four to five. This average age range of children between the ages of 6 and 16 equates to middle childhood and adolescence, or school age children. As mentioned in the literature review, literature available on dyadic art therapy with this age group is sparse.

4.3.2 Parent/carer involvement in assessment and therapy sessions

When a person is referred to art therapy there is likely to be a period of assessment at the start of the treatment process. Results showed it was more common to involve parents or carers in assessment sessions than in subsequent therapy sessions. Over half of respondents (55%) reported that in many or almost all cases they include parents and carers in the initial assessment session and 79% of respondents described this as occurring with some degree of frequency (i.e. in some, many or almost all cases). On the other hand only 22% reported frequent inclusion of parents and carers in all the assessment sessions, although 49% reported doing so sometimes. Although only 12% of respondents described inclusion of parents or carers in art therapy sessions as frequent, and only 1% employed this approach in almost all cases, 60% of all eligible respondents reported that they did employ this approach in some, many or almost all cases. See Table 4.3.

Table 4.3: Frequency of Parent/Carer Involvement in different types of sessions

	Never	In some cases	In many cases	In almost all cases
Include parents / carers in the INITIAL assessment	18 (21.4 %)	20 (23.8%)	9 (10.7%)	37 (44%)
Include parents / carers in ALL the assessment sessions	42 (51.2 %)	22 (26.8%)	9 (11%)	9 (11%)
Include parents / carers in art therapy sessions	34 (40%)	41(48.2%)	9 (10.6%)	1 (1.2%)

The data can be simplified to show art psychotherapists who sometimes, with any degree of frequency, involve parents and carers in art therapy sessions compared to those who never employ the approach (see Table 4.4).

Table 4.4: Frequency of Parent/Carer Involvement (Simplified)

	Never	Sometimes
Include parents / carers in the INITIAL assessment	18 (21.4 %)	66 (78.6%)
Include parents / carers in ALL the assessment sessions	42 (51.2) %	40 (48.8%)
Include parents / carers in art therapy sessions	34 (40%)	51 (60%)

4.3.3 Work settings where dyadic art therapy is used

The results showed that the likelihood of a respondent adopting a dyadic approach, by involving parents and carers in therapy sessions, varied according to work settings (see Table 4.5). A Chi-square test was undertaken to compare any CAMHS setting (i.e. inpatient, outpatient and multiple settings including CAMHS) with the other settings (i.e. Education, Private practice and any others). The difference across these two groups was found to be statistically significant (Chi-square = 12.65, df = 1, $p < .001$), with the dyadic approach more prevalent in CAMHS settings.

Table 4.5: Likelihood of including parents and carers in different settings

Work setting	Inclusion of parents or carers in art therapy sessions (the number of therapists is given, followed by the percentage of therapists this equates to within the given setting)	
	Never	Sometimes
Any CAMHS setting	9 (21.4%)	33 (78.6%)
Any non-CAMHS setting	25 (59.5%)	17 (40.5%)

4.3.4 Length of Experience

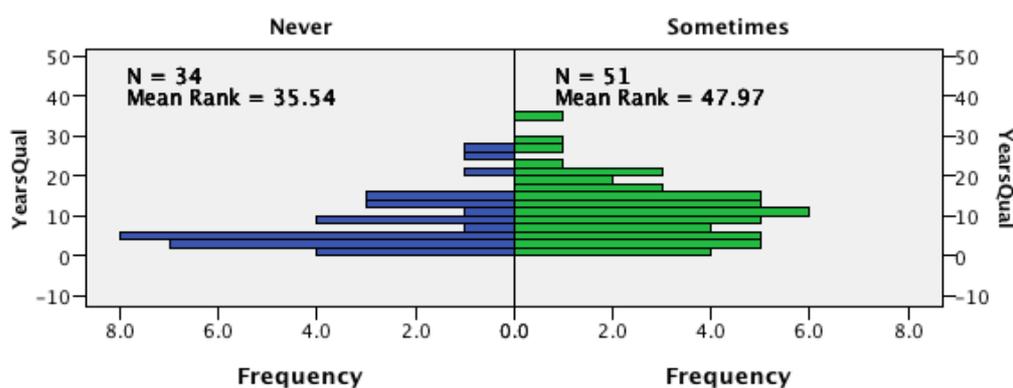
The results highlighted a difference in the mean length of experience between art psychotherapists who sometimes adopt a dyadic approach by including parents or carers in therapy sessions, and those who do not, as shown in Table 4.6.

Table 4.6: Length of Experience of art therapists

		N	Mean (Std Dev) experience in years
Frequency of adopting a dyadic approach	Sometimes	51	12.0 (7.6)
	Never	34	8.6 (6.7)

As the distribution of number of years qualified was not normal (see figure 4.1) a non-parametric test was used to compare the two groups. The Mann-Whitney U test showed a statistically significant difference between the two groups ($u = 613.5$ $p = 0.023$). See Figure 4.2.

Figure 4.2: Length of experience of art therapists who sometimes work dyadically compared to those who never work dyadically



4.3.5 Age of client group

Respondents were asked about the youngest children they worked with (i.e. the minimum age limit) and the oldest children that they worked with (i.e. the maximum age limit). The results show that art psychotherapists who do sometimes adopt a dyadic approach by including parents or carers in sessions, work with younger children than those who do not ($t = -2.09$, $df = 82$, $p = 0.04$). See Table 4.7.

Table 4.7: Age of client group

		N	Mean (Std Dev) minimum age limit of clients
Frequency of adopting a dyadic approach	Sometimes	50	5.0 (3.1)
	Never	34	6.5 (3.5)

4.3.6 Theoretical Influences

About three quarters of respondents (74.4%) said that attachment theory informed their work to a great extent, compared to 54.2 % for psychoanalytic theory and 44.4% for object relations. Fewer people said their work was informed to a great extent by systemic family therapy (15.1%), Jungian psychology (13.9%), solution focussed therapy (11.3%) or cognitive behavioural therapy (5.7%).

I tested whether dyadic art therapy was more likely to occur under any of the above theoretical influences and found nothing that was statistically significant with the exception of systemic family therapy. This result is not unexpected since art therapists who adopt a systemic family approach would be likely to include other members of the family in art therapy sessions.

4.3.7 Reasons for involving parents and carers in art therapy

Respondents who said they at least sometimes used a dyadic approach were asked about their reasons for adopting a dyadic approach. They were given a list of six reasons and some blank boxes to provide their own reasons, if not present on the list, and rate them accordingly. For each possible reason, respondents were asked to say if they never adopted a dyadic approach for that reason, or alternatively that they occasionally, sometimes, often, or almost always adopted a dyadic approach for that reason.

Respondents who did not work dyadically were given the option of saying the question was not applicable. For the purposes of analysis, people who did not answer the question or those who ticked the not applicable option were removed from the results, and the occasionally, sometimes, often, or almost always answers were combined into one category which was labelled 'sometimes'. These results are shown in Table 4.8.

Although it can be seen that observing the relationship was the most frequently cited

reason, while sharing therapeutic skills or modeling interaction was the reason least given, a chi-square test showed that there was no statistically significant difference between any of the reasons given (chi-square =6.08, df=5, p= .30)

Table 4.8: Reasons for involving parents and carers

Reason	Sometimes use dyadic approach for this reason	Never use dyadic approach for this reason	Total
To observe the relationship between the child/young person and the parent/carer	51 (92.7%)	4(7.3%)	55
To enhance parent/carer observation, sensitivity and reflective functioning	50 (91%)	5 (9%)	55
To offer the child/young person and the parent/carer a shared creative/playful experience	50 (89.3%)	6 (10.7%)	56
To work directly with the relationship between the child/young person and the parent/carer	49 (87.5)	7 (12.5%)	56
To reduce any anxiety the child/young person might feel when first engaging	47 (81%)	11 (19%)	58
To share therapeutic skills or model a way of interacting with the child/young person	43 (81.1%)	10 (18.9%)	53

Free text comments were also invited from respondents as to the reasons they might have for working with the parent-child dyad. However, analysis of the additional reasons given indicated that they appeared to corroborate or slightly elaborate the fixed

choice answers and did not provide motivations for dyadic work that were not covered by the questionnaire.

4.3.8 Familiarity with other relationship based interventions

Participants were asked to rate their familiarity with a selection of other relationship based interventions. The fixed choice options were: Not aware of this approach; Aware of this approach but no practical experience; Use elements of this approach but no formal training; Training or expertise in this approach. Table 4.9 shows the interventions and the degree of familiarity or expertise reported by respondents.

Table 4.9: Familiarity with other interventions

	Theraplay	Webster Stratton	Mentalisation-Based Therapy	Relationship Play	Filial Therapy	Watch Wait and Wonder	Parent Child Game	The Solihul Approach	Dyadic Developmental Psychotherapy	Circle of Security
Respondents using elements of this approach with no formal training	18 21.2%	14 16.5%	21 25.3%	13 15.3%	9 10.6%	10 11.8%	3 3.5%	4 4.7%	3 3.5%	5 5.9%
Respondents reporting training or expertise in approach	4 4.7%	4 4.75%	2 2.4%	1 1.2%	1 1.2%	1 1.2%	2 2.4%	2 2.4%	3 3.5%	0 0%

It can be seen that 25.3 % of respondents report using elements of Mentalisation-based therapy although they do not have formal training in the approach. This is the highest percentage, closely followed by Theraplay. Far lower percentages were reported for expertise or formal training in any of these interventions, the numbers for which were very low.

Analysis of the free text comments from respondents highlighted a few other interventions that had not been on the original list, which were ‘training with Rene Marks on Attachment therapy’; ‘Triple P (Positive Parenting Programme)’ and ‘CATT (Children's Accelerated Trauma Treatment)’. Each was mentioned only once.

4.3.9 Description of clients

The respondents worked with a wide range of client groups and many respondents reported working with more than one client group. The client groups listed by respondents were:

- Generic CAMHS including children with emotional, psychological needs or psychiatric disorders such as eating disorders, PTSD, attachment/relationship issues, bereavement, borderline adolescents, ADHD, loss, separation, anxiety, trauma and complex trauma.
- Children and young people with learning difficulties, special needs, social communication difficulties, ASD, statements of educational need, low self esteem, behavioural problems and those excluded from mainstream school.
- Children and young people who have been adopted or are in care.
- Vulnerable children including those affected by parental drug abuse, from deprived families, from separated families, or those who have suffered abuse, neglect, or witnessed domestic violence.
- Children and young people at risk of offending or those already involved in youth offending services
- Young people who have been sexually exploited or who are at risk of sexual exploitation

Nearly half of respondents reported that children referred to them often had attachment issues as the presenting difficulty and 88% (82) of respondents thought that children referred to them often had attachment issues as an underlying difficulty.

4.3.10 Continuing professional development

There was interest in continuing professional development in dyadic art therapy. Almost three quarters of respondents (73.5%) reported some experience of parent-child art therapy, but 36% of them said it was only a little. 98% of participants expressed an interest in finding out more about attachment-based approaches to parent-child art therapy.

4.4 Discussion

4.4.1 Summary of findings

The issue of most relevance to the aim of the survey was the percentage of art therapists working with children and families who practised dyadic art therapy during treatment sessions as opposed to other types of sessions. In this survey, 60% (95% confidence interval 50% to 70%) of respondents reported that they involved parents and carers in art therapy sessions with some degree of frequency. Therefore, based on this survey, it can be inferred that the majority of art psychotherapists working with children have, at least sometimes, worked with both the children and their parents or carers in the art therapy sessions. However, it has been shown that questionnaires are more likely to be returned if they are salient to the respondent (Heberlein & Baumgartner, 1978), and as such it is likely that this is an overestimate of the true prevalence.

The survey also aimed to identify the reasons and influences for delivering dyadic parent-child art therapy in the UK. Respondents reported that they worked dyadically to observe and work directly with the caregiver and child's relationship; to enhance caregiver sensitivity and reflective functioning and model or share therapeutic ways of interacting with the child; to offer a shared creative or playful experience; to reduce the child's anxiety when first engaging.

Theoretical influences identified by the respondents included attachment theory, psychoanalytic theory, object relations, systemic family therapy, Jungian psychology, solution focussed therapy and cognitive behavioural therapy. A variety of settings was also identified with the dyadic approach more prevalent in CAMHS settings.

4.4.2 Putting findings in the context of other research

Prevalence

These findings are in stark contrast to the results of an older survey of arts (i.e. not just art therapists, but also including music therapy, dramatherapy and dance and movement therapy) therapists carried out in 1998 (Karkou, 1999) which reported that whilst 11% of music therapists working in education worked with parent-child combinations or families, ‘none of the AT [art therapy] respondents who worked primarily for schools mentioned any involvement of parents within the sessions’ (p. p.65). Karkou reflects on the lack of parental involvement, and cites Case and Dalley (1990) who have suggested that the lack of parental involvement is a characteristic of the culture of schools in which children are predominantly viewed as individuals. Karkou suggests that ‘possibly this was one of the reasons for AT [art therapy] practitioners not making any attempt to undertake work with parents’. The results of my survey would seem to support the idea of a slightly different culture in education-based settings, with 39% of respondents who work in education reporting involving parent or carers with some degree of frequency compared to 78% of their colleagues in the CAMHS based settings. Another plausible explanation of this difference would be that in education settings art therapy sessions are likely to take place during the day when parents or carers are not on-site. However, in a CAMHS outpatient setting it is more likely that a child will have been brought to the session by a parent or carer who will perhaps remain in the building for the duration of the session. Therefore CAMHS outpatient settings may be more conducive to dyadic work simply by merit of the physical proximity and availability of parents and carers.

Theoretical influence

My survey confirms Waller’s (2006) assertion that art psychotherapists working with children are increasingly turning to attachment theory, with 74% of respondents describing attachment theory as informing their work to a great degree. It is interesting again to compare this with the results of the 1998 survey (Karkou, 1999) in which psychoanalytic theory was seen as one of the ‘Very important influences’ whilst ‘Bowlby’s ideas’, which presumably refers to attachment theory, was only seen as one of the ‘Semi-important influences’ for art therapists in general. Waller’s assertion that art psychotherapists are turning increasingly to ‘family systems theory’ (2006, p. p.281) is less well borne out by the current survey, with only 15.1% describing it as influencing their work to a great degree. However, this may be a significant increase

since the 1998 survey in which systemic family therapy did not even appear as a listed influence.

There was some indication in the survey that art therapists who are influenced by systemic family therapy are more likely to involve parents or carers in art therapy sessions. This might be explained by enquiring in more detail into the reasons behind involving parents or carers. For example one reason given by a respondent for inclusion of parents and carers was *'To facilitate discussion around particularly difficult experience the family has had; to try and open up discussion about the family's responses and recollections of experience e.g., domestic violence.'* This type of aim would clearly fit well with a systemic family approach, with the emphasis on the family process and facilitation of dialogue. However, other reasons given, particularly those referring to attachment issues and maternal sensitivity, would seem to fit better with approaches that have grown out of attachment theory (Moss, et al., 2011) and psychodynamic psychotherapy (Muir, Lojkasek, & Cohen, 1999). In practice it may be difficult to create a distinction between family art therapy and dyadic art therapy, particularly for example in a one-parent, one-child family. Possibly in such cases theoretical influences could be seen as the distinguishing feature, but even then it is not hard to find family therapy interventions that draw on both systems theory and attachment theory (Asen & Fonagy, 2011). Clarity between the two models may emerge with further research, or the two ways of working might evolve in similar directions and possibly merge.

The survey also demonstrated that art psychotherapists are gaining experience and skills in attachment-based approaches and 67% reported incorporating these approaches into their art therapy practice. In terms of related interventions, the approaches which the greatest percentage of respondents reported familiarity with were Mentalisation-based therapy and Theraplay. Few of the respondents had formal training or expertise in these other interventions, with the highest percentages having training in Webster Stratton or Theraplay.

4.3.3 Strengths and limitations

All registered UK art psychotherapists working with children and young people were invited to take part in the survey. However, those art psychotherapists who chose to complete the questionnaire may have done so because they had a specific interest in the

area (P. Edwards et al., 2002). It is likely that the results are not representative of all art psychotherapists and over estimate the use of dyadic therapy. However, even if the true prevalence was half that found in my survey, this is a significant number of art therapists in the UK using this approach. Also, the survey focused on one specific aspect of art therapy with a specific client group and as such the findings are not expected to be generalisable to a wider body of art therapists or to different client groups or different countries.

4.3.4 Implications for development of the manual

This survey helps to provide background for the manual. It clarifies and defines what art psychotherapists working with children and young people do in terms of dyadic therapy, and why they do it. It demonstrates that:

- A dyadic approach is common enough amongst UK art therapists for the development of a manual.
- UK art psychotherapists find the subject matter relevant, supporting the potential usefulness of a manual.
- Many respondents described a keen interest in parent-child work but little specialist training, identifying an unmet need for training in this specialist area.
- Dyadic work is more prevalent in CAMHS but still used in a range of settings. The implications of this are that the manual should not just cover CAMHS but be flexible enough to cover other settings too.
- There are a variety of reasons and influences for working in this way and so the manual would need to be inclusive of a range of influences.
- A dyadic approach is common as part of an assessment and the manual could address this as well as art therapy sessions.

4.3.5 Conclusion

The primary finding of this survey is that up to 60% of British art psychotherapists working with children and young people adopt a dyadic parent-child approach to some extent. Within CAMHS settings the survey showed that this percentage was much higher.

The results of this survey have been published in a peer reviewed journal (Taylor Buck, Dent-Brown, & Parry, 2012). For more information see Appendix 1.1.

CHAPTER 5: Delphi study of experts

5.1 Introduction

The survey discussed in the previous chapter indicated that a dyadic parent-child approach to art psychotherapy is being used by up to 60% of UK art psychotherapists working with children and young people with some degree of frequency (Taylor Buck et al., 2012). The literature review in Chapter 2 showed that there is little evidence on which to base the content of a manual for dyadic art therapy for children in middle childhood. Therefore I designed a Delphi study with the aim of seeking expert consensus on core principles, practices and competences (PPCs) for dyadic parent-child art therapy.

5.2 Methods

5.2.1 Consensus methods

There is a range of consensus methods, but the three main approaches used in health services research are the Delphi method, the nominal group technique (NGT) and the consensus development conference (Murphy et al., 1998). These formal methods of sharing decision making between a group rather than leaving it to an individual have the following benefits: reducing the likelihood of arriving at a wrong decision; having more authority than a single individual's opinion; creating a forum in which assumptions can be challenged and views must be justified; providing structure and a degree of protection to eliminate negative group processes; and having scientific credibility (Murphy et al., 1998).

Of the three main approaches cited by Murphy et al (1998), only the Delphi has no face-to-face contact: 'In the Delphi method the only interaction is in the form of written feedback of the other participants' judgements, whereas in NGTs and consensus development conferences the interaction is face-to-face' (Murphy et al., 1998, p. 17). I decided that a Delphi would therefore be most suitable as it would enable a broader range of panellists, both national and international, to participate. The absence of face-to-face meetings would also minimise the time commitment being asked of panellists, which given the voluntary, unpaid nature of participation seemed an important consideration.

5.2.2 The Delphi method

The Delphi method was originally developed as a way of offsetting the subjective bias that can inform group discussions, in which more vocal or persuasive individuals can skew the consensus at which the group arrives. Delphi participants ‘never meet or interact directly. Instead they are asked to suggest the factors or cues that should be considered by the group’ (Murphy et al., 1998, p. 4). Delphi is often used as ‘a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem’ (Linstone & Turoff, 1975, p. 3). The method aims to synthesize information and reach consensus amongst a panel of individuals deemed to have expertise in the given field of enquiry.

There are many different views about the most appropriate or useful ways of conducting a Delphi (Linstone & Turoff, 1975). No particular method has been agreed upon and researchers do not follow consistent methods or report findings in a uniform manner (Schmidt, 1997). Variations in the methods used in published studies include the recommended number of rounds, what each round comprises, panel size, and pre-determined levels of consensus.

Number of rounds

During a Delphi researchers develop statements relating to the subject of enquiry and select panellists who are asked to rate these statements in series of postal (or electronic) questionnaires. Once the answers have been received and collated for the first round, the questionnaire is re-circulated. Sometimes it is the original questionnaire that is sent out in this second round and sometimes it is one that has been modified in light of the feedback from the first round. There may also be an anonymised summary of the responses to the first round sent out with the second round questionnaire. This process is repeated for a predetermined number of rounds (Mullen, 2003).

Panel size

The size of a Delphi panel varies between published studies, with reported sample sizes varying from four to 3000 (Mullen, 2003). The RAND Appropriateness Methods (RAM) User’s Manual presents a standardised modified Delphi method, and states that there is no magic number: ‘panels can be of any size that permits sufficient diversity (a minimum of 7), while ensuring that all have the chance to participate (probably a maximum of 15)’ (p.25).

Level of consensus

The level of consensus within the Delphi panel that is considered acceptable by the research team also differs, with some studies reporting an agreement level set at 90% (Pfleger, McHattie, Diack, McCaig, & Stewart, 2008) and others setting the agreement level at 70% (Persoon, Banningh, van de Vrie, Rikkert, & van Achterberg, 2011).

Delphi method followed

There is little consistency in published Delphi studies (Schmidt, 1997) and efforts at defining a ‘true Delphi’ are often contradictory (Mullen, 2003). However, Mullen warns that to realise the full potential of a Delphi ‘it is essential to avoid over-restrictive narrow prescriptions’. I therefore adopted a pragmatic approach to designing the Delphi, checking that I structured the panel’s interactions during the Delphi in a way that was consistent with the broad description of Delphi methods given in the Health Technology Assessment on consensus development methods (Murphy et al., 1998).

5.2.3 Selecting the panel

I selected Delphi panel members with demonstrable expertise in one or more of the following areas:

- Art therapy with children and young people, evidenced by authorship or editorship of professional texts which I judged to be influential.
- Dyadic art therapy, evidenced by specialist papers written about parent-child art therapy.
- Art (or arts) based therapy and attachment, evidenced by substantial experience of working in specialist attachment treatment settings and/or clinical expertise in attachment

More information is given about the composition of the panel in Section 5.3.1.

5.2.4 Setting the questions

I wanted to find out about the key elements of a dyadic approach to art therapy pertaining to the underpinning principles, the actual practices and the skills required to deliver these. I therefore decided to categorise the key elements as principles, practices and competences (PPCs). In the first round of the Delphi study I sent out a questionnaire asking members of the panel to rate a researcher-generated list of potential PPCs comprising seven principles, eight practices and four competences. I

identified these potential PPCs from a literature review (see below) describing dyadic therapeutic interventions for caregivers and children.

Deciding how to generate the PPCs

I decided to use PPCs from existing dyadic interventions that were not art therapy based for a number of reasons. The first was to provide a model for potential PPCs based on interventions which were already seen as sufficiently clearly and systematically described to enable involvement in robust outcome-based research. However, it was clearly explained to panellists that this was only a list of ‘suggested’ PPCs which might, or might not, be important for the therapist to bear in mind when adopting a dyadic approach to art therapy. Panellists would then be invited to suggest further PPCs themselves which they considered appropriate. Given the degree of expertise amongst the panellists, this elicitation was seen as key to the Delphi process. As such, the original set of PPCs was not intended to be an exhaustive or even a coherent list: instead I wanted to provide a model and to stimulate thoughts about panellists’ own experience and practice. A further reason for not starting with items from the art therapy literature was that art therapists identified by the literature review were going to be invited to be members of the Delphi panel. This could have introduced a degree of bias that would have been hard to account for given that the strength of a Delphi is that each panel member has equal weight or influence. Finally, I hoped that seeing PPCs from other related interventions might lead to an interesting and creative cross-fertilization of ideas, and recognition that dyadic art therapy can be seen as part of a wider group of parent-child approaches.

Identifying relevant papers

The databases I searched to identify the research-based papers were CINAHL, PsycINFO, Web of Science, BIOSIS Previews, MEDLINE, and Journal Citation Reports. The search terms I used were: therapy OR psychotherapy; approach OR treatment OR model OR intervention; dyad OR dyadic OR mother-child OR father-child OR parent-child; attachment-based. The search strategy, which combined these four searches using the AND operator, elicited 35 results. However, some of these articles did not refer to a model of treatment which directly involved both children (or young people) and parents (or carers) in at least some joint therapy sessions, and some papers were referring to the same interventions, so papers such as these were excluded. The remaining nine papers all mentioned specific interventions for children and young

people which included at least one component of direct parent-child contact, and these became the interventions which I used to generate the suggested PPCs.

I also found two review papers using the search strategy; one was a review of interventions in the parent-child relationship (Broberg, 2000) and one of attachment-based interventions (Van Ijzendoorn, Juffer, & Duyvesteyn, 1995). The first review outlined the positive intervention results achieved with Toddler-Parent Psychotherapy (Cicchetti, Toth, & Rogosch, 1999) and described a comparative study of the Watch Wait and Wonder (WWW) technique (Muir, Lojkasek, & Cohen, 1999) in which mothers ‘reported significantly more satisfaction and fewer feelings of ineffectiveness in the parenting role... Furthermore, infants/toddlers in the WWW group made significantly greater gains in Bayley developmental scores and in emotion regulation scores’ (Broberg, 2000, p. p.41). WWW and Toddler-Parent Psychotherapy were also singled out as showing good results by both Prior and Glaser (2006) and Howe (2005) in their comprehensive examinations and analyses of the field and so they were included in the group of interventions from which the PPCs would be derived. The final list of papers and related interventions from which the PPCs were generated is shown in Table 5.1.

Table 5.1: Papers identified from literature search

Article Title	Intervention discussed
Efficacy of a home-visiting intervention aimed at improving maternal sensitivity, child attachment, and behavioural outcomes for maltreated children: A randomized control trial (Moss, et al., 2011)	Intervention Relationelle
Identifying therapeutic action in an attachment-centered intervention with high risk families (Steele, Murphy et al. 2010)	Attachment-Centred Parent-Child Therapy
The Mothers and Toddlers Program, an attachment-based parenting intervention for substance using women: Post-treatment results from a randomized clinical pilot (Suchman, et al., 2010)	The Mothers and Toddlers Program
Generating nonnegative attitudes among parents of depressed adolescents: The power of empathy, concern, and positive regard (Moran & Diamond, 2008)	Attachment-Based Family Therapy (ABFT)
Effects of an attachment-based intervention on daily cortisol moderated by dopamine receptor D4: A randomized control trial on 1-to 3-year-olds screened for externalizing behavior (Bakermans-Kranenburg, Van Ijzendoorn, Mesman, Alink, & Juffer, 2008)	Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIIP-SD)
Treatment for children with reactive attachment disorder: dyadic developmental psychotherapy (Retraction of November, pg. 43, 2006) (Becker-Weidman, 2008)	Dyadic Developmental Psychotherapy
Using Theraplay in shelter settings with mothers and children who have experienced violence in the home (L. R. Bennett, Shiner, & Ryan, 2006)	Theraplay
Parent and child therapy (PACT) in action: An attachment-based intervention for a six-year-old with a dual diagnosis (Amos, Beal, & Furber, 2007)	Parent and Child Therapy (PACT)
Attachment-based treatment for vulnerable children (Dozier, 2003)	Attachment and Biobehavioral Catch-up

Identifying PPCs

I examined descriptions of the interventions identified in the review of literature to identify relevant PPCs. I selected PPCs for inclusion in the questionnaire if they were: shared by three or more interventions, contradictory or I deemed them potentially contentious. This was to elucidate whether commonly held elements of dyadic work were also relevant to dyadic art therapy, and to gain insight from the experts when the available literature about dyadic approaches appeared either contentious (for example the issue of touch within therapy might be seen as contentious by some therapists) or contradictory (for example some interventions advocate a child-led approach while others advocate a more directive approach).

I grouped the PPCs derived from the literature search into clusters according to common themes. When I found clusters that had PPCs from three or more separate interventions I called these ‘shared PPCs’ and included at least one of them in the round one Delphi questionnaire (Table 5.2).

Table 5.2: Cluster themes and the representative PPC

Cluster Theme	Representative Principle, Practice or Competence
Developing carer’s reflective functioning	The therapeutic work aims to develop the carer’s capacity for reflective functioning (principle)
Includes consideration of non-verbal communication	Ability to maintain an intersubjective stance, communicating verbally and non-verbally the personal impact of the process (competence)
Includes psycho-educational discussions about attachment or emotion-regulation	The therapeutic work includes discussions of attachment and emotion regulation (principle)
Consideration of parent/carer’s own history and internal working models	The therapeutic work addresses how the carer’s own internal working models are enacted in the relationship with the child (principle) Ability to help carers think about the impact of their own history on their current parenting (competence)

Cluster Theme	Representative Principle, Practice or Competence
Consideration and containment of parent/carer's own experience and emotions	The therapist is alert to the carer's own affect and helps the carer to recognize, contain and eventually understand this (practice)
Parent/carer observes and reflects on period of joint activity	The carer observes the child's behaviour and interactions and reflects on the child's inner world and relational needs (practice)
Seeks to enhance parental sensitivity	The therapeutic work seeks to enhance the carer's sensitivity to the child's emotional and behavioural signals (principle)
Focus on carer-child relationship: engagement and repair	The therapeutic work promotes carer-child relationships characterized by both connectedness and autonomy (principle) Carers are helped to engage with their child through creative activity, non verbal attention and child-directed descriptive speech (tracking comments) (practice)
Includes sessions just with parent/carer	The therapist meets alone with the carer to establish a therapeutic alliance characterized by safety and trust (practice)
Based on Attachment Theory	Understanding of attachment theory (competence)

As well as including common and shared PPCs, I asked panellists to rate PPCs from different interventions which appeared to be contradictory (Table 5.3).

Table 5.3: Contradictory PPCs

1st Position	2nd Position	PPCs illustrating contradiction
Includes periods of child-led activity	Adults lead activity	The therapeutic work includes periods of child-led activity (principle).
		The therapist takes charge of the interaction during the session and guides the carer to do the same (practice).
Constructing narrative of past events	Focus on here and now	The story of the relationship between carer and child is retold with emphasis on emotional meaning of shared events (practice).
		Ability to use within-session events to address carer's affective responses and understanding of child's behaviour (competence).

In addition to shared and contradictory PPCs, I also asked panellists to rate PPCs which I considered potentially contentious (Table 5.4).

Table 5.4: Potentially contentious PPCs

Contentious Theme	Representative PPC
Use of Touch	The therapist uses touch to enhance his or her interpersonal connection with the child (practice)
Psychodynamic	The therapeutic work is psychodynamic (principle)
Sensory-motor stimulation	The therapist provides sensory-motor stimulation and rhythmic movement and guides carers to do the same (practice)

The Round 1 Delphi questionnaire can be viewed in full in Appendix 5.1.

5.2.5 Data collection

The Delphi study was conducted between June and December 2011. Ethical approval was granted by the East Midlands NHS Research Ethics Committee.

The Delphi study consisted of two rounds, with questionnaires being emailed to all the panellists. In round one, panel members were asked to rate the validity of each researcher-generated PPC, i.e. how appropriate they considered each potential PPC to be for the delivery of dyadic art (or arts) psychotherapy with children in middle childhood. Rating was on a nine point scale where 1 = not at all appropriate and 9 = very appropriate. For consensus to be achieved, a PPC needed to have been rated by 80% or more of the panel within the same tertile. Consensus on a PPC falling into the first tertile (1,2 or 3) equated to agreement that the PPC in question was ‘not’ appropriate; consensus on a PPC falling into the second tertile (4,5 or 6) equated to agreement that it was ‘only moderately appropriate’; consensus on a PPC falling into the third (top) tertile (7,8 or 9) equated to agreement it was ‘highly appropriate’. I analysed responses to the first round questionnaire and PPCs rated between 7-9 by 80% or more of the panel were retained for inclusion in the final list of agreed PPCs. If any PPCs had been rated between 1-3 by 80% or more of the panel at round one they were discarded at this stage. I included the PPCs that had not achieved consensus at round one in the second round questionnaire and asked panellists to re-rate them.

In the second round questionnaire, I informed panel members which PPCs had been retained and asked them to re-rate the PPCs which had not achieved consensus at round one. As well as giving panellists the mean rating of each PPC from round one, I also provided them with the distribution data (i.e. the number of responses for each point on the nine-point scale) and an appendix of anonymised comments made by panel members in response to the round one questionnaire.

The experts had been asked, in the first round questionnaire, to provide additional PPCs based on their own clinical experience and judgment. I included these newly generated PPCs in the second round questionnaire for panellists to rate on the 9-point scale (see results section below for these items).

5.3 Results

5.3.1 Composition of the panel

I invited ten art psychotherapists and three specialist attachment therapists trained in one of the other arts therapies (i.e. drama, music or creative therapy) to join the Delphi panel. Of those thirteen, eight individuals agreed to join the process and completed both

the first and second round questionnaires. Of those eight participants, seven were trained as art therapists and one as a dramatherapist. All participants met the pre-determined criteria of required expertise. During the conduct of the study, the Delphi panellists had quasi-anonymity with all their ratings and comments being shared among panellists anonymously. However, I offered panel members the option of having their participation acknowledged and all panel members were happy to have their involvement made public (see the acknowledgement section for the names of panel members).

5.3.2 Retained PPCs

At the start of the study I set a pre-determined level of consensus of 80% which, with an eight-person Delphi panel, translated as 7/8 or 8/8 of the participants. If more than one participant disagreed then no consensus was achieved.

Ten of the nineteen researcher-generated potential PPCs presented in the round one questionnaire achieved consensus with 80% or more of the panel rating these PPCs in the same tertile, which in every instance was the top tertile (7-9). The third tertile consisted of the “highly appropriate scores” i.e. 7, 8 and 9, thus indicating that the panel agreed that these ten PPCs were very appropriate for the implementation of dyadic art therapy.

In the Round 2 questionnaire, I asked panellists to re-rate the PPCs that failed to reach consensus at Round 1 and then to rate the new PPCs that were generated from the panellists’ suggestions at Round 1. None of the original Round 1 PPCs that were re-presented and re-rated in Round 2 achieved consensus (n=9). These nine rejected PPCs will be discussed in section 5.3.3 below.

Sixty new PPCs were generated from suggestions made by the Delphi experts, and of these sixty PPCs, twenty-one achieved consensus in Round 2. All those achieving consensus were rated in the top tertile (7-9) indicating agreement that these PPCs are very appropriate. These 21 PPCs were therefore retained.

All the PPCs that were retained either at Round 1 or Round 2 are shown in Table 5.5 which displays the level of consensus and a brief analysis of the comments panellists wrote about each PPC. It also notes at which round consensus was achieved and

whether the PPC was researcher generated (RG) or elicited from panellists (EP) during the first round. The tertile consensus achieved for all retained PPCs was the third, i.e. 7-9, equating to very appropriate.

5.3.3 Rejected PPCs

Nine PPCs failed to achieve consensus at Round 1 and were re-presented to panellists at Round 2. However, again these failed to achieve consensus. There were also 39 PPCs that were generated at Round 1 but failed to achieve consensus at round 2. Both sets of rejected PPCs are shown in Table 5.6 which also gives the median rating, the predominant tertile and the percentage who rated it thus, and a brief analysis of any comments given by panellists. Following the table a more in-depth analysis of the emergent themes is given.

Table 5.5: PPCs reaching consensus after Round 1 or Round 2

PPC	Retained PPC	Consensus ¹	Analysis of comments
Principle (RG) ²	The therapeutic work aims to develop the carer's capacity for reflective functioning	100% R1	The importance of the therapist's role in helping the carer respond sensitively to the child was highlighted, and one panel member described how the art psychotherapy process might achieve such changes: <i>'through the process of working together with the art materials with the art therapist acting as container and reflecting on what is happening in the room'</i> . However, one expert sounded a slightly more cautious note saying that development of the carer's reflective functioning should not be at the expense of the child's needs and <i>'separate sessions with another clinician may sometimes be advisable for a carer with significant personal issues'</i> .
Principle (RG)	The therapeutic work addresses how the carer's own internal working models are enacted in the relationship with the child.	100% R1	One panellist explained how the child will have learnt attachment behaviours but so will the adult and the interaction between their relational patterns might need to be thought about: <i>'Equally the carer will also produce their own adaptive survival strategies under stress - which can be when a child is acting out their survival strategies - so in these interactional dances the interactions between the carer and child can be very maladaptive. If one side changes their interaction then inevitably the other has to change'</i> . Although this aspect of the work was seen as appropriate panellists also highlighted the importance of keeping the relationship between child and carer in central focus, so focusing on the carer's internal working models was seen as best addressed in separate parent sessions.

¹ Consensus level and round in which consensus was achieved

² (RG = researcher generated)

PPC	Retained PPC	Consensus ¹	Analysis of comments
Principle (RG)	The therapeutic work promotes carer-child relationships characterized by both connectedness and autonomy.	100% R1	Comments on this principle explored different ways in which the work might achieve this. One panellist thought it was because the work could give insight and help the dyad to see each other in new ways, another thought that promoting a more secure attachment relationship would promote the child's sense of autonomy. Others saw the therapeutic frame, or boundaries, coupled with the creative process as key: <i>'The use of art making within the therapy session has the capacity to give the child an experience of both connectedness and autonomy, this experience should not to be underestimated.'</i>
Principle (RG)	The therapeutic work includes discussions of attachment and emotion regulation.	87.5% R1	This principle also had 87.5% consensus as very appropriate, so there was one panel member who disagreed. This panel member did not think that such discussions should take place in the joint sessions: <i>'This might be discussed with the parent before the therapy begins, but not during the dyad art therapy sessions.'</i> The issue of where the discussions should take place was also raised by the rest of the panellists, one thought that starting caregivers off with some theoretical background or training would be helpful, another thought discussions would most likely be in carer only sessions. Caution was advised that discussions such as these did not dominate joint session and one panellist suggested that the discussions evolve naturally once some trust had been built up with the caregivers.
Principle (RG)	The therapeutic work seeks to enhance the carer's sensitivity to the child's emotional and behavioural signals.	87.5% R1	This principle also had 87.5% consensus as very appropriate, so there was one panel member who disagreed. This panel member rated it as a five, i.e. moderately appropriate, although the panellist's comment echoed the PPC quite closely and did not elaborate on why it was not seen as more appropriate: <i>'The therapeutic work is to strengthen the parent-child attachment. The process of the work is to help the carer become attuned to the child's needs.'</i> However, the other panellists saw this as a core aim of the work, and one of them elaborated on the contribution that the art could make to the work: <i>'In the process of the work the child is being "known and contained". Dyadic art therapy develops co-operative and expressive ways of being between carer and child. It gives a space for thoughtfulness and fun'</i>

PPC	Retained PPC	Consensus ¹	Analysis of comments
Principle (EP) ³	Great flexibility is employed in the planning of the treatment programme, respecting diversity of family history, culture and individual experience.	87.5% R2	This principle also had 87.5% consensus as very appropriate, so there was one panel member who disagreed. This panel member rated it as a five, i.e. moderately appropriate and commented that while agreeing with the principle this should be the case for any child involved in any therapeutic work. However, another panellists saw specific resonance with art therapy: <i>'One of art therapy's advantages is the flexible nature of the process which opens up many possible ways of working with the parent-child relationships'</i>
Principle (EP)	Therapeutic work creates links with the present and past, in a historical, developmental and social context.	87.5% R2	Seven of the eight panellists (87.5%) rated this principle in the top tertile. The panellist who did not do so commented: <i>'I think this is about integration of experience but I am not sure I would put it this way'</i> . Another panellists considered this appropriate as an 'aim', and a third expert commented that <i>'this will inevitably happen if the work is successful'</i> .

³ EP = elicited from panel

PPC	Retained PPC	Consensus ¹	Analysis of comments
Principle (EP)	Within the safe, boundaried space of art therapy the child is encouraged to expand their ability to recognise his/her own feelings in the context of being together with the carer.	87.5% R2	All but one rated this principle in the top tertile, however one of the panellists rated it in the second (middle) tertile and added <i>'I would not see this as the main aim.'</i>
Principle (EP)	Focusing on moments of attunement when warmth and playfulness emerge is at the heart of the work.	87.5% R2	This principle had 87.5% consensus as very appropriate, so there was one panel member who disagreed. This panel member rated it as a six, i.e. moderately appropriate but did not add a comment. There were few comments on this principle in general just brief notes about the importance of positive reinforcement and that <i>'everything needs attention'</i>
Principle (EP)	Therapeutic work aims to enhance the carer's capacity for openness, working with experiences as they occur within the session.	87.5% R2	This principle had 87.5% consensus as very appropriate, so there was one panel member who disagreed. This panel member rated it as a six, i.e. moderately appropriate. The associated comment suggests that the issue may have been with the clarity of the principle rather than the validity, as the panellist seemed to be wanting to check the meaning: <i>'If this means tackling issues as they arise rather than avoiding difficulties then yes. Difficult behaviour can be positively reframed'</i> . No other detailed comments were given for this principle.

PPC	Retained PPC	Consensus ¹	Analysis of comments
Practice (EP)	The therapist observes attachment related behaviour.	100% R2	This was one of only two practices rated by every member of the Delphi panel (100%) as very appropriate. Panellists expanded that the therapist not only observes this, but also reflects on it and makes a choice about whether or not to comment or feedback: <i>'They may or may not comment on it. They certainly need to be observant to foster the understandings of parent and child'</i> . Another panellist suggested that such observations could help with reviewing the work: <i>'Through assessment of attachment, the carer and therapist can determine when the work is ready to come to an end.'</i>
Practice (EP)	The therapist develops an understanding of the child for the carer and for the child, so that the child's feelings can be seen and acknowledged, and so the child can begin to regulate his/her own feelings and the carer can help to soothe and contain them.	100% R2	This expert-generated suggestion was originally given as a competence, but as the wording is describing a practice I moved it to this section. The suggestion achieved 100% consensus with no additional comments except that it was part of the aim of the work.

PPC	Retained PPC	Consensus ¹	Analysis of comments
Practice (RG)	The therapist is alert to the carer's own affect and helps the carer to recognize, contain and eventually understand this.	87.5% R1	87.5% of panellists saw this practice as very appropriate but one panellist gave it a rating of three, i.e. not at all appropriate and commented: <i>'Only in private never in the sessions.'</i> Other panellists recognised that the issue required careful handling: <i>'Yes, it is complex work – a lot goes on therefore reflecting subtly, gently and non-judgmentally on the carer's state, possibly through the art work could be useful.'</i> Two other panellists cautioned that the therapist must also be alert to their own process.
Practice (EP)	The therapist does not become the child's therapist or the carer's therapist. The art therapist is the relationship's therapist.	87.5% R2	This practice had 87.5% consensus as very appropriate, so there was one panel member who disagreed. This panel member rated it as a one, i.e. not at all appropriate stating that it was the child's therapy. However other panellists supported it as appropriate, as one of them commented: <i>'I like this one: simple, clear and accurate'</i> .
Practice (EP)	Through observations the therapist determines the functional emotional level of the child.	87.5% R2	This practice achieved 87.5% consensus for the top tertile, with one panellist not concurring and rating it as a six (moderately appropriate). Other panellist commented that the functional emotional level might fluctuate through the session, and also that such observations could be a helpful part of the assessment process.

PPC	Retained PPC	Consensus ¹	Analysis of comments
Practice (EP)	The therapist receives supervision.	87.5% R2	Although this practice did not achieve full consensus (87.5%), the only panellist not to place it in the top tertile clarified that she was not querying the necessity of supervision but wanting to clarify that as supervision is a professional requirement for all art therapists it is not specific to dyadic art psychotherapy.
Competence (RG)	Understanding of attachment theory.	100% R1	All panellists rated this competence as highly appropriate, describing it as <i>'important'</i> , <i>'essential'</i> or <i>'imperative'</i> . However, one panellist pointed out that <i>'other ideas enlarge and enrich the work along side it'</i> and another expert advised art therapists to hold the knowledge lightly.
Competence (EP)	Understanding developmental trauma and the impact this has on every aspect of the child's development.	100% R2	This competence was deemed very appropriate by all the panel who described it variously as important, essential and even vital. One panellist explained that sharing this understanding with the caregivers could help them make sense of the child's actions: <i>'By understanding the impact of trauma on the psyche the carer is helped to make sense of the child's behaviour and interactions'</i>
Competence (EP)	Understanding trauma in the context of therapy, PTSD symptoms, and sensitivity to the child's ability to tolerate traumatic memories being exposed etc.	100% R2	Panellist thought this competence, which achieved 100% consensus, was essential as part of the art therapist's on going training.

PPC	Retained PPC	Consensus ¹	Analysis of comments
Competence (EP)	Ability to make a broad assessment of an adult's and a child's attachment style. In particular to recognise unresolved trauma in an adult.	100% R2	Panellists thought this competence would be important and useful. All of them rated it as very appropriate. However, one panellist pointed out that <i>'these skills can be learnt over time'</i> .
Competence (EP)	Knowledge of parenting strategies particularly those for working with children with disturbed attachment behaviours (it is not enough to understand disturbed behaviours, a carer also has to respond to them, so this inevitably will be part of the work with the carer).	100% R2	100% consensus was achieved for this competence. One panellist suggested carers may be asked to attend parenting courses. Another provided a clinical vignette to demonstrate how difficult it can be for carers to compassionately parent disturbed children: <i>'Carers will need support, without a doubt. I remember a child in care killing all the goldfish at the home of the carer and torturing the pets. The dog would not go anywhere near the child. The carer needed help to feel compassion for this child as they themselves were so appalled by the child's behaviour. By going through the child's background and listening the carer's own sense of outrage did help this particular carer continue to look after this child.'</i>

PPC	Retained PPC	Consensus ¹	Analysis of comments
Competence (RG)	Ability to use within-session events to address carer's affective responses and understanding of child's behaviour.	87.5% R1	This competence achieved consensus with 87.5% of panellists placing it in the top tertile. The one panellist who did not rate it in the top tertile felt it was not appropriate for the dyadic sessions, only the separate parent meetings. Those in favour of this approach liked the directness of the here and now, commenting: <i>'It is vital to use what happens in the session in the here and now as part of the work to make sense of what both carer and child are bringing to the session'</i> . However, other experts qualified the statement: <i>'Also the ability to hold back and let the relationship evolve at its own pace. Given the chance and encouragement people are creative in finding their own idiosyncratic ways of relating to one another.'</i>
Competence (RG)	Ability to maintain an intersubjective stance, communicating verbally and non-verbally the personal impact of the process.	87.5% R1	This competence was rated as very appropriate by seven of the eight panellists (87.5%). The one panellist who rated it as only moderately appropriate (6) commented that being in tune with the process was essential but therapists should be aware that their subjective experience was just part of the story: <i>'being in tune with the process and demonstrating this is essential to therapeutic engagement but the experiences of the therapist may not be that of the dyad/others [...] so minding the power (whose voice/experiences get privileged) - compatible supervision is essential.'</i> On the subject of non-verbal communication, panellists highlighted the potential of the mediation of the art work and the potential of joint engagement: <i>'In some circumstances the art therapist may choose to be involved in the image making process, thus adding to the process of verbal/nonverbal communication.'</i>

PPC	Retained PPC	Consensus ¹	Analysis of comments
Competence (RG)	Ability to help carers think about the impact of their own history on their current parenting	87.5% R1	The majority of the panel (87.5%) thought this very appropriate, even essential. The one panellist not to rate it in the top tertile gave the competence a five, i.e. moderately appropriate and commented that although it was essential it should take place in separate sessions with the carer. Other panellists recognized that this could be a very painful process for caregivers who needed to be willing and able to take risks. As such the therapists needed to judge the appropriate depth and intensity depending on the carers own circumstances, beliefs, and abilities
Competence (EP)	Knowledge of stages of a child's art development.	87.5% R2	87.5% rated this competence as very appropriate but one panellist rated it as only a three, i.e. not at all appropriate, commenting that this was: ' <i>Only a part and not the key part</i> '. Others commented that while this is perhaps a given competence for an art psychotherapist it is also very useful.
Competence (EP)	An understanding of child development.	87.5% R2	Seven out of eight rated this as highly appropriate and the one panellist who didn't clarified that it was a basic competence for any therapist working with a child and as such not specific to dyadic art therapy.

PPC	Retained PPC	Consensus ¹	Analysis of comments
Competence (EP)	Knowledge about the nervous system and how this is impacted by trauma and stress and how to help it calm as well as how to assess whether a child is being activated into a stress response (fight, flight or freeze) or whether they are able to manage higher level reflective functioning.	87.5% R2	While seven of the eight panellists rated this in the top tertile (87.5%), one panellist rated it as only moderately relevant and clarified: <i>'If the basic principles are understood then this can come later'</i> .
Competence (EP)	Ability to recognise contra-indicators to Dyadic Art Therapy.	87.5% R2	Seven of the eight panellists rated this as very appropriate and the remaining panellist rated it at six, i.e. moderately appropriate, with the comment: <i>'Essential in any therapy'</i> , implying that the issue is that the competence is not specific to dyadic art therapy. Other panellists emphasised the importance of this competence particularly if the caregiver is ambivalent, abusive or has significant unresolved issues: <i>'At times the carer may have too many unresolved problems to be able to attend to the child in Dyad work'</i>

PPC	Retained PPC	Consensus ¹	Analysis of comments
Competence (EP)	Understanding the difference between therapy with a birth parent and their child and therapy with a fostered or adopted child.	87.5% R2	Seven of the eight panellists rated this as very appropriate but one panellist rated it as only moderately appropriate, arguing perhaps for a change of emphasis, a move from the official status (i.e. adopted or fostered) to the relational status: <i>'It is all about understanding who is the child's attachment figure.'</i>
Competence (EP)	Awareness of alternative theoretical frames and an openness to many ways of working.	87.5% R2	The general consensus (87.5%) was that this was a very appropriate competence although one therapist saw it as only moderately so, commenting that it is part of <i>'on going learning aims'</i> .
Competence (EP)	Understanding of psychotherapeutic ideas of how the self is built up and strengthened including infant-parent psychotherapy, Winnicott and Daniel Stern.	87.5% R2	Seven out of the eight panellists rated this competence as very appropriate although one rated it as a four, i.e. moderately appropriate. No comment was added to that rating. A different panellist commented, <i>'These books and papers all contribute to the bigger picture and should be encouraged to be read'</i> .

Table 5.6: PPCs that failed to achieve consensus either at R1 or R2

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Principle (RG)	The therapeutic work is psychodynamic	6.5 3 rd 50%	Comments from panellists clarified that while the work may be psychodynamic, this was not necessarily the best way to describe it because therapist might also be using other therapeutic models or theories such as attachment theory, personality development, child development, or systems theory. One panellist felt it was too general and open to interpretation: <i>'there would be different understandings of what exactly we mean by psychodynamic and that it is too general to be helpful as a principle.'</i>
Principle (RG)	The therapeutic work includes periods of child-led activity	8.5 3 rd 62.5%	All the ratings were above 5, so none of the panellists saw this as inappropriate, there was just not consensus about whether was moderately or very appropriate. One of the panellists who scored this as five teased out the difference between a child-led process and a process which followed the child's cues: <i>'one is following the child's process but it is not a child led process rather a process in which one follows the child's non verbal cues and signs of dys-regulation etc.'</i>
Practice (RG)	The therapist takes charge of the interaction during the session and guides the carer to do the same	4 2 nd 57.1%	Panellists appeared not to like the wording of this practice, taking exception to the phrase 'takes charge' and to the general lack of clarity: <i>'not a very clear statement. The therapist takes charge of the outer boundaries and is facilitating all to have a voice, but may not be guiding the carer to take charge in all sessions.'</i>

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Practice (RG)	The carer observes the child's behaviour and interactions and reflects on the child's inner world and relational needs	6 3 rd 50%	Comments highlighted that while the caregiver may be encouraged to reflect on the child's behaviours internally or in separate sessions, it might not always be appropriate for the caregivers reflections to be voiced out-loud to the child in the joint sessions: <i>'Yes, however not to be over insistent on what is being observed as it might feel that the carer is all knowing, which could be experienced as persecutory.'</i>
Practice (RG)	The therapist uses touch to enhance his or her interpersonal connection with the child	1 1 st 62.5%	Panellists were wary of this PPC and saw it as dependent on the given dyad. One of them said it was rarely appropriate another seemed to concur but didn't want to be rule out such a basic human communication as touch altogether. Another pointed out that it is the caregivers use of touch that is critical: <i>'it is the parent touching the child to regulate and connect with them that is key'</i>
Practice (RG)	The therapist meets alone with the carer to establish a therapeutic alliance characterized by safety and trust	8 3 rd 71.4	None of the comments appeared to disagree with this practice, although one of the panellists who wrote a positive comment did not add a rating and this may be why the practice did not achieve consensus.
Practice (RG)	The therapist provides sensory-motor stimulation and rhythmic movement and guides carers to do the same	4.5 Split between 1 st and 3 rd	Some of the panellists found the wording of this practice awkward and rigid. However they thought it possible that sensory-motor stimulation and rhythmic movement could play a part through the creative work: <i>'I'm sorry that I can't be more positive about this one because the first part of the principle is really important and if you cut out 'and guides the carers to do the same' and added 'through the use of art materials' I'd be fine with it'.</i>

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Practice (RG)	The story of the relationship between carer and child is retold with emphasis on emotional meaning of shared events	7 3 rd 66.6%	One panellist had an issue with the wording of this practice specifically that the stories can be told nonverbally through the imagery. Another felt that unless the story emerged through the imagery it would be out of place in the joint sessions: <i>'Only in private with the carer. Unless it comes up in the art work'</i>
Practice (RG)	Carers are helped to engage with their child through creative activity, non verbal attention and child-directed descriptive speech (tracking comments)	9 3 rd 75%	Although some of the panellists saw this as an essential component, moving away from the verbal to the non verbal and listening to language in another way. However, two of the panellists did not see it as so pertinent and so scored it as a four and a six respectively. One said that there were other more helpful activities: <i>'This could happen and it could be useful – but you might be building / constructing a new story which might be even more helpful.'</i>
Principle (EP)	Carer and child are helped to read each other's non verbal cues	7.5 3 rd 62.5%	Five of the panelist thought this very appropriate. However, one panelist felt this had been better expressed in other principles and so scored it as only moderately appropriate. Another expressed caution that the process of reading cues needed to be transparent: <i>'This to be achieved with open questioning at some points in the work, otherwise the child may feel that the career is a mind reader and vice versa'</i>
Principle (EP)	Carer and child are enabled to enjoy their relationship, take pleasure in each other and in what happens in the interaction between them	9 3 rd 75%	Two panellists seemed uncertain about this principle which one described as too general and vague.

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Principle (EP)	Therapeutic work seeks to understand the impact of the wider context on the child and carer i.e. siblings, other foster children, carers and their partners	7.5 3 rd 75%	One panelist felt that this was too generic as all therapies should do this. Others felt it was part of the aim but there were other areas to be addressed in joint sessions too: <i>'The bigger picture is important, however what will inevitably be played out in the session will be the important issues for the child at that point in their life'</i> .
Principle (EP)	At times it is helpful to review with whole system so that there is an agreement and understanding within the whole system as to the work	7.5 3 rd 62.5%	Those who rated this as only moderately relevant saw it as too general and pointed out that all therapy should take this into account and have a reviewing process
Principle (EP)	Therapeutic work focuses on listening and accepting the other's experience	7 3 rd 75%	Two panelists who rated this at four or below. One did not see it as essential, the other felt it had already been expressed in other principles.
Principle (EP)	Dyadic Art Therapy aims to promote brain development	8 3 rd 62.5%	Although two panellists took issue with the wording and emphasis, drawing out instead the role the work can have in linking feeling and so that new connections and understandings are made, two others commented enthusiastically citing research by Fonagy et al [Given as Fonagy P, Steel H, Moran G & Higgitt A (1991) 'The capacity for understanding mental states: the reflective self in parent & child & its significance for security of attachment. <i>Infant Mental Health Journal</i> 13, 201-218.]

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Principle (EP)	There is equality of contribution from all participants, including the image which is seen as a participant.	7 3 rd 50%	There was a mixed response to this principle with panelists suggesting a less rigid approach which welcomed contributions from all but recognized a fluidity about each person's contribution and that sometimes the focus might be more on discussions or relationships than imagery: <i>'this is the ideal and sometimes it works like this at other times more might happen through the art process, or more through verbal discussion.'</i>
Principle (EP)	Dyadic Art Therapy can be used in supervised visits to help create an attachment with the estranged parent	4 Split between 1 st and 3 rd	This suggestion was seen as a possibility but how appropriate it was could only be determined on a case-by-case basis following an assessment. One panellist commented that rather than being a principle it was in fact a practice issue.
Principle (EP)	The carer's unresolved attachment issues can be addressed in Dyadic Art Therapy	4 1 st 50%	Some panelist thought this might come into the work, although most of the comments stressed that this should not become the focus of joint sessions and was better addressed in a separate forum: <i>'They might well be part of the work, but the carer might need some individual work to look at these often complex, painful issues as well.'</i>
Principle (EP)	Dyadic Art Therapy is suitable for work with adolescents and a carer, to resolve the adolescent crisis	5 3 rd 42.9%	This suggestion was seen as insufficiently clear by some. Although one panellist thought it could be used in this way, another reported no experience of this. The issue was also raised that this might be more of a practice than a principle.

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Principle (EP)	In the school, Dyadic Art Therapy sessions can be held weekly to help children resolve classroom behavioural problems	5 1st 42.9%	Panellist were uncertain that this was appropriate as a principle although some of them saw it as a possibility depending on the school environment and the circumstances of the dyad: <i>'Only if the parent came into school too and I am not sure that this would be appropriate.'</i>
Principle (EP)	Sessions include only one parent or carer and the child at a time. If both parents want to participate, they can be given separate appointments. Several appointments can be arranged consecutively with one parent and then the same number with the other parent, followed by a meeting with both parents to discuss the experience with them	4 Split between 1 st and 3rd	One panellist agreed that work generally only involved one caregiver, but others demurred saying that, depending on the case, working with two caregivers present could be helpful. One commented on the importance of maintaining flexibility: <i>'This relates to the desirability of flexible programme planning for parent s and children.'</i>

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Principle (EP)	Therapeutic work uses ‘mirroring transference’ (Kohut 1979), with the possibility of a narcissistic self-object which is not interpreted, but allowed to emerge, so that the missed phase can be gone through, and an intersubjective experience can be had.	5.5 3 rd 50%	Three panellist felt they either didn’t understand this statement or couldn’t comment on it. Two others echoed elements of the statement using simpler language, focusing on facilitating positive interactions that could give new experiences: <i>‘missed phases may have a chance to be lived through in a positive way’</i>
Principle (EP)	Therapeutic work takes into account Winnicott’s (1975) notion of ‘false self’, located in the infant-parent relationship. The ‘true self’ begins to appear as soon as there is mental organization, which leads to ‘sensor-motor aliveness’	6 Split between 1 st and 3 rd	Three of the panelists took issue with the wording and clarity saying that they didn’t know what was meant by all of it or that the ideas were better expressed in other principles. However two others commented positively. One said that that the sense of aliveness was vital and that using the art materials together could facilitate this. The other said that helping the caregiver see when the motivations underlying the child’s presentation could be very helpful: <i>‘Awareness that the child’s aim might be to please is as important a realization as the awareness of the child’s need to repeat negative patterns to gain some form of attention. Commenting on these behaviors as and when they seem apparent, can bring relief and self awareness to the child’s modus operandi’</i>

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Principle (EP)	Therapeutic work allows for the child's sense of 'empathic failures' in relation to the carer and other people as well	4.5 Split between 1 st and 2 nd	Panellists generally felt uncomfortable and unclear about the wording and meaning of this statement
Principle (EP)	Dyadic Art therapy can be used to promote attachment with foster parents and adoptive parents	9 3 rd 75%	The two comments on this statement were that this was neither an aim or a principle but a practice issue to be decided on a case-by-case basis.
Practice (EP)	The therapist uses the child's and carer's suggestions for themes of exploration on the art work	7 3 rd 62.5%	Some panelist felt this was a given, but others thought it could happen, but might not always be the case: <i>'Maybe but maybe not, it will depend'</i>
Practice (EP)	The therapist provides a range of materials	9 3 rd 75%	The majority of panelists rated this as very appropriate. The one negative comment given was that the principle should have said 'art material'. The panelist who wrote that statement rated it as a five which meant there was not sufficient consensus in a single tertile to retain the statement.
Practice (EP)	The setting is relaxed and appropriate for creative work	9 3 rd 75%	The only negative comment given about this statement was that it didn't go far enough: <i>'It is important to get the art making process in somewhere but I would want to add the notion of a place for mess making so this doesn't quite say enough for me'</i> The panelist who wrote that statement rated it as a five which meant there was not sufficient consensus in a single tertile to retain the statement.

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Practice (EP)	The therapist encourages the carer to engage with his/her own childhood experiences with the child present	5.5 Split between 1 st and 3 rd	Panellists did not seem to feel this would necessarily be the case although some of the comments given did not rule it out as a possibility if the balance between the caregiver and child's needs could be held. However, one panelist did not feel it should be done in joint sessions at all: <i>'I would not see this as an aim. This should be done outside of the work with the child.'</i>
Practice (EP)	The therapist validates the hurt, and the ambivalent feelings of the carer through warm, empathic acceptance of the carer and of the art work	8 3 rd 57.1%	One panelist did not rate this practice, so there were only seven ratings, four of which were in the top tertile and three were in the middle tertile. Some comments indicated that it was appropriate, but not to the exclusion of the child and the child's art work. Others that it was not appropriate within the work with the child, and one panellist pointed out that the carer might not always be making images.
Practice (EP)	The therapist meet with the parents before therapy begins and gathers information e.g. about the pregnancy and the birth of the child; the parent's own attachment relationship; socio-economic factors affecting the family; history of other offspring.	8.5 3 rd 75%	<p>Comments on this statement tended to say that if this is possible then useful, however, one pointed out that it isn't always possible for the art therapist to be the person who does this.</p> <p>One panelist felt that the wording should be different and should say carer not parent to emphasise that a foster-carer or adoptive parent may not have all the history at their disposal. This panellist rated the suggestion as a six as a result.</p>

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Practice (EP)	The therapist writes a diary in terms of personal feelings that might arise in the work	5 Split between 1 st and 3 rd	Comments upheld the importance of note keeping, but panelists did not necessarily feel this should be in the format of a diary .
Practice (EP)	The therapist works together with other colleagues	8.5 3 rd 75%	Panelists felt that this would be helpful and good practice but not necessarily always the case or always even a possibility. One panelist commented that if it was not possible then regular supervision was vital.
Competence (EP)	The ability to hold in mind and work with the complex implications of this extension of art therapy's 'therapeutic triangle', traditionally consisting of client, art therapist and image	9 3 rd 75%	One panelist who rated this a nine commented that it was good practice while the only other comment was questioning how relevant this practice was.
Competence (EP)	The ability to maintain a balance between art making and thinking/talking time in sessions and to ensure that all images created by both children and adults in a session are sensitively received and recognised to be of equal validity	9 3 rd 75%	Six panelist rated this as a nine, one as a five and one as a one. The panelist who rated it as a one wrote simply that they did not agree.

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Competence (EP)	Awareness of transference and counter transference	9 3 rd 75%	Although some panelists comments indicated that this was a given, one panelist commented that the competence was not specific enough: <i>'To general and ignores the art therapy literature about where the image fits into this'</i>
Competence (EP)	Ability to facilitate an exploration of phantasies	8 3 rd 62.5%	Although one panelist wrote that this was not key, two others saw it as a helpful to be sensitive to the self-protective capacity of the children and to help them distinguish between phantasy and reality.
Competence (EP)	Ability to use open questions	9 3 rd 75%	Comments differed on this competence, from essential, to a part but not all of the process. One panelist felt it was too general a statement.
Competence (EP)	Some understanding of systems theory and interactional patterns	9 3 rd 75%	One panelist comment indicated complete agreement while two reflected on whether they were being asked to agree on things that were helpful, or things that were essential: <i>'All these principles are well and good, but what are the core principles (as essential) and what are the secondary principles. I would say yes to systems theory and interactional patterns but this becomes another level of training.'</i>
Competence (EP)	Knowledge of Eric Erickson's Stages of Development	6 Split between 1 st and 3 rd	Again the comments queried whether consensus was being sought on what was helpful or what was essential. While some model of child development and personality development were seen as important there was a sense that it wouldn't necessarily be the one specified here. Very similar comments were made about the next proposed competence too.

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Competence (EP)	Knowledge of Stanley Greenspan's Functional Emotional Stages	6.5 3 rd 50%	See above
Competence (EP)	Knowledge of Crowell Relationship Assessment	3 1 st 66.7%	Only two panelist rated this as appropriate. Comments from the others indicated that they did not use this or were not aware of it. It was not seen as essential.
Competence (EP)	Thorough knowledge of the art materials used, and an understanding of the symbolic use of the materials	9 3 rd 75%	One comment was that this was not essential. The only other comment appears to indicate that the panelist was thinking about whether this knowledge should be imparted to the caregiver, rather than whether it was a necessary competence: <i>'This may not be possible in every instance and therefore awareness of the carers capacity to understand the process of art therapy is a question to be asked before work begins. How much support and training will be needed?'</i>
Competence (EP)	An understanding of psychoanalytic theory	8 3 rd 62.5%	There was a split reaction to this illustrated by the comments. Some categorically agreed, some saw it as not essential, and one, as before, appeared to be reflecting on whether this was a competence to be fostered in the caregiver.
Competence (EP)	Arts therapy training to provide a way of relating other than words	9 3 rd 71.4%	The comments that were given on this competence queried whether this was a given or not, and therefore whether it need explicit stating.

PPC	PPCs with less than 80% consensus	Median rating Predominant tertile Consensus level at R2	Analysis of comments
Competence (EP)	Ability to make use of support systems such as supervision and personal therapy	9 3 rd 62.5%	This was seen by some as a requirement of any therapist and so too general for inclusion
Competence (EP)	Understand new developments in relation to the convergence of knowledge in neurobiology, developmental psychology, trauma theory, psychoanalysis and attachment theory and how this relates to Dyadic Art Therapy	9 3 rd 75%	Only one comment was given for this one which was: <i>'I agree'</i> . All ratings were in the middle or top tertile indicating that it was appropriate to some degree but there was not consensus over whether it was only moderately so or very.
Competence (EP)	Ability to play with materials and design art based interventions for each particular dyad that will support them in their explorations.	7 3 rd 75%	One comment was that this was an important element, but three other panellists picked up on the implication in this competence that the therapist will take a directive stance. One panelist challenged that this should ever be the case, another pointed out that it might not always be the case: <i>'This implies a directive model in terms of use of art materials which maybe used in some DAT but not all'</i>

5.3.4 Themes emerging from the Delphi

Thematic analysis of the PPCs and the comments identified a number of themes: the relationship's therapist; emotional understanding and regulation; enhancing caregiver sensitivity; what therapists need to know; the role of the art; and flexibility.

The relationship's therapist

Many of the PPCs proposed by panellists in round one, and agreed upon in round two, elucidated how dyadic art therapy focussed on the caregiver-child relationship. As one panellist eloquently put it:

'The therapist does not become the child's therapist or the carer's therapist. The art therapist is the relationship's therapist.'

This could be done by creating positive opportunities for engagement and interaction. One panellist suggested that it was helpful to focus on moments of attunement between the dyad, when warmth and playfulness emerge.

Another way in which the relationship could be worked with appeared to be simply by having the caregiver present as an active and integral figure in the therapeutic work with the child. The adult's presence might serve to help the child feel safe and contained, it might also help the dyad to develop a shared understanding:

'The therapist develops an understanding of the child for the carer and for the child, so that the child's feelings can be seen and acknowledged, and so the child can begin to regulate his/her own feelings and the carer can help to soothe and contain them.'

Emotional understanding and regulation

The panellists also described how in dyadic art therapy sessions the child can learn to recognise their internal states, feelings and emotions and how the caregiver can acknowledge and contain these feelings, something that they would be able to continue to do outside of therapy:

'Within the safe, bounded space of art therapy the child is encouraged to expand their ability to recognise his/her own feelings in the context of being together with the carer.'

Some of PPCs indicated that the focus was also on developing caregivers' emotional understanding. It was seen as within the therapists' remit to help the caregiver build up a picture of their own emotional world, including understanding here-and-now feelings and understanding events in their past which influenced how they feel and how they react to their child:

'The therapist helps carers think about the impact of their own history on their current parenting and how the carer's own internal working models are enacted in the relationship with the child.'

As well as recognition of the importance of such work, the panellists also highlighted the need for careful thought about how and when this work could take place. Many of the panellists felt that there were some discussions which were better had in separate sessions alone with the caregivers, particularly work relating to the impact of the caregiver's own history:

'Individual space for the carer might often be necessary to look at these issues that reflect on difficult or painful childhood experience'

However, a cautionary note was sounded to remind therapists to tread carefully with an awareness that the work could be painful for caregivers and also to remember to hold the balance between the needs of both halves of the dyad.

Enhancing caregiver sensitivity

Developing caregivers' sensitivity to the child's internal states and behavioural signals was also seen as an important. The retained PPCs indicate that the panellists saw the potential of dyadic art therapy to do this. Using and responding to events which cropped up in sessions was seen as potentially a helpful way to focus on and enhance the caregivers' sensitivity and understanding of the child's behaviour. One panellist described the importance of this work:

'The ability of the carer to read and understand the child's signals means that they are able to respond in a thoughtful, reflective and responsive way, avoiding repeating negative interactions'

What therapists need to know

The comments that panellists gave indicated that while there was a large body of knowledge that it might be helpful for the therapist to know about, not all of this knowledge was essential. Competences which mentioned specific assessment tools or developmental models were often criticized as being overly specific and not all the panellists were necessarily familiar with them.

While there was a sense that panellists embraced a heterogeneous body of knowledge and one of the retained PPCs related directly to this, there were also some areas of knowledge that panellists felt were essential. In particular this related to knowledge of issues relating to: attachment; trauma and the nervous system; and child development. The panellists also mentioned the interaction of these areas, so they were keen that dyadic art therapists understood the impact of developmental trauma on child development, and the impact of a child's past on current attachment relationships.

The role of the art

The panellists' comments helped to elucidate the contribution that the art process can make in dyadic sessions. Joint engagement in art making activities with the therapist was seen as having the potential to achieve changes in the caregiver's capacity for reflective functioning:

'This tends to happen through the process of working together with the art materials with the art therapist acting as container and reflecting on what is happening in the room.'

Panellists clearly saw many aspects of the art process as critical, including how the therapist responded to the images produced. One panellist suggested that the therapist by treating the child's art with great care and respect could model or show a corresponding degree of respect for the child's internal world:

'Respect for the child's art/mark making process and the equal care taken of the child and adult images alike fosters belief in, and sensitivity to the child's inner world.'

However, not all the suggestions relating to the contribution of the art process were retained. Some of them, perhaps a little surprisingly, were rejected. It should be noted

however that some members of the panel had expertise in attachment therapies rather than art therapy and so were not necessarily so interested in image-based approaches and this may have mediated the tendency to highlight the part played by the image. The advantages and disadvantages of including people in the Delphi who were not practicing specifically as art therapist will be discussed later in the chapter.

Flexibility

The panellists spoke about the importance of taking a flexible approach to planning dyadic art therapy, ensuring that the work that was offered respected the diversity of family history, culture and individual experience. One panellist commented that a strength of using art therapy was the flexible nature of the process which allowed for many ways of working with the caregiver-child relationship. Other comments underlined that there might be a variety of different approaches employed in dyadic art therapy:

'This implies a directive model in terms of use of art materials which maybe used in some DAT but not all'

Flexibility was also advocated in terms of theoretical underpinning. Rather than advocating a single or orthodox way of working, panellists recommended having an awareness of alternative theoretical frames and an openness to many ways of working. Although an understanding of attachment theory was seen as appropriate as a competence it was recommended that other ideas would enlarge and enrich the work and therapists should *'hold the knowledge lightly'*.

Analysis of the rejected PPCs demonstrated that the panellists also valued flexibility when it came to writing the PPCs. The consensus appeared to be that PPCs should not be too prescriptive and comments given on some of those which did not achieve consensus implied that a case-by-case approach was favoured over a more prescriptive one. Panellists commented that some suggestions might be appropriate for some dyads, but equally so, with a different dyad, they might not:

'No this may be the case but certainly isn't always so for example it's generally not the case when working with a foster parent/foster child dyad'

While valuing flexibility, panellists did not endorse wooliness. They tended not to agree on suggestions which were too generalised and thus applicable to any therapeutic modality. Issues such as supervision, dealing with transference, and reviewing work were seen as being a given for any therapy and therefore some panellists indicated they did not think them suitable for inclusion in specialist PPCs.

5.4 Discussion

5.4.1 Summary of findings

Ten of the PPCs achieved 100% consensus as very appropriate and twenty-one of the PPCs achieved 87.5% consensus, leading to a total of thirty-one retained PPCs. Forty-eight other PPCs did not achieve consensus and were not retained.

Analysis of the PPCs and the accompanying comments highlighted the importance of work with caregivers, although therapists were warned to tread carefully as this work could be challenging for the caregivers, and to maintain a balance between the needs of both halves of the dyad. The work with caregiver-child relationship was seen as key, as was the focus on developing the child's affect recognition.

Panellists favoured a flexible approach both to the work and to the required competences, distinguishing between areas it might be useful to know about, which were many and varied, and a handful of areas it was essential to know about. The unique contribution of the art was highlighted, although this was clearly more important to some panellists than to others, and issues of training and professional background may have come into play here.

In some instances, suggested PPCs were not seen as sufficiently specific to dyadic art therapy, and while panellists commented that they could see the relevance to general work they did not think it necessary to include them in the specific dyadic PPCs, as they were a given. Another reason that was cited on more than one occasion for not rating PPCs as very appropriate was the issue of whether the given PPC was appropriate in joint sessions or should take place in sessions alone with the caregiver. This highlights the question of whether dyadic art therapy refers to the whole intervention, or just to the joint sessions.

5.4.2 Putting findings in the context of other research

There already exist some practice frameworks that are relevant to dyadic art therapists, for example there are established Standards of Proficiency (HCPC) which apply to all arts therapists (i.e. art therapists, dramatherapists and music therapists) and competence frameworks have also been developed for working in child and adolescent mental health services (Roth, Calder, et al. No date). However these standards of proficiency and competence are generic and do not relate specifically to art therapy let alone dyadic art therapy. The existing frameworks are generic ones and would be complementary to the more specific guidance which the PPCs provide.

The Delphi took place in the context of burgeoning interest in the use of consensus methods in the art therapy profession as a whole. Until recently there has been no history of formal consensus methods being used by UK Art Therapists. However, the British Association of Art Therapists Council has recently asked special interest groups (SIGs) to provide more clarity about the process and practice of specific art therapy interventions by developing clinical guidelines for specific client groups and has issued a protocol for doing so (BAAT, 2012); some of the SIGs have used consensus methods (ATCAF, 2013; Springham, Dunne, et al., 2012) to do this. My own SIG asked me to facilitate the process which I was able to do following my experience of conducting this Delphi.

5.4.3 Strengths and limitations

Strengths

Current descriptions of dyadic art therapy are sparse and represent single experts' self-report. The Delphi study has produced a set of principles, practices and competences for dyadic art therapy that represent a panel of experts' views on these important aspects of dyadic art therapy.

Limitations

On reflection, I can see the limitations of using a consensus method because of the small number of expert's in dyadic art therapy and the possibility that there was limited consensus to be found. The panel of experts included therapists specialising in related therapies: one in dramatherapy and one who had trained as an art therapist but who

practiced as a family therapist. The small panel size meant that the scoring of each individual carried considerable weight and this may have led to PPCs relating specifically to the art or art-making not achieving consensus. The Delphi might have found out more about a specifically art therapy-based approach if there had only been art therapists on the panel or if there had been a larger panel to balance the impact of individual perspectives. It is also a limitation that the Delphi did not specify that the process sought to identify unique and essential elements rather than generic or common elements of dyadic art therapy and, more seriously, that it did not enquire about appropriate applications or mechanisms of change. In light of these reflections, if I were to have my time again, I might not include a Delphi in the design, particularly one with such a small panel size. Instead I might adapt the other studies to focus more on applications and mechanisms of change.

5.4.4 Implications for the manual and future research

'The output from consensus approaches... is rarely an end in itself. Dissemination and implementation of such findings is the ultimate aim of consensus activities' (Jones & Hunter, 1995, p.380).

The Delphi produced a set of results that could potentially form the backbone of a manual for dyadic art therapy. The strength of the PPCs is that they do not come from a single perspective, or represent an individual therapists' practice. Instead they represent the areas that a group of eight experts could readily agree upon. They define many of the essential elements of the work and provide insight into the thinking of a group of highly experienced therapists.

While a surprising amount of detail can be gleaned about the way of working, there are also indications about the optimal level of flexibility and prescription that the panellists would favour. For the most part the panellists seemed to favour a flexible open approach which learns from the best currently available practice and knowledge.

The findings illustrate that panellists were not unanimously content with the inclusion of generic competences and practices within the grouping of PPCs. Within the manual, the PPCs will stand alongside the Health and Care Professions Council (HCPC)

Standards of Proficiency which apply to all arts therapists and which must be adhered to in conjunction with the manual.

The results of this Delphi have already been published in a peer-reviewed journal (see Appendix 1.1) and I have used the paper as part of two recent trainings in dyadic art therapy that I have co-facilitated.

CHAPTER 6: Stakeholders' perspectives: The therapists

6.1 Introduction

The survey provided an understanding of the prevalence of the approach and the Delphi process gave an understanding of how experts view the practice of dyadic art therapy by identifying key principles, practices and competences. However, the results of the survey and the Delphi could remain relatively abstract if not grounded in an understanding of how dyadic art therapy is practiced and received. To ground the manual in clinical practice and prevent it straying too far towards the arcane, a third study was undertaken to understand the experience of practitioners and service users engaging in this endeavour.

There were three different aspects to this stakeholder views study:

- Semi-structured interviews with art therapists who currently offer dyadic art therapy
- Semi-structured interviews with dyads (parents or carers and children who are currently receiving dyadic art therapy)
- A longitudinal survey (over a maximum of eight sessions) of parents' or carers' views using an adapted version of The Helpful Aspects of Therapy (HAT) (Llewelyn, 1988)

The therapist interviews focused on dyadic practice in general, rather than on work with a specific dyad. Therefore I will report the different components of this study separately. This chapter focuses on the therapist interviews, and the following chapter focuses on the interviews and survey of dyads and integration of the three components of the stakeholder views study.

6.2 Methods

6.2.1 Qualitative interviews with therapists

For this part of the thesis a qualitative method was selected. Mason (2002) gives a working definition of qualitative research, outlining a broadly interpretivist stance concerned with the interpretation and understanding of experience, and flexible methods

of data generation that are sensitive to social context. Mason describes qualitative data analysis as involving understandings of complexity, detail and context and aiming 'to produce rounded and contextual understandings on the basis of rich, nuanced and detailed data' (p.3).

There are a variety of methods for qualitative data generation including: interviewing; focus groups; observation; and the use of visual or written documents. I chose to undertake individual interviews because I wanted to find out about the therapists' views and experiences relating to dyadic art therapy and individual interviews allow depth exploration whereas focus groups use interactions between people to identify the breadth of issues. Qualitative interviews can be used to find out about the participant's lived experience (Seidman, 1998), allowing the researcher to discover new ideas or probe areas of particular interest. A qualitative interview can surprise the researcher, giving new insight and allowing them the freedom to follow the individual participant's perspective. Interviews can be structured, semi-structured or depth (Britten, 2007). Depth interviews and semi-structured interviews are likely to be less artificial than a structured interview and therefore are perhaps less likely to 'miss the point' through interviewer assumptions or oversight. Although depth interviews would have allowed more flexibility and the freedom to follow the participant's thoughts and agenda, there were specific areas that I wanted to ask about, such as contraindications and the structure of the intervention, so a semi-structured interview method was chosen, to provide a degree of flexibility and a degree of focus.

In practical terms, qualitative interviews can be time consuming and expensive and establishing access to potential participants can be difficult (Seidman, 1998). Compared to participant observation, interviews are more partial, relying on the individual participants' own reports. Exaggeration, accidental omission and self-editing may occur and the interviewer may hear only one side of the story. As Mason (2002, p. p.83) points out, interviewing relies on dialogue 'generated through the rather specific and refined context of an interview'. Analysis of the qualitative data produced can also be time consuming.

6.2.2 Sample

Purposive or theoretical sampling is the selection of a group to study on the basis of their relevance to the research question (Mason, 2002). A purposive sampling strategy was used since the research question required participants to be qualified art psychotherapists with current dyadic art therapy cases. I also wanted to include therapists in different settings because the practice of dyadic art therapy might differ in different contexts.

6.2.3 Recruitment

An electronic recruitment strategy was chosen for this part of the study. A primary consideration in making this decision was to reach as many potential participants as possible. An electronic flyer inviting qualified art psychotherapists to express an interest in involvement in the project was posted on the British Association of Art Therapist's (BAAT) Appointments Memorandum and Bulletin; on the Art Therapy Practice Research Network (ATPRN); to members of the special interest group for Art Therapists working with Children and Families (ATCAF); and to any other art therapists who had been in touch with me during the course of my research to express an interest in being personally involved in the research. The BAAT bulletin was chosen as it would have the widest possible audience, i.e. all members of BAAT; ATCAF was chosen because it is a special interest group for art therapy with children and families; and ATPRN because members were deemed to have a specific interest in research and therefore be more likely to have an interest in participation. Additionally, I knew that other requests for research participation have been successfully made through the ATPRN. Via these forums art therapists were asked if they would be interested in participating in a semi-structured interview about their dyadic practice and if they would be able to identify suitable service users (parent/carer and child) who could also be recruited into the study.

6.2.4 Data collection

Art Psychotherapists who expressed an interest in participating in the study received an electronic letter explaining the process and detailing what their involvement would be. Twelve art therapists expressed an interest or requested further information following the initial round of recruitment. However, it transpired that not all of the people who initially responded worked with the appropriate age ranges or had active dyadic cases,

and some therapists who were appropriate did not pursue their interest beyond the initial correspondence. Detailed discussions took place with seven potential participants, although two of these did not ultimately participate in the research due in one instance to insufficient experience and lack of active clients and in the other due to difficulties with arranging local governance issues within the allotted time frame. One further therapist was recruited through snowballing techniques. All the therapists who were finally recruited signed a consent form prior to being interviewed. Some of the therapist participants were further involved in the research by identifying and helping to recruit appropriate dyads.

Appointments were made with the therapists, at a mutually convenient time. Seidman (2006) suggests that ‘the First Commandment of interviewing’ is to be equitable (p.40) so, in recognition of participants’ generosity in giving their time to be interviewed, I offered to travel to a place that was convenient for them. The majority of interviews took place at the interviewee’s workplace and took up little more than one hour of their time. The therapists were interviewed using a semi-structured schedule (see Appendix 6.1). The schedule was developed with reference to Seidman’s (1998) three phases of qualitative interviews:

- A focused history to put experiences in context in relation to the topic of the study.
- Details of the experience, in this case asking therapists what they actually do in dyadic art therapy.
- Reflection on meaning, during which respondents are asked to reflect on the meaning of their experience.

Seidman (1998) recommends separate interviews for each phase, lasting up to 90 minutes each. However, as that would have taken up too much of the therapists’ time and would have necessitated repeat visits, a single interview schedule was designed to cover all three phases. The length of the interviews ranged from 58 minutes to 71 minutes. The interviews were recorded and transcribed verbatim.

6.2.5 Analysis

Analysis of the transcripts began using thematic analysis. The approach initially taken was based on that described by Braun and Clarke (2006; 2013) and was a recursive

process, including the following steps: familiarisation with the data; coding; searching for themes; reviewing, defining and naming themes. Towards the later stages of the thematic analysis, one of my supervisors highlighted the relevance of the actantial model to my emerging themes. I explored the background of this model and its utility for my data. I found it to be an excellent way of framing my findings. Below I detail each step of my thematic analysis and then describe the actantial model and how I used it to evolve a model which I could use in my analysis.

6.2.5.1 Familiarisation

The interviews were spaced over a period of nine months, dependent on when a convenient time could be found for the therapists. Once I had completed the first interview I had it transcribed and then I listened carefully back to the audio recording to check the accuracy of the transcripts. This checking was done in great detail and thus began the process of immersion and familiarisation with the data. I read through the transcript and began to look for ‘patterns of meaning and issues of potential interest in the data’ (Braun & Clarke, 2006, p. 15) and to try to name these passages or fragments of text. At this stage these were little more than ‘ideas and potential coding schemes’, described by Braun and Clarke as the start of the process of thematic analysis (2006, p. 15). As other interviews were completed, I repeated this process adding in new potential codes and noticing which ones were being repeated across different interviews. However, I kept the potential codes very fluid and descriptive and did not attempt to standardise them across the first four interviews.

6.2.5.2 Coding

I then began the process of moving from fluid descriptions of potential codes to ‘generating pithy labels for important features of the data’ as described by Clarke and Braun (2013, p. 121). In supervision I coded a passage alongside one of my supervisors and this illustrated to me how there can be both a semantic and a conceptual reading of the data (Clarke & Braun, 2013). I found I was coding largely on a semantic level, while my supervisor was more easily able to identify concepts. This felt like an ability to be able to see the wood, not just the trees.

In an attempt to gain a more conceptual understanding of the data, after the fourth interview, I gathered all the codes together and began grouping them. I had identified in

excess of 200 potential codes at that point. Some of these codes were very similar and so I was able to easily condense them down, after which I arranged the remaining codes into coherent groupings, which I labelled with a phrase or a sentence that expressed what they had in common. This led to a shorter list but with 57 codes it still seemed a long list. This felt like a messy and inexact science, as described by Clarke and Braun: ‘We always describe and explore the practicalities of qualitative research and its often messy reality, something usually hidden in published research or textbook guides’ (2013, p. 122).

6.2.5.3 Searching for themes

Following the initial coding process I tried to group the fragments into more coherent themes and began to draw diagrams to try to conceptualise the data. The diagrams began with the therapists whose viewpoints I was immersing myself in. I identified a number of inputs such as support and influences impacting on the therapists, and a number of outputs, or what I was conceptualising as *things the therapist does*. I also used the diagrams to think about whom the *things the therapist does* could be directed towards: the child, the relationship, the caregiver or the system.

The actantial model

During this process of searching for themes, one of my supervisors used the term ‘actant’ to describe some of the facets I was identifying. This term was coined by the French structuralist Algirdas Julien Greimas (1983) who proposed the ‘Actantial Model’. I decided to look into this further and discovered that the model is a tool that can be used to analyse any action, but particularly those depicted in literary texts or images (Hébert, 2011). I discovered that, using actantial analysis, an action can be broken down into six facets, called actants, and this is often represented visually with a diagram which I found bore a striking resemblance to those I had been creating to conceptualise my data. As a result, part way through the analysis, I began to develop and use a framework based on the actantial model to help me further analyse the data. Before describing how I reviewed, defined and named my themes, I give an overview of the actantial model.

Origins

During the 1960s Greimas proposed the actantial model which was based on the theories of Vladimir Propp (1968) whose study *The Morphology of the Folktale* was originally published in Russian in 1928. An actant is not always a living character; it can also be inanimate, such as an image, place or concept (Hébert, 2011). Greimas divided the six actants into three axes:

The axis of desire

On this axis there are two actants: the subject and the object. The subject is the main protagonist and the object is the subject's goal or aim. For example, in *Sleeping Beauty*, the wicked stepmother can be seen as a subject who desires to be rid of her beautiful stepdaughter, and so this becomes her object.

The axis of power

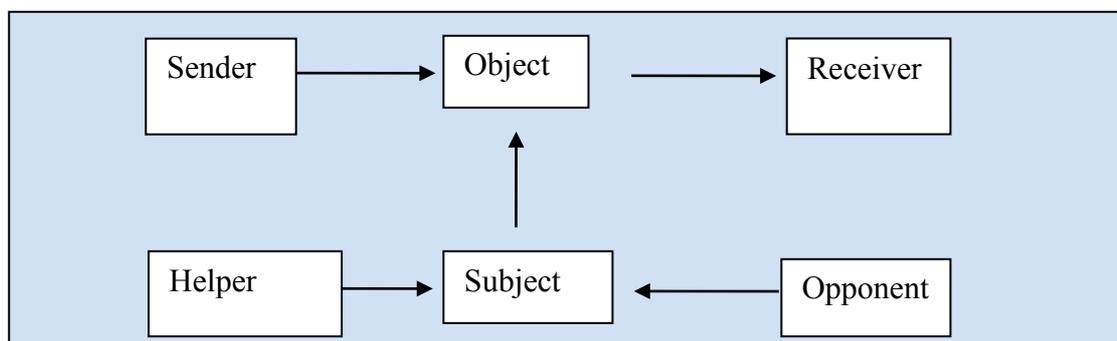
On this axis there are two actants: the helper and the opponent. The helper assists in achieving the desired goal while the opponent hinders it.

The axis of knowledge

On this axis there is the sender and the receiver. The sender is someone or something that sees and advocates the value of the subject's goal. The receiver is the person, people, thing or situation that stands to benefit from the goal being achieved.

A common visual conceptualisation of the model is shown in Figure 6.1

Figure 6.1: Visual representation of Greimas' six actants



Use of the actantial model in health research

Given the relevance of this model to my study, I felt it was important to understand whether and how it had been used in other health research to ensure that my application of the model was based on learning from this experience. A search of Web of Knowledge using the search terms *Actantial AND Health* retrieved two references. Aarva and Tampere (2006) describe an ‘Actantial Model of Health Promotion (AMHP) for studying health promotion cultures’, identifying the actants of health promotion. The authors argue that the AMHP ‘can be used to identify the value dimensions and the boundaries between the dominant and the opposite discourses of health promotion in various communications such as advertising and health education’ (Aarva & Tampere, 2006, p. 160). The second paper, by Sorensen et al (2011), analysed the dynamics and conflicts arising in the provision of emergency obstetric care in a local Tanzanian rural setting. The authors proposed a modified actantial model as a supplementary analytic model that can focus on the health system as the central agent responsible for improving maternal health. The modifications made by the authors were designed to ‘keep the analysis as clear and simple as possible’ (p.120). As such they omitted the sender-receiver axis of knowledge which ‘was considered of more peripheral relevance given that the study focus was the dynamics in a local setting not covering more general political and organisational structures’ (Sorensen et al., 2011, p. 120).

Both of these papers report using a modified version of the actantial model and provide diagrams to illustrate their versions. These are shown in Figures 6.1 and 6.2.

Figure 6.2: From Sorensen et al (2011) Simplified Actantial Model

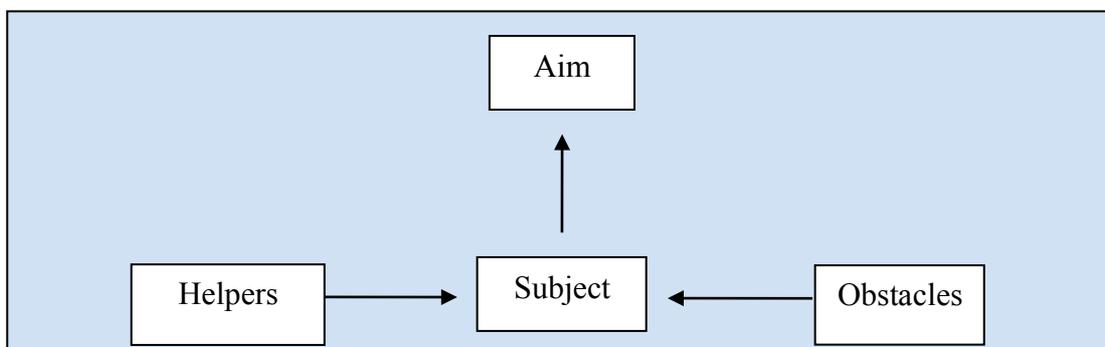
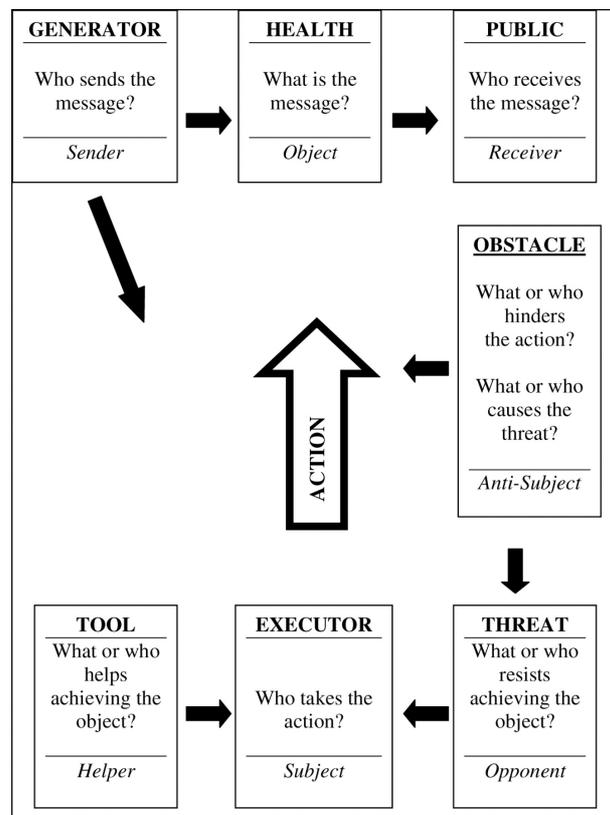


Figure 6.3: Actantial Model of Health Promotion

(from Aarva & Tampere (2006) in *Health Promotion International*, 21(2), 160-168 reproduced by permission of Oxford University Press)



I understood from these researchers' experiences of using this model that I might need to follow their initiative and adapt the model for my research. Of these two papers, although both relate to health services research, the greatest similarity to my research was with the Tanzanian obstetrics research (Sorensen et al., 2011). In this instance a pared down model with just four actants on two axes is used to 'disentangle the users' and providers' perspectives' (p.120). The authors rename some of the actants, with object becoming aim, which is clearer to understand, and opponent becoming obstacle.

Aarva and Tampere (2006) on the other hand developed a model to facilitate a more narrative understanding of contemporary discourses of health promotion, and have introduced an anti-subject into their model, referring back to the work of Propp (1968). Reading these two papers indicated ways in which I could adapt the classic model to address the needs of my research, either through renaming actants to be more relevant or focussed, or by adding in elements which the classic model did not specify in sufficient detail.

Developing a dynamic actantial model

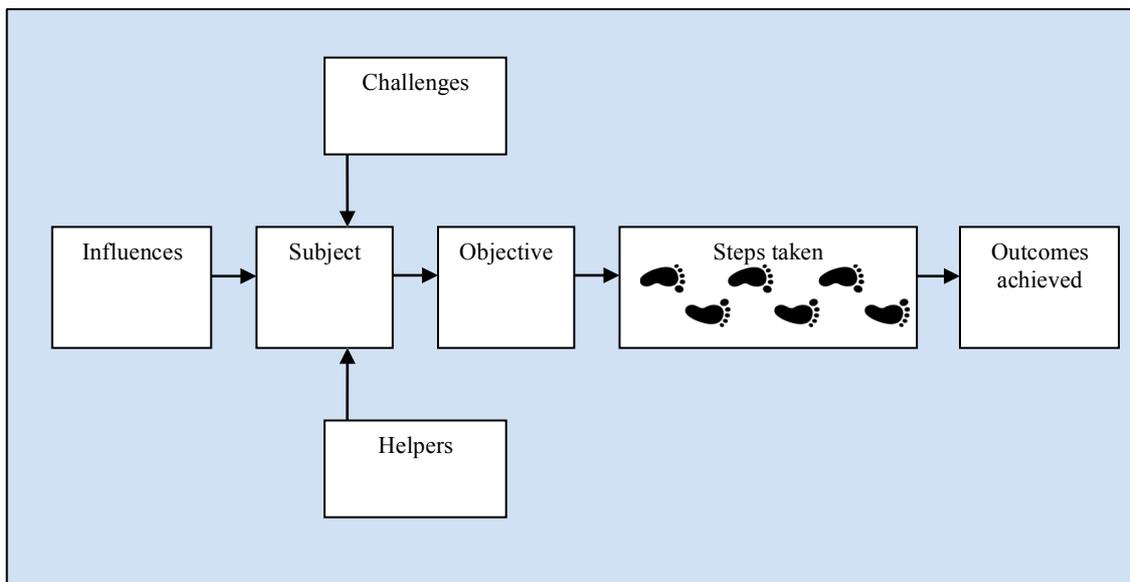
Sorensen et al (2011) found it expedient to omit the sender-receiver axis of knowledge. However, I found it useful to keep that axis but to reframe the sender influences, that is, the actant or actants which influence the subject's decisions about what the objectives are and which steps should be taken to achieve them. In the classic model the receiver is the actant or actants that benefit from the action. However, I found in my data detail about the benefits and outcomes of the actions and so wanted to incorporate this into the model, with the focus on what these benefits were rather than who received them. So, the receiver actant evolved to become the outcome actant, describing what is actually achieved by the subject's efforts to reach the established goals or objectives.

The term 'subject' seemed helpful and I left it unchanged. However, in line with Sorensen et al (2011), I found it more helpful to think about the object as the subject's objective, i.e. the aim or goal. So this actant, although essentially unaltered, was renamed as the objective in my model. The helper remained unaltered but the opponent actants were renamed challenges.

Greimas' original model was designed to analyse narrative action, however, there is no place for the action in the conceptualisation, which leaves it somewhat static and lacking animation. I was interested not only in the subject and the subject's goals but, crucially, also in what steps the subject takes to achieve these goals. So I evolved a more dynamic model which included a new facet: the steps the subject takes towards achieving the desired goal. The word 'step' was chosen to describe *things the therapist does* in pursuit of their goal objective. As such 'step' is used in the sense of a step taken to achieving a goal, and is preferred over alternative words such as 'action', which seems incongruent with some of the more passive *things the therapist does* such as witnessing or reflecting, or the term 'intervention', which is frequently dually used to describe both the whole macro-intervention and the micro-interventions within it. In opting for the term steps the metaphor was of dance steps that can be stand alone or individually choreographed into a unique free-style dance. This image was suggested by the data, which did not identify rigid patterns for the *things the therapist does*. Instead, the therapists were keen to emphasise the need for flexibility, the impossibility of producing a blueprint and the need for a case-by-case, individually choreographed,

approach. A diagram of the dynamic actantial model used in this study is shown in Figure 6.4.

Figure 6.4: The dynamic actantial model



6.2.5.4 Reviewing, defining and naming themes

I combined my existing conceptual diagrams with Greimas' actantial model, which led to the development of the *Dynamic Actantial Model* (see Figure 6.4). With this in mind, I went back into my data and reviewed it through the lens of this new framework. Most of the data fitted well with the model and I could see that the model might be a helpful way of thinking about and reporting the themes. However, there was one part of the data that did not sit easily in the model. I had asked the therapists about their views on manualising dyadic art therapy which was a shift in focus from the rest of the interview which focussed on their clinical practice. This meant that there had been two separate foci: one on the operationalisation or content of dyadic art therapy and the other on the therapist's views of a manual. I therefore decided to use the actantial model for the content and to report this separately from the views about the manual which will be reported later as a stand alone theme.

Themes relating to operationalising dyadic art therapy

The coded data was arranged into the actant groups. This produced a series of lists, which were helpful for the manual, but which did not amount to a thematic analysis. For the analysis, themes were sought which would illustrate the interplay between the actants. A review of the data once it had been arranged into actant groups highlighted the objectives as the pivotal actants, with the other actant groups mapping on to them.

That is: the steps were what the therapists did to achieve the objectives; the influences were what made the therapist value the objective; the helpers were what helped achieve the objectives; and the challenges were the obstacles to achieving the objectives; and the outcomes were the results relating to each objective. This interplay of the actant groups could be visualised as a grid (see Table 6.1).

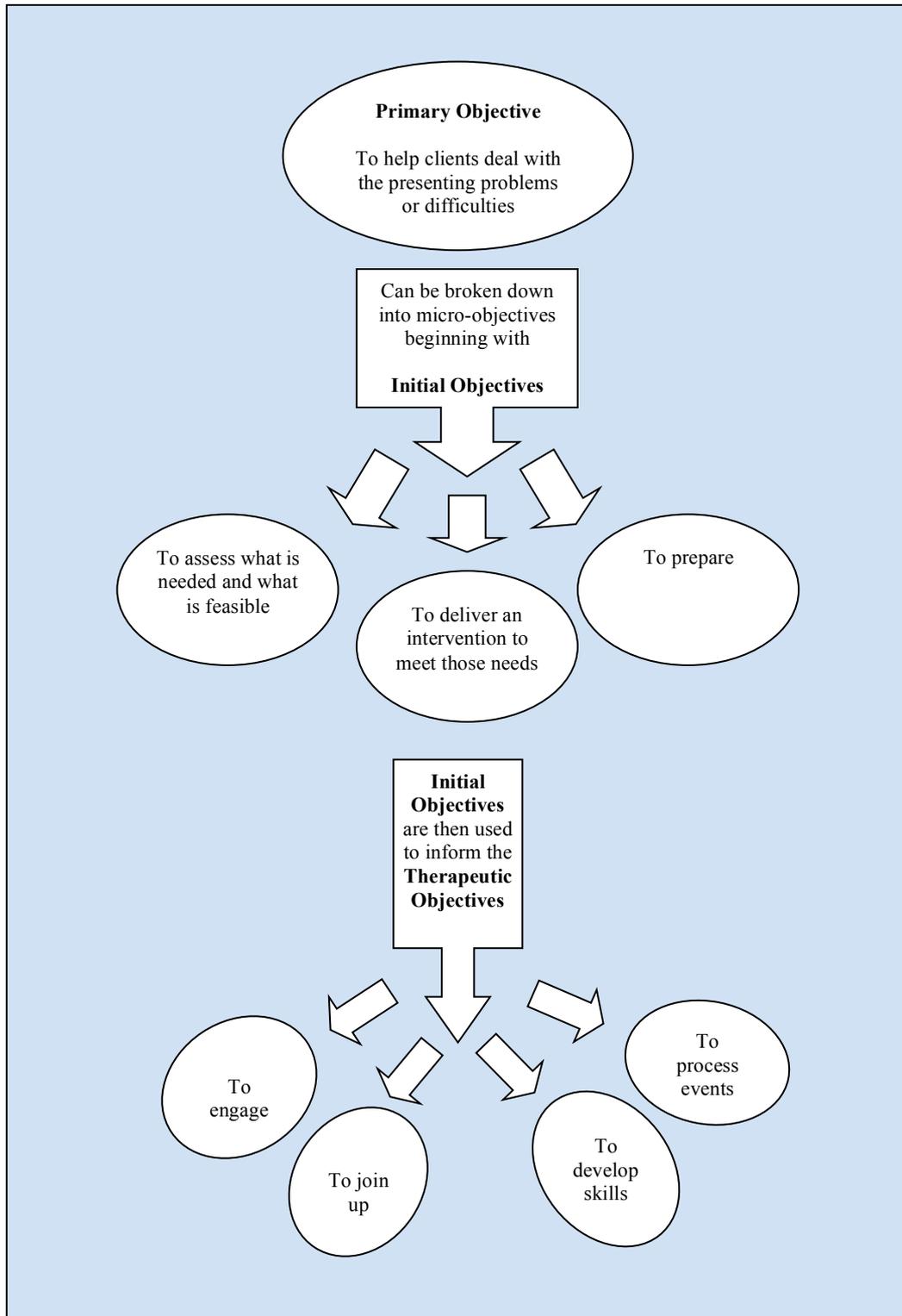
Table 6.1: Grid showing interplay of actants

	Objective
Influence	<i>A description of what influenced the therapist to value the given objective</i>
Steps	<i>A description of the steps the therapists describe taking to achieve the given objective</i>
Helpers	<i>A description of the factors which the therapists describe as helping to achieve the given objective</i>
Challenges	<i>A description of the factors which the therapists describe as obstacles or challenges to achieving the given objective</i>
Outcomes	<i>An understanding of has been achieved in relation to the given objective</i>

Mapping the interplay of the actant groups revealed that the objectives could be seen as the cornerstones of the therapy and that these objectives would be the themes displayed in the findings. The idea that the therapist’s objectives might be the cornerstones led to a closer examination of the objective actant group. The term objective appeared a little ambiguous because it could refer to an overarching ‘goal in the back of the net objective’ or it could refer to smaller intermediary micro-objectives which the therapists saw as necessary to achieve the desired end goal. Indeed it seemed possible that this process of breaking down the overarching or primary objective could happen in stages, with some intermediary or micro-objectives needing to happen before others. For example the primary objective (which was framed albeit briefly by interviewees as: helping the child make progress, improving the quality of the caregiver-child relationship, or helping with the presenting problems) might be broken down into some initial objectives (such as assessing needs and planning the best way to meet those needs) and those objectives, once achieved, might inform a new set of micro-objectives

(such as engaging with the dyad or processing trauma). A visual representation of the unpacking of the primary objective is shown in Figure 6.5.

Figure 6.5: Unpacking the therapists' objectives



A review of the data indicated that although each therapist did briefly describe or allude to overarching or primary objectives there were only very brief discussions of these. It was the intermediary goals that were more readily articulated and elicited and it was in fact these objectives that formed the cornerstone of the actant groups. I therefore decided to define and name themes based on the micro-objectives described by therapists.

6.3 Results

6.3.1 Description of participants

Six therapists were interviewed. The therapists ranged from recently qualified therapists in their first post-qualifying role to therapists with in excess of 15 years post-qualifying experience. There was a range of ages and therapists of both genders. Work settings were varied, as intended: health (n=3), social services (n=1) and voluntary sectors (n=2). The therapists are identified in the thesis when quotes are used as: therapist 1 (T1); therapist 2 (T2); therapist 3 (T3); therapist 4 (T4); therapist 5 (T5); therapist 6 (T6). No background detail is given about an individual therapist to maintain anonymity.

6.3.2 Overview of themes

As has been described, the themes identified related directly to the micro-objectives which the therapists implicitly or explicitly described. As such, each theme is presented in terms of the objective it relates to and:

- The factors which *influenced* the therapist to value that objective
- The *steps* the therapists describe taking to achieve the objective
- The factors which the therapists describe as *helping* them achieve the objective
- The factors which the therapists describe as obstacles or *challenges* to achieving the objective
- The *outcomes* which may be achieved in relation to the objective

The themes that have been drawn out of the data are:

- A. Assessing need and feasibility
- B. A flexible needs-based approach
- C. Preparing
- D. Engaging
- E. Joining up
- F. Developing skills and understanding
- G. Dealing with events

As described above, there was an additional theme about the process of putting together a manual which did not fit the actantial model which focused on the operationalisation or content of dyadic art therapy. This theme is reported after the actantial themes.

6.3.3 Assessing need and feasibility

Micro-objective A: Assessing what is needed and what is feasible

One of the ‘initial objectives’ (as illustrated in Figure 6.6) which emerged from the data was the therapists’ desire to get an in depth understanding of the child’s needs, so as to get an indication of how best to meet those needs and achieve clarity about what might be feasible with a given family.

Influences for assessing need and feasibility

As outlined earlier, within each theme there is an exploration of what influenced the therapists to value the objectives that relate to each theme. In this theme this means identifying what or who influenced the therapists in their thinking about how best to assess therapeutic needs. The key influences were the workplace and direct clinical experience.

The workplace

The therapists described how their methods of assessment were, to some degree, influenced by their work settings, some of which had set assessment procedures dictating the number of sessions offered.

Clinical experience

The therapists described how their own first hand clinical experience had led them to value the importance of a thorough assessment of what was needed and of what was

feasible. This was illustrated by some of them describing how they had learnt from their own mistakes, referencing instances in which they felt they had not done sufficiently rigorous assessments:

'I think that if your assessment of that carer and that initial relationship isn't robust, and I can think of one [...] when it's been really tricky and I shouldn't, with hindsight I shouldn't have taken that route' T5

Steps for assessing need and feasibility



Within each theme, once the objectives and influences have been outlined, there is an unpacking of the steps the therapists take to achieve the objectives. In this instance, this means gaining an understanding of what it is that the therapists actually described doing to assess the therapeutic needs of the children they were working with, and to understand what might be feasible in terms of therapeutic work. Steps identified from the data were: observing and formulating; determining dyad specific goals; reviewing work and gauging goals.



Observing and formulating

During the assessment period the art therapists described how they tried to understand what was happening in and around the child. Their focus was on: understanding the child's relationship with their primary caregiver; getting a clearer picture of the adult, the child and the wider systems around the child; and thinking about what might be helpful including making decisions about the feasibility of dyadic work.

When trying to get an understanding of the relationship between the child and the primary caregiver the therapists spoke about how helpful it could be to observe the dynamics and interactions between them in joint sessions because it could help the therapists to understand issues which might not be so apparent during individual sessions with the child:

'I could see in the relationship there were things that were coming out... that I hadn't been able to maybe get a grip on... when I had been seeing the child on his own' T4

Therapists described paying attention to: how the children signal their needs and feelings to their caregivers; whether or not caregivers pick up on these signals; how caregivers respond to signals; the emotional availability of caregivers; how decisions are made; patterns of interaction that have developed.

To get a clearer picture of the adult, the therapists described trying to understand the extent of their capacity to think about their child and also their own experience of being parented. In terms of building a picture of the child the therapists described trying to understand the therapeutic needs and the child's level of understanding including emotional literacy.

With children in care, therapists were curious about whether the caregivers were going to be able to maintain the placement and to what extent they were willing or able to put in the work to do so. The therapists also spoke about taking account of the child's past history and their current placement and how the child felt about where they had been placed: *'how long have they been there? Do they want to be where they are? Is it a carer that's going to be long term?'* T1

Therapists also thought about other significant people involved in or with the family, and how they might play a part in therapeutic work. Some therapists involved people from the wider system in network meetings and review meetings. This will be discussed in more detail in the step *Reviewing Work and Gauging Goals*.

When thinking about what might be helpful and whether dyadic work was feasible or not, the therapists thought about: the length of the intervention; the frequency and format of sessions; the timing of the intervention; and the adult and child's capacity to make use of the work:

'So when I first start I am I suppose I'm just, I'm really formulating what's this mum going to be able to manage... What's this child going to manage? Are they in the right place... is this helpful right now? What's the timing like? You know what else is going on for this family? Who else is involved?' T6

If the adult was unable to think about the child, or openly hostile, then this could lead to dyadic work being ruled out. Parental mental health was seen as an important

consideration during the assessment, although, if there was sufficient support for the parent, it was not necessarily seen as a contraindication:

'[T]hat's not to say if there is a parental mental health problem I wouldn't work with them in that way but... I'd want to know, you know, if they'd got support and who I could talk to and get permission to keep things safe'. T6

This therapist spoke about how it was useful to formally share any understanding that had been gained with the family. This involved writing a therapeutic letter to the family outlining thoughts and observations of the family as well as conversations that had taken place during the assessment process. The therapist saw this as helpful to both therapist and family:

'I think it helps me to think about what's happened as well and where I'm going but I think it helps the family to have something... concrete to refer back to and to think about what that journey's been and help them to understand' T6



Determining dyad specific goals

Another step in the assessment process was identified as thinking about what the aims of the therapeutic work would be. Some of the therapists did not discuss the process of goal setting at the start of the work with the dyad, while others talked about it being a new venture, or one that was not as established or universal as they would like.

Some described impromptu or informal goal setting either at the beginning of therapy or as an on-going process during therapy. There was a sense that explicitly setting goals with the dyad and evaluating them at the end of the work was something new, but something that the interviewees were happy to embrace:

'[W]e're now going to start doing goal based outcomes so setting goals and aims with the child at the beginning, scaling how they're feeling about different areas of their life and then... repeating those measures at the end but that's new to this team.' T5



Reviewing work and gauging goals

As therapy progresses and the child reaches new developmental milestones, there might be an expectation that the child's therapeutic needs will change. The therapists described reviewing the work with the child and adult and gauging how far they had travelled towards meeting their objectives. There seemed to be a more explicit focus on goals in review meetings than there had been in the assessment phase. Reviews were seen as a time to reflect on whether the goals were being met and decide if the approach that had been adopted at the outset was still the right one. In some cases this might mean switching from individual to dyadic or vice versa:

'[W]e'll think about where we've come from, we'll think about where we want to be heading. Is this still the right thing? What do we need to be thinking about next? All that kind of stuff so I always do that but the length of time between reviews will vary from child to child.' T5

One therapist, who works with looked after children, distinguished between two different types of review meeting. The first type of review meeting, which was described in very similar terms to the one above, happens when the child is engaging and the intervention *'feels appropriate'* T1. The second type of review meeting happens when things aren't going so well or if the child is not able to engage with what is being offered. For this therapist, a situation like the latter would indicate the need for a professionals' review meeting to liaise with key adults in the child's life and find out if there are events happening outside of therapy that might be impacting on the work and, if necessary to review the aims and on-going suitability of the therapy.

Helpers for assessing need and feasibility

Seven key helpers were identified across the data set. Some helpers resonate with just one theme, others are more universally helpful. For each theme the most pertinent helper or helpers will be expanded on.



Seeing the dyad making art together

The therapists described how seeing the dyad together in some of the assessment sessions was very helpful because they could see the child interacting with their caregivers which directly informed the assessment and formulation. In particular, setting art-based joint engagement tasks was seen as helpful as the therapist could witness at first hand how decisions were made and what sort of discussions took place:

‘[T]hen what I would do from that is watch negotiations, how the family negotiate, what decisions they make, who takes lead, who doesn’t, whose ideas are thrown out and whose ideas are put forward. T6

Challenges for assessing need and feasibility

As with the helper actants, a number of key challenges were identified across the data set, and again, for each theme the most pertinent challenge or challenges will be expanded on in detail.



Workplace constraints

Some therapists described how constraints and limitations associated with the workplace could represent a challenge in terms of what therapy it was feasible for them to offer. Constraints came in the form of: existing models of assessment or therapy which the art therapists were expected to fit in with; financial and practical limitations including cutbacks, reductions in services, and heavy case-loads; physical limitations in terms of work spaces and venues.

Most of the workplaces had some set procedures in terms of number of assessment sessions or therapy sessions. Some of the therapists were working within quite tight time constraints with time limited sessions.

One therapist spoke about how cutbacks had impacted to change the way assessments took place in the service:

I was part of an assessment day [...] that was myself, nurse, psychologist, psychiatrist [...] they’d be with us for about five hours and they’d have lunch [...] some people could hold things together for an hour, an hour and a half but

by the end of the day you see what's going on [...] when families were stuck on this child's got ASD or ADHD and actually we know it wasn't that it's something about the way the family functions [...] We haven't got that unfortunately anymore because of the cost of it although I think it's a bit of a false economy because it just gets done in a different way and probably [takes] longer. T6

Another therapist spoke about the pressures of case-loads and waiting lists: *'I think one of the challenges I face really is just the pressure on waiting lists'* T3

The physical limitations of the facilities and spaces available were described as having an impact on what it was feasible or possible to offer. One therapist described how it was not ideal to offer sessions in a school environment and highlighted how the setting could either impede or facilitate the art making:

'If we're seeing people out in the community we're much more limited in... If I'm here there's much more opportunity for them to be able to use the art materials and make a mess and use it to sooth themselves whereas when I'm out and about it's much more difficult to do that because you can't make a mess can you?' T5

Outcomes for assessing need and feasibility

Through a thorough assessment of the child's needs, the therapists described building up a picture of each child's internal and external world. This metaphorical picture could be shared with the child's caregivers during the therapy. The therapists also described building a picture of the caregiver and their specific capabilities. These two pictures helped the therapists to structure and plan a realistic intervention designed to help the child with the identified difficulties, whether internal (i.e. emotional) or external (i.e. relational), within the parameters of what was feasible with that family.

6.3.4 A flexible needs-based approach

Micro-objective B: Taking a flexible needs-based approach

A second 'initial objective' that emerged from the data was the desire to offer an intervention that responded directly to the needs of each child. This meant that the therapists were generally not following a blueprint or prescription for what the

intervention should look like. Instead, a flexible case-by-case approach to structuring and planning each intervention emerged as a key consideration. Although great emphasis was placed on flexibility, the therapists also described their desire to offer a coherent or consistent intervention. The skill of holding this balance is summarised by Rubin (2012) ‘It seems to me that the artistry of good therapy lies in being flexible, but within certain guidelines, rather than being either rigidly unbending or fluidly unpredictable’ (p.54).

Influences for a flexible and needs-based approach

Clinical experience

Again clinical experience was seen as a key influence. The therapists described how they had evolved ways of working, learning from one case to the next, and the upshot of this learning cycle was a belief that it was most helpful to remain flexible and tailor each intervention to the needs of the dyads on a case-by-case basis.

Traditional models

There was another influence which the therapists identified, although this was one which they appeared to be resisting or reacting against. It was traditional, or old school art therapy models, which did not generally include adults in sessions but focused on individual sessions with the child. A discussion of what influenced the therapists to resist that influence and invite the children’s adults to join in the sessions will be discussed later in the theme ‘*Joining up people, ideas and actions*’.

Steps for a flexible and needs-based approach

This section explores the steps which the therapists described taking towards the objective of delivering a flexible needs-based intervention. Steps identified from the data were: structuring the intervention and sessions; and adopting an appropriate approach.



Structuring the intervention and sessions

Following the assessment and the goal setting, the intervention the therapists then described a process of tailoring the intervention to meet the needs of each dyad. The term ‘structuring’ is used to include decisions made about: who is to be invited or

included in sessions; the venue for sessions; the duration of sessions; the frequency of sessions; the structure or format of sessions.

Flexibility

The therapists highlighted the importance of being flexible in thinking about what could be offered and how the sessions would be structured. However, it was apparent that the therapists were striking a balance between flexibility and coherence, not wanting the intervention to be so flexible that it became unpredictable or inconsistent. So, for example, therapists described how session times and venues would ideally be consistent with any alterations or breaks being carefully and clearly negotiated ahead of time, and it appeared that the therapists aimed to be clear about what was being offered and why:

'I might say right I'm going to work six sessions with the child then we're going to come back and then we're going to have a period of time where I'm going to see [parents] for two or three weeks on your own... and then I'm going to come back and we're going to work together'

A period of preparation

Some of the therapists described a period of preparation prior to the start of joint sessions, and a lack of preparation was seen as a potential stumbling block, which could interfere or sabotage dyadic work. For more information about preparation see the steps *Preparing Parents and Carers* and *Preparing the System*.

Separate sessions with parents and carers

Some therapists described separate sessions or conversations with parents or carers in which continued alongside the joint dyadic sessions with the child. These sessions, which were sometimes face-to-face, by phone, or by email, were seen as providing opportunities for the therapists to have discussions with the adults, which it might not be appropriate or helpful to have with the child present. The focus of these separate discussions was sometimes on issues in the adult's own past such as their own experience of parenting, or on more day-to-day issues to do with their experience of parenting the child.

Focus on individuals not groups

Although some interviewees expressed an interest in the idea of group dyadic interventions, none were offering the intervention in a group format. All of them were

working with individual dyads with the exception of one of the therapists who had run caregiver groups followed by child groups, which had culminated in a single joined up group session. This therapist had reflected at the time of running this group that it might have been helpful to have had more time with the parents and children together in the group. However the group had been helpful in offering the parents space to think about own their experiences of being parented and the group format had allowed them to share experiences with other parents which had reduced feelings of guilt and shame. The therapist observed that parents who had attended the group were also more consistent at bringing the children to the children's group that ran after the parent group had finished. The therapist hypothesised that this was because the parents had experienced the group for themselves and so understood what the children might get from it.



Adopting the most appropriate approach

The data from the interviews indicated that not all dyadic sessions were run in the same way, instead, the therapists made judgments about the most helpful way to begin. There emerged three broad, potentially overlapping approaches, which were:

- Joint engagement
- Child led art making with parent or carer as witness
- Parent/carer and therapist working together as a therapeutic team

One of the therapists explicitly identified two out of these three ways of working as distinct approaches to dyadic art therapy: *'Maybe there's a distinction there, because there's work where they work together and then there's work where you know we ask the parents to be more a co-therapist in thinking about their child.'* T4.

Joint engagement

Joint engagement activities were seen as useful in helping the dyad to engage with each other in new and perhaps unexpected ways, facilitating new connections between them, breaking stalemates, and helping them to learn about the other's perspectives. Joint engagement activities seemed to require less preparation than other approaches with the therapists simply asking the adult and child to join together and make an image. More information is given on this in the step *Facilitating Joint Engagement*.

Parents and carers in other roles in the sessions

Some of the therapist encouraged parents and carers to go beyond joint art making and to take on specific roles in the sessions.

One role some therapists described caregivers in was as a witness to the child's art making. In sessions such as these the caregivers did not lead or direct the activity. It appeared that their role in sessions was to follow the child's lead, offer appropriate help, to reflect upon what they have observed and perhaps to join in reflective discussions. In some examples the therapists spoke about how having the caregivers witness key events in therapy helped them to gain an insight about the child or a better understanding of the therapeutic process:

'I think the carers get frustrated with the children [if] they don't feel like they're reflecting or looking at their own behaviours and stuff [and seeing this event] seemed to give the carer an insight into how difficult that was which I think sometimes they don't kind of realise' T2

The therapists described a degree of preparation needed with the caregivers before starting with this way of working. The preparation seemed to focus on clarifying the different roles the adults might be expected to take.

Some of the sessions described involved reflective discussion in which the therapist asked the parent or carer, and maybe the child, to reflect on the process of the session and the image created:

'[T]he structure is often to say to the parents you know that this is a time [...] for us to try and understand and that we would work together and we would think [...] about maybe what's happening in the room with the child' T4

Other roles which the therapists described caregivers taking on in sessions included being a safe base for the child when difficult or traumatic issues are being dealt with, or actively working with the child to develop a coherent narrative.

Careful preparation of parents and the carers for these roles was also seen as important and seemed to involve explaining why the child might feel safer in the presence of their main caregiver or planning together the next steps in giving the child the appropriate

information needed to help them make sense of their past.

One therapist described consulting carefully with caregivers about therapeutic direction and strategy when approaching discussions of difficult or traumatic material with a child:

'Sometimes I might have those conversations [...] because I think you've got to have them on board' and described essentially *'a collaborative process between me and the carer: this is what I'm thinking, I'm not sure, how do you feel he is in the room?'* T5

Helpers for a flexible and needs-based approach



Support from workplace, colleagues and supervisors

In order to be able to have the flexibility to offer what the dyad needs, the therapists needed the support of the people around them. Some workplaces were more able or willing to support and encourage flexible working than others.

Therapists also spoke about the support they got in thinking about the needs of the dyad. They received help from colleagues, supervisors and peer supervision groups:

'I feel really supported and it's really useful to use that space to kind of explore [...] different dynamics and relationships so it's really useful. Always need it. It's always great to have supervision.' T2

Challenges for a flexible and needs-based approach

A number of challenges relating to this theme were mentioned by the therapists.

Workplace constraints have already been discussed in the previous theme, but were pertinent in cases where perhaps the child's needs did not fit well with the service or model offered in a given setting. Examples of this included time limited work rather than interventions tailored to last to the optimal duration for a given dyad.

Other challenges related to the caregiver and child's capacity to engage in dyadic work, in as much as it might be thought to be helpful for the child but the reality of the work could feel very challenging for some families. These are discussed below.



Can be demanding work for the caregiver

Therapists described how the focus on reflexivity could be quite challenging for parents and carers, particularly if have not had much experience or practice of reflective thinking. One therapist described how it was the policy of the team to give foster carers reflective diaries to use as a way of thinking about events that had occurred between sessions. However, it transpired that the diaries were not widely used in practice.

Another aspect of the work which was seen as potentially challenging for parents and carers was the idea that it might be helpful to modify or change firmly held patterns of relating. One therapist described how caregivers might be reluctant or find it difficult to take on new ways of relating to their children:

'[I]t's really difficult because you have carers over a long period of time, and you think they've got it and then all of a sudden they do something where you think they really haven't got it [...] it's continuous so you just have to kind of keep plugging away at it really.' T2

Also, it could be hard for some caregivers to understand that they might need to put their own agenda on hold in some of the joint sessions:

'I would try to avoid getting into a position where the carer is giving you all the negatives of what has happened in the week right at the beginning because you get that sometimes don't you [...] 'Oh you'll never believe what he did yesterday?' T5

One of the steps the therapists took to overcome this challenge was to offer a separate space for discussions with the parents and carers. More information is given about how therapists met this challenge in the steps *Preparing parents and carers* and *Structuring the intervention and sessions*.

Finally, a number of the therapists described some instances when the parent or carer was not able to meet the challenges presented by dyadic work, so even though this had been initially been seen as potentially the most beneficial approach for the child, the plan of work had to be changed:

' [I worked with a] young mum with four kids, really struggling, and really struggling with one little boy in particular and [...] there was a push for me to work individually with him but really the work was on the relationship but she was so cross with him that she couldn't leave that at the door when she came in the room so it was so hard for her to be empathic, so hard for her to be positive, so hard for her to play with him and be alongside him. She was so cross with him and actually I did stop that piece of work because it just felt like it was another opportunity for [...] him to be shamed, for him to be embarrassed [...] but I still kind of stand by the fact that the work was in the relationship' T5



Can be demanding work for the child

The therapists also described how child's capacity to tolerate therapy could have an impact on the pace of the work. If the child had had traumatic experience they might find it hard to regulate emotions in sessions. One therapist spoke about how this needed to be taken into account with the work moving at the child's pace:

'We've had maybe twelve or fourteen sessions but the beginning bits have all been about helping her try to get control of her wobbly lip because when things just start to shift slightly towards being uncomfortable she collapses, she disintegrates so we've done lots of all art making but all stuff about self-esteem and what she's great at and what her favourite thing ... all of that that's all we've done so far and she's tolerated that' T5

Outcomes for a flexible and needs-based approach

Just as the approach was seen as being dependent on the needs and situation of each dyad, so too the outcomes were seen as dependent on the difficulties presented by each dyad. Some of the therapists discussed formal evaluations of outcomes, whilst others monitored this informally or implicitly. All of the therapists were asked about what they saw as the most likely outcomes of delivering their dyadic art therapy intervention. Therapists discussed the outcomes that they thought it might be most useful and illuminating to measure post-intervention. Some of these outcomes related to the relationship, some directly to the caregiver and some to the child.

The relationship outcomes related to the quality of the attachment relationship between child and primary caregiver and, in children in care, the stability of the placement. The

outcomes in the caregiver which therapists suggested it might be useful to measure were: increased empathy and understanding of what under-lies the child's behaviours; attunement to the child's needs; understanding of how the child shows what they need; and caregiver stress levels.

Outcomes which therapists suggested measuring in the child were: engagement; the ability to make links with current behaviours and past events; the child's ability to manage relationships; the child's reflective functioning; school attendance; attachment behaviours; emotional literacy; PTSD type symptoms such as flashbacks, nightmares; regulatory difficulties such as sleeping, eating and soiling; general growth and development; the child's stress; cognitive gains; regulation and arousal levels.

In line with the idea that the design of the intervention is based on the individual dyad's need, one therapist highlighted how the outcomes should reflect the dyad's presenting difficulty: *'I suppose it depends what the child comes with doesn't it? Or what their difficulties are when they first come. So you would hope for an improvement in those difficulties, whatever they were'* T4

Examples of actual outcomes related to delivering a flexible client-led intervention

In many of the interviews the therapists described real case material that gave practical illustrations of outcomes. One therapist highlighted how a flexible structure that allowed for some individual sessions and some joint sessions could give the therapist time to build a picture of the child in the individual sessions as well as the opportunity to share that picture with the parent in joint sessions. The therapist gave the following clinical vignette which illustrates this point well:

'[T]he little boy had been brought along by a voluntary organisation ... It was a very chaotic family and he was presented as the most terrible child ever. He was pulling radiators off the wall, mum was terrified of him... she wasn't really engaging with the service... he was brought along by his worker and I think actually it was quite good to do a combination because I think in the process of getting to know him... I saw... a child who was very vulnerable and we arranged one session with mum... [T]ogether they made this kind of clay scene which was... an underwater party and they covered things in glitter but they worked

very collaboratively together in making rooms for different things and this huge scene kind of unfolded and what was good was that he obviously felt less anxious about working with her as the session went on but that also I think at one point there was a bang or something in the distance and he kind of jolted and it was obvious that he was frightened in some way and I was able to say to mum that I think that you know the noise that he's heard has just made him feel frightened and I could see her that she was actually able to think about his emotions and at that point I think that... the penny dropped and she was able to just see him as a child who was very frightened rather than a child who was very aggressive... their relationship really, really improved after that one session.'

T4

6.3.5 Preparing

Micro-objective C: Preparing for the work

All of the therapists talked about some degree of preparation prior to the start of dyadic sessions. Their objective was to provide sufficient preparation to facilitate the subsequent dyadic work. The focus tended to be on preparation with the parents or caregivers but also sometimes involved the wider system around the child.

Therapists also spoke about how they had prepared themselves for starting dyadic work.

Influences for preparing

Clinical experience

The primary influence was first hand experience. The therapists discussed cases where they felt they had done insufficient preparation and this had, in some instances, resulted in a break down in the therapy.

Steps for preparing

This section explores the steps which the therapists described taking towards the objective of preparing for dyadic work. The steps identified from the interviews that relate to this objective are: preparation for the therapist; preparation with the parents or carers; and preparation with the system.



Preparation for the therapist

The therapists spoke about what they had originally done to prepare themselves to start delivering dyadic art therapy. All of the interviewees had completed the formal art therapy training, and some had also completed other in-depth therapeutic training. Some of them had completed short courses designed to train practitioners to deliver specific interventions such as Theraplay or evidence-based parenting programmes. The therapists had also read around the subject as well as drawing on expertise from supervisors and colleagues if this was available, which was not always the case.



Preparation with the parents or carers

Different dyadic approaches appeared to require different types and amounts of preparation. However, in general, the preparation described involved discussions of:

- Parents and carers' own life experiences and the impact these experiences have had on how they now parent their children
- What the child has experienced and the challenges they currently face
- What might happen in joint sessions and how to respond
- Roles which the parents and carers might take on in sessions
- Clarification about the use of the art materials
- Reassurance about materials in terms of how much the child uses and how messy the child might be



Preparation with system

It was seen as important to ensure that there was sufficient scaffolding around the child to support them through the therapeutic process. Preparatory work with the wider system surrounding the child was seen as helpful particularly when working with vulnerable or looked after children. This might involve meeting with key people in the wider group of adults supporting the child such as social workers and teachers. Network meetings were seen as potentially helpful when setting up therapy and periodically

throughout the therapy to keep the key people on board and aware of any developments or difficulties which arise.

Helpers for preparing



Experiential art therapy tasks for parents and carers

One therapist explained that it was a great help if the parents or carers come to sessions ready and willing to think about their children. Another therapist described an art task that she sometimes used in preparatory work with parents and carers that might help them to achieve this frame of mind by thinking back to their own experiences of being a child:

'I ask them to do things like draw a picture of themselves any time in their life from 0-18... not asking them about the history but the history would come out because often they'd choose a time that was quite difficult' T6.

The therapist had used this task in a parents' group and found that as well as helping the parents think about their own internal parenting schemas, it had also helped the group members to bond as parents and had taken away some of their sense of guilt and shame at the difficulties they and their children were having.

Challenges for preparing



Level of preparation needed

Many of the therapists spoke about how on occasion they had underestimated the amount of preparation required with a parent or carer. Although the therapists felt it was within their remit to do some degree of preparatory work with the parents, the amount of time they felt able to spend on this work varied from service to service:

'Dan Hughes suggests that you have a good few sessions with the carers to work through their attachment issues and spend some time with them first and that's not always a luxury we're afforded' T1.

Direct therapeutic work with the adults was rarely seen as core business although one therapists described being able to arrange some art therapy sessions for a parent, to help them think about their parenting, which could run alongside work with the child:

'[I]t was kind of tolerated but I mean it is about how you phrase it as well because [...] there is a legitimate place for parent work so I think that the art therapy was offered on the basis that it was there to support mum to help her think about her children and her parenting' T4

However, in general the therapists described signposting parents and carers to more appropriate services if they felt the parent needed more support than they could offer them.

Outcomes for Preparing

Helping the adults to understand the process of therapy, and the roles which they might need to take on in sessions was seen as having a positive outcome in terms of reducing any anxiety they might have about this.

Also, one therapist spoke about when parents had been offered the opportunity to take part in an art therapy parents group that had seemed to help them understand the potential benefit of art therapy for their children, as evidenced by the attendance rates of the children for subsequent sessions.

Inadequate preparation of parents and carers was seen by many of the therapists as one of the most common stumbling blocks and pitfalls of dyadic art therapy.

6.3.6 Engaging

Micro-objective D: Engaging with the dyad

The therapists spoke about wanting to find a way of engaging their clients to bring them on board with the therapeutic tasks ahead and forging a therapeutic alliance with them. Some of the therapists spoke of managing to build trust and alliance with wary or ambivalent people, who had perhaps developed a mistrust of professionals. Their intention was to build a sense of safety that would enable the child to engage with therapy and make use of the sessions. At the same time they described needing to make the therapy sessions feel safe enough for the caregivers to engage with the process and

not feel too exposed or criticized. Balancing the needs of the adults and the children was seen as important and therapists described how, if this balance was lost, the therapeutic engagement could be jeopardised.

Influences for Engaging

Clinical experience

Therapists described how they had gained from experience an understanding of how best to create a sense of safety for the child, often by having their primary caregiver in the room with them. This is how one therapists described outlining to caregivers the role they can play in helping the child feel safe enough to engage in therapy:

'Your job is you're the key person for this child. You're their safe base and you're the person that they kind of look to. I'm a stranger essentially, I'm the new person, why should they trust me. So the idea is that they'll feel safer with you being in the room and if they're going to be exploring difficult things I think it's helpful if you're there because you can witness it' T1

The therapists also described how experience has shown them the importance of engaging simultaneously with both adult and child:

'I had another case as well where I had a mum and a daughter who came into this room and were absolutely screaming at each other and had dropped out of family therapy because... the girl had felt that the family therapist had taken the mum's side rather than her side' T4

Steps for Engaging



This section explores the steps which the therapists described taking towards the objective of Engaging with the dyad. These are: Balancing the needs of adult and child; and Safety building.



Balancing the needs of the dyad

The therapists described the importance of recognising that in dyadic art therapy there were two different points of view to be heard and responded to. The therapists described needing to hold both of these perspectives in mind. The therapists described paying

attention to the needs of the adult and the child, but at the same time recognised that the adult might have certain issues, which were beyond the therapist's remit. When this was the case, the therapist indicated to the adult that these issues should be addressed elsewhere, and if possible signposted them to the appropriate services.

Issues relating to the adult which therapists described needing to signpost or refer on to other services included:

- Untreated or undiagnosed mental health needs
- Safeguarding issues which the therapist will report as appropriate

However, there were also some adult needs which the therapists did describe themselves working with. These included:

- Needing to feel comfortable and not too exposed in sessions
- Needing a forum to explore and reflect on issues relating to parenting approaches
- Needing a forum to let off steam about the difficulties of parenting the child.

This latter issue was seen as unhelpful for the child to hear so parents and carers were often offered a separate session or phone-call.



Safety building

In the early stages of the work, the therapist described building a therapeutic alliance with the dyad. An important step in this process was creating a sense of safety. With adults, the therapist sought to reduce or contain feelings of exposure, anxiety, guilt or shame. Clarity about the adults' role in the sessions was seen as helpful to contain parents' anxiety. More information has already been given about this in the step *Preparing Parents and Carers*.

With the child, it was suggested that the easiest route to safety was having the child's safe-person or primary caregiver in the room with them so they could provide a safe haven at difficult times.

In addition to having the caregiver present there were other things the therapist described doing to build a sense of safety for the child. One of these was to link up with the wider system, alerting other key adults if the child was having a difficult time in

therapy. Some therapists described how they actively let people know if there were times when the child required additional support.

Pace and timing was also seen as contributing to trust and safety building. The therapists allowed enough time to build up a trusting relationship with the child. Some therapists said that early sessions might be more structured to begin with to minimise the anxiety non-directive therapy could sometimes provoke, and some the therapist described choosing non-threatening activities such as playing games or celebrating the child's strengths. Some psycho-education early on with the child was seen as helpful to explain and normalise how they might feel in sessions if difficult feelings came up or traumatic past events were discussed.

Helpers for Engaging



Art materials as a bridge

The art and the art materials were seen as a helpful tool for engaging the clients. They were seen as a way of minimising anxiety in the early days and helping the process of alliance building. One therapist described how the use of art materials helped an anxious child feel more able to stay in an early session which he had been ambivalent about: *'He was drawing actually, he was just using pencils and paper but in that instance he was comfortable doing that really. What he didn't want was a replica of the assessment where he'd just been sat there talking'* T3.

Challenges for Engaging

Engagement and alliance building is significant in many therapeutic modalities and has been shown to be a powerful indication of positive outcomes. However, it is not easy at the best of times and two key challenges emerged relating to dyadic work, these related to: initial wariness as the families get used to a new or different approach and the difficulties of engaging hard to reach families.



Parents and carers wary of a different approach

One challenge identified related to the degree of wariness parents and carers might feel about engaging in an approach where the emphasis was slightly different to what they

had expected or to what they had experienced before. The caregivers may have engaged on the basis of the difficulty being something exclusively located in or with the child, and this may be at odds with the therapist formulation if it is that at least some of the difficulty is relational:

'[Dad] was prepared to bring his child to therapy but he wasn't prepared to engage in thinking about his parenting with the family therapist [...] really I felt that for things to change that there needed to be some intervention with the parents so I asked him in to the sessions with the little boy so that we could set up something where he would be involved with me in thinking about this child but actually he was so full of what was going on for himself' T4

The shift of the focus from the individual child to the dyad or family was seen as potentially challenging and the therapists took steps to ensure that parents and carers were not left feeling blamed by the approach. Some therapists described parents who had engaged with the service on the basis that their child would receive therapy, and who might therefore be uncomfortable about being invited to sessions without the child. Parents may feel that having sessions without the child present is odd or even indicative of some degree of blame or shame being imputed to them. They might also feel that making art in the session alongside their children was potentially a little exposing and anxiety provoking. The therapists described how parents and carers needed to feel they could trust the therapist before opening up with them. The process of engagement and gaining trust was seen as an important step the therapists could take to overcome the challenge of initial wariness. As such some therapists described biding their time and engaging at first at the level the family felt comfortable with:

'[I]t depends what the parents are coming with. Sometimes parents come with the idea that they want their children seen for therapy so actually trying to get them come in, forget it, it's not going to happen [...] so provide what the parents want and then [...] after three sessions [... the] parents sort of get to know me and feel a little bit more at ease and then if I've noticed something you know that from the history [...] then I would say to the parent well I'm going to ask to meet with yourself because I just want to gather a history and get an understanding of your experiences with your child and what experiences you've had and just let me know how it is for you really, but also thinking about your

parenting, you know, your experience of being parented and yes on the whole most parents would sort of sign up to that' T6,



Work with hard to reach families

Dyadic work may be seen as appropriate for families struggling with relational or attachment difficulties and children who have had disrupted lives with and relationships. However, families with avoidant or ambivalent patterns of interaction, and high levels of disruption, may also be the most likely to struggle both with the process of the therapy and the level of commitment required. This conundrum was expressed by one of the therapist:

P: So what I'm saying is you know you might start off with a plan in mind and I think by the nature of the work it's quite challenging isn't it for a lot of families?

I: What would you say was the challenging element of it?

P: Well maybe it's the people I've been choosing [...] maybe it's the attachment issues.

I: So you're thinking it'd be suitable with families where there are already attachment issues.

P: Yes and in which case you know and then, you know, I'm probably not doing enough preparation.

I: Okay. So it's the attachment issues themselves that kind of trip you up? It seems appropriate because there are attachment issues then the work falls foul because there are attachment issues.

P: And because it's too...my hunch is it's just too challenging and too painful I don't know it's too hard for the parent. T3

Outcomes for Engaging

The interviewees gave some clinical vignettes demonstrating the sense of safety and trust that they had been able to establish with both caregivers and children. They described successfully establishing trusting relationships with people who had previously had negative experiences that had made them disinclined to engage with other therapies or therapists. Some examples related to parents who felt wary of professionals and perhaps had a sense of having been let down or betrayed in the past.

Other examples related to the process of engaging with traumatised children who were then able to trust the therapists enough to address important issues with them:

'[A] young girl who'd had a really difficult kind of background and had quite a disorganized attachment pattern and was quite controlling of the carer and it was really useful after we'd built up a relationship for so long for me then to introduce (unclear) why maybe she does those things because I don't do that until I've built up that kind of trust. I don't like, kind of, work in a way where I expect them to be delving into their backgrounds [...] but because I'd worked long term in therapy, because she knew that I knew all that kind of background stuff, it seemed easier to be able to approach them things with her, so that was really useful to be able to do that with her and her carer.' T2

6.3.7 Joining up

Micro-objective E: Joining up people, ideas and actions

As opposed to the more traditional or 'old school model' of art therapy, in which the child would be offered individual sessions with the therapist, which would be treated as confidential, the emphasis in the dyadic art therapy approaches described in the interviews appeared to be on joining-up or bringing together people and ideas. The therapists spoke about offering the dyads the opportunity to make art together and also to reflect and talk together. Joint art therapy sessions provided opportunities for perspective sharing and developing a sense of the other person's mind.

The invitation to think together was also sometimes extended to the wider network. People in the wider network were invited to network meetings and sometimes review meetings to think together with the therapist about the needs of the child and to plan what would be best.

Influences for joining up

As with the other objectives, the therapists had all been influenced by their own clinical experience and by workplace structures and ethos. Particularly as two of the workplaces were specialist services for children in care and they had an expectation that therapeutic work would involve joint sessions with caregivers and children.

Alongside these influence, there were two other main sources of influence: the influence of other therapists they had contact with; and the influence of materials or training relating to other therapeutic modalities.

Colleagues and supervision

The therapists were influenced by discussions, and in some instances, shared therapeutic work with colleagues and supervisors. One therapist said that she felt a previous supervisor had given her permission to take a more flexible approach and she had also been influenced to some extent by co-working cases with family therapists.

Training and training material

The two specialist services for looked after children had offered training in Theraplay, which the therapists described as having an influence on the way in which they worked. One therapist described how the Theraplay assessment model, which looks closely at relational patterns between parent and child, had influenced thinking about the way art therapy was delivered. Both of these therapists also talked about the influence of Dan Hughes, an attachment-based therapist who developed Dyadic Developmental Psychotherapy, now renamed Attachment-Focused Family Therapy.

Other therapists described other therapies and theorists who had also, to some degree, influenced their ideas about joining people up in therapy. These were: systemic family therapy; child psychotherapy; adult psychotherapy; Relate training; Lucille Proulx.

Steps for joining up

The steps identified from the interviews were: facilitating joint engagement; helping caregivers to see for themselves; facilitating reflective discussions.



Facilitating joint engagement

With parents and carers present in sessions, the therapists sometimes took the step of setting up or encouraging joint art-making activities for parent and child. Sometimes therapists set specific tasks for the dyad, perhaps asking them to draw an image relating to a particular question or task, at other times they were less directive and just suggested that the dyad make something together. These joint-engagement activities offered the

dyads some ring-fenced time together with opportunities to work co-operatively, be creative and have some fun or be playful.

One therapist described sometimes actively joining the dyad in their joint making activities so the dyad could experience the therapist as helpful and present rather than as an external onlooker, which might raise too much anxiety:

'I think that sometimes it's important for some families to experience you as being part of what's going on and not being this kind of external observer [...] particularly for people who are struggling to think about what they're doing, that at some levels of emotional disorganisation and distress I think that people need to experience you very physically as being present and as being part of what they're doing rather than as somebody who is external and who is thinking about you, that that can be experienced as quite persecutory' T4



Helping caregivers to see for themselves

Having the parents or carers present in sessions allowed them to witness significant therapeutic events at first hand, potentially leading to a more joined-up understanding of what was going on for the child.

The therapists said they sometimes chose to highlight certain events that happen in the session, drawing the parents and carers attention to important factors. These discussions sometimes took place at the time of the event, or sometimes happened later.



Facilitating reflective discussions

The therapist described how one of the steps they took was to offer people the opportunity to think with them in a reflective dialogue or conversation. This offer appeared sometimes to be extended just to caregivers and at other times to be extended to both caregiver and child to provide some shared thinking space. The offer was also sometimes extended to the wider network of people who support and scaffold the child.

Reflective conversations with the parent or carer

Thinking together with the caregiver appeared to involve asking them to reflect on both events in the sessions and events outside of the session. The therapists sometimes invited parents and carers to think with them about their own interpersonal experiences and to develop an understanding of their own relational patterns and how these impact on their relationship with their child. The therapists also invited parents and carers to think with them about their child's experiences, building a picture of the child's internal world.

Reflective conversations with other people in the wider system

The therapists also described thinking together with the wider network, which might involve network meetings with schools, health services and social services. The therapists aimed to scaffold the child providing sufficient support for them to engage in therapy and more generally in their lives outside of the therapy sessions. Therapists described sometimes using such meetings to share their own picture or understanding of the child's feelings and needs, with the people best placed to respond to these.

Reflective conversations with the dyad

The therapists also described facilitating reflective dialogue between the adult and child. The therapists invited the parent or carer and child to think about: past events; recent events; things that had happened in the sessions; or images that had been made in the sessions. The therapists encouraged recognition that there could be multiple perspectives, and each one can be valid:

'I might draw a W and I will say to the child what do you see and they will say W and I've got mum this side and I'll say what do you see and they'll say an M and I'll say ah, but you're both right aren't you and so I'll get the child to understand that [...] we can move around something to see it from a different angle, from a different perspective.' T6

These reflective conversations were sometimes in the sessions and sometimes they were conversations outside of sessions which related to the therapy in some way. The therapists talked about 'getting the ball rolling' with the latter conversations. In both scenarios the therapists helped the dyad to talk about issues, which it has not been easy to do on their own:

'I got an email from the carer this week actually saying after the session on the car journey home lots of discussion came out of what had started in the session

and I think that's something that we see quite often is that it starts something and moves things along a little bit' T1

Helpers for joining up



Art materials as a bridge

Art materials have already been discussed as helpers in terms of creating a bridge or way of engaging in therapy and establishing a connection with the therapist. However the therapists also described how art could act as a bridge to communicate between caregiver and child, joining up thinking and ideas. The therapists talked about how using the art materials could help the child to express or communicate their feelings in a direct way to the adults in the room, perhaps better than words alone:

'[The boy] came to art therapy with his foster carers... and he struggled quite a lot at the beginning to use art materials. He was quite rigid with what he was doing [...and struggled with...] expressing an opinion or deciding what to do. It gradually veered more towards messy paint mixing and he would put the carers names on to the bit of paper, and he'd repeat that quite a lot: mixing paint and just putting the carers names and his name [...]and then he gradually started putting his birth family members names on the paper as well, to the point where he managed, it seemed quite difficult, but he managed to put all of his birth family members and his foster carers names and his name on the same bit of paper which felt like quite a big kind of achievement just to have them all in the same place [...]So that seemed to work with him in a way in which a talking therapy perhaps wouldn't have but there was something about having the foster carers there to witness it' T1.

They also described how dyadic art therapy sessions offer the opportunity for joint art making which could create a bridge to connect two separate perspectives or minds:

'I had another case as well where I had a mum and a daughter who came into this room and were absolutely screaming at each other and had dropped out of family therapy because they felt that, the girl had felt that, the family therapist had taken the mum's side rather than her side and I was able to interrupt that, by asking them ... to make something using anything in the room to think about

a time that they could remember where they had enjoyed spending time together, which had been a good time for them, and actually that, from there, it did lead to them being able to think about each other... over the period of time I saw them, in a very different way... it definitely broke a sort of period of conflict between them'. T4

Challenges for joining up



Complex therapeutic dynamics

The dynamics of dyadic sessions were reported as different from those in individual sessions, in the first instance simply because there were at least two people to engage and two perspectives to be held in mind. However therapists reported additional challenges relating to the therapeutic dynamics. One was that dyadic sessions could feel exposing, not only for the parents or carers, but also for the therapist. Having another adult observing them had the potential to make both parties initially feel quite uncomfortable. Feelings of being judged could become quite powerful. Other dynamics occurred in sessions too and the therapist had to be mindful of these and make sure they didn't get too drawn into them or lose their therapeutic poise and equilibrium:

'I think at the beginning it's all very exposing [...] sometimes they might be somebody watching you work and it can put you off I suppose is the simple part of it and you've got more potential to be drawn in terms of being pulled on to somebody's side if there's that kind of dynamic.' T1

It was also a challenge if the dynamic in sessions between the caregiver and child became undermining, punitive or hostile. In some instance this did not emerge until the dyadic work was underway and the resulted in the therapists having to stop the therapy and pursue alternative treatment plans, possibly reuniting later in some form:

'I stopped it because I felt that the foster mum was quite undermining of him and also had quite a lot of needs herself and [...] I organised for the child psychotherapist to see the foster mum and actually [...] you have reviews I mean and they're not dyadic art therapy but it's a way of bringing them together, that seemed to be the best way and because this boy has had so little sense of his own mind and you know making decisions about anything or being able to articulate his emotions at all that foster mum was totally taking over because she felt very

inpatient and very irritated by his struggles to make any decisions so she just took over the sessions so that's why I didn't feel that it was helpful for him and in fact [...] he used the individual sessions I think really well and she's been supportive and he's a lot more confident so I think that was the right thing for them' T4

This challenge has been discussed further in the challenge *Demands on caregivers*.

Residential placements mean that the therapists were not always dealing with family dynamics; sometimes there were institutional dynamics too. One therapist described how, if the child is living in a residential care setting, serious thought would need to be given to planning dyadic work. However, this therapist did not necessarily see a residential placement as a contra-indication, in fact he thought that it could provide a useful insight into the child's lived experience:

'I have found even that can be quite helpful in a way because you see a bit more about the child's kind of relationship with their key-worker. I feel like in those sessions I lead it a bit more rather than co-work it. But [...] you see how they are with different staff members and in a way that's their reality, they've got lots of parents in that sense, and whilst we're still trying to focus on their relationship with their staff in that situation they do have lots of attachments and lots of carers and that's their reality so [...] that can be more chaotic' T1

Finally, there may be complex dynamics within the wider system around the child which might not always operate co-operatively in the child's best interest:

'There's always tensions between the local authority and our company for what information they will give [...] sometimes it can be quite difficult working with the uncertainty and the unknown' T1.

Outcomes for joining up

Bringing people together resulted in increased understanding and movements and changes within key relationships. Some of these were described on a micro level, perhaps as a small shift in understanding or attitude within the sessions, and sometimes the interviewees gave illustrations of more perhaps longer-term more global outcomes.

One therapist reported that small shifts in the relationship might be visible over the span of one session, with the dyad being more attuned, connected, with more eye contact at the end of the session:

'[A] lot of the time we find that the child will want to move closer to the carer which is nice you know [...] usually, because we've structured it to come down, if you like, have a good ending [...] they usually want to be closer or they'll look more.' T2

Another therapist described how a series of dyadic sessions had offered the opportunity, the containment and the thinking to a dyad struggling in relation to each other. The dyad accepted the invitation to think together with the therapist and were able to use the sessions to connect and relate in a more positive way:

'[T]he parents were separated and it had been a very acrimonious separation and [...] the little girl was very identified with her mum [...] and she was very contemptuous [of her dad]. She was a very articulate little girl and her dad was a lot less academic and able than she was and verbally [...] could be, you know, very attacking towards him but [...] they were able to work on something together and to have ideas together and I could see that actually she did want to engage with him so we were able to reflect on the fact that she was wanting to make more of a connection with him. [...] I think that it helped them actually have a closeness which they weren't having [...] and would never have initiated themselves.' T4

6.3.8 Developing skills and understanding

Micro-objective F: Developing Skills and understanding

The interviews with the therapists illustrated how some of the time the therapists were intent on developing the skill sets of either the caregivers or the children. With caregivers the primary focus was on caregiver sensitivity, including reflective function, that is the ability to think about the internal world of both themselves and their children. With the children the skills the therapists aimed to develop were, reflective functioning, regulation and emotional literacy.

Influences for developing skills and understanding

Clinical experience

Again the main influence seemed to be clinical experience. One therapist spoke about how the caregivers' skills could be overlooked in favour of work with the child:

'[M]ost of the time parents are going to need some work as well [...] but obviously with resources as they are that became more and more difficult [...] and we do have parent groups and things like that but what I didn't feel that they addressed was the emotional parenting' T6

Another therapist spoke about how clinical experience had influenced her to focus on helping the children to regulate their emotions in order to enable more in-depth, and potentially upsetting, work:

P: [...] I think unless you pay attention to that part of her brain [...] you're not going to get to a point where she's able to articulate what she's thinking and feeling you've got pay attention to that first [...]

I: Paying attention to regulating her?

P: To regulating yes to teaching her ways of regulating of actually of surviving those peaks of stress hormones and learning ways of regulating [...] and I think that's really important and with quite a few of my kids actually. T5

Steps for developing skills and understanding



This section explores the steps which the therapists described taking towards the objective of developing skills. The steps are explaining and educating; modelling and practicing skills with the caregiver; modelling and practicing skills with the child.



Explaining and Educating

The therapists sometimes described share information or knowledge with child, the caregiver or the system in a didactic way. The data contains examples of therapists explaining about: the art materials; the process of dyadic art therapy; the impact of trauma and past events on the child.

The art materials

The therapists explained that dyadic art therapy might feel strange to people starting out and there was sometimes some anxiety about the art materials. In their experience, the adults might be unfamiliar with the materials or worried about whether the child was using them appropriately. Therapists therefore explained to parents and carers that the responsibility for ensuring materials were used appropriately would lie the therapist:

'[I]t's okay to make a mess or you know we don't have to tidy up as we go along or you know its okay to use that amount of glitter' T3

The process of dyadic art therapy

There were other processes and 'ground rules' T1 which the therapists explained to the children, caregivers and sometimes people in the wider system. With caregivers, as has already been discussed in *Preparation with Parents and Carers*, there were comprehensive discussions about what their role would be in the sessions and about basic boundary setting. With the wider system, as has already been discussed in *Preparation with the System*, some therapist explained the possible impacts of therapy to schools and social workers so they had a greater understanding of what the child was going through. Issues of confidentiality and what would be shared with whom were explained carefully to all concerned.

Unpacking past events and the impact on the child

Some of the therapists highlighted the importance of clear explanations for the child about significant past events which had had an impact on the child. For a child in care this might involve helping the child to understand why they were been removed from their birth family and filling in any gaps in knowledge or understanding relating to their life narrative. One therapist, working with children in care, suggested that helping the child to understand why they had been removed from their birth family, as some children *'don't understand why they're in care, they don't understand what's happened'* T2.

Some therapists also described offering aspects of psycho-education, talking to the child, the parent or carer and sometimes other key adults in the system about the psychological, behavioural and physiological impacts of trauma. One therapist described how the aim was to develop an understanding of underlying drivers and to normalise the child's experiences and behaviour: *'that's absolutely normal in that*

situation that's what everybody's bodies do and what's happening in your body is quite normal so let's have a think now about how you get control over that' T5.



Modelling and practicing skills with the caregiver

The therapists described a process of helping the caregivers develop skills in relation to parenting their children. The skills they focussed on seemed to be about parental sensitivity, including attunement, reflecting on the child's inner world, and appropriate communication and discussion with the children.

Social learning theory suggests that new behaviours can be acquired through verbal instruction and explanations or through live models. The therapists described developing caregiver's skills through a combination of explaining and more hands on ways of modelling and practicing skills during live therapeutic interactions: *'kind of modelling or teaching to the carer, helping them to attune but also saying this is what we do and what bits of that might you be able to carry on with [...] something about skilling the carer up' T1*

In terms of modelling the therapist might respond directly to the child themselves in an attuned or sensitive manner: *'oh gosh that's amazing, I love what you made... or you know, conversely, that sounds like it's been really difficult. Just a bit... especially for those carers who are not as psychologically minded as you might like' T5*

Alternatively the therapist might encourage the caregiver to respond directly in an attuned or sensitive way: *'I would try and help them just think about the child again, just think about what would come up for the child and what would ... you know their role, their support through that process' T2*



Modelling and practicing skills with the child

Just as the therapists sometimes focussed on helping the caregiver to be sensitive to what might be going on about the child, they also spent time developing the child's ability to reflect on their own, and other people's, internal processes and perspectives.

The therapists spent time developing the idea that there were multiple perspectives to be considered and appreciated. :

'we've kind of moved towards talking about different perspectives and maybe that is how he feels like it happened [...] but acknowledge that there's different perspectives on it' T1

Other skills which they helped the children develop were being able to identify, name and own emotions:

P: I'm working with a child that's very withdrawn at the minute and she's getting more mouthy and I think that's brilliant and letting people know exactly how she feels.

I: She's articulating her feelings?

P: Yes [...] we know that children who talk about their difficulties are the children who do better. T6

The therapists also described developing the children's ability to regulate those emotions, and getting them to practice those skills both in the sessions and at home.

One therapist gave an example of how she might teach those skills:

[Y]ou've got your bowl of soup [...] So you're going to breathe in through your nose and smell the delicious smell of the soup and then blow out gently through your mouth to cool the soup so it's just a breathing thing [...] I think just more and more I'm getting kids to try to start practising that outside of the session everyday just for five minutes and then it's easier then to cue them in when they start to fizz a little bit' T5

Helpers for developing skills and understanding



Building a sense of safety and trust

Therapists described how having the caregiver in the sessions could provide a safe base for the child, which was often extremely helpful:

'I often feel like if I've got the foster carer or adopter or whoever in the room with me that's my shortcut to safety almost really. It doesn't mean that I don't have to pay attention to creating a sense of safety in the room with that child but

you get there much quicker I think (I: right, yes) with the a containing safe adult in the room with you' T5

In terms of helping the caregiver develop their own skills the therapists highlighted how it was helpful to have already gained their trust and established a therapeutic alliance, and it was also important to be sensitive about the timing and manner in which the caregivers' skills were focussed upon:

'I wouldn't do that straight away because I think, I think you've got to sort of build-up that rapport and trust and actually let them know that that's what you're going to be doing as well and then I would say, 'This session what we might be doing is thinking about if I see something and I think, oh that's not helpful or might something else might be more helpful, then I might point this out to you'. T6

Challenges for developing skills and understanding

Caregiver expectations of what therapy would involve were seen as a potential challenge, as the focus on their skills could be unexpected and potentially quite challenging. This has been unpacked earlier in the challenge *Parents and carers wary of a different approach*.

Other challenges therapists described relating to developing skills related to the demands that learning and using new skills put on the caregiver. This has been discussed in the challenge *Demands of the work on the caregiver*.

Outcomes for developing skills and understanding

In terms of outcomes, some child-focussed outcomes resulted from clear explanations. One therapist described how clear explanations about significant life events could reduce the child's confusion and sense of blame and help them to relax a little:

'[A] lot of these children have all these meetings going on and nobody actually explains to them what's going on and then there's all these anxieties and they play up at school and you know just tell them the truth about what's going on and why you're doing it for them and usually they can relax a little bit more' T2

In addition, helping the child regulate and articulate emotions led to an increased ability

to articulate thoughts and feelings and tolerate potentially stressful situations. One therapist described her tentative progress with an extremely anxious traumatised child:

'[W]e've spent, yes, probably twelve, fourteen sessions trying to help her, help normalise that response and think and give her a framework for understanding it that actually that's absolutely normal in that situation that's what everybody's bodies do and what's happening in your body is quite normal so let's have a think now about how you get control over that so we've done lots of breathing stuff but again lots of stuff about being more assertive' T5

6.3.9 Dealing with events

Micro-objective G: Dealing with Events

The discussion so far has highlighted how the children and young people who come into dyadic art therapy can be helped to engage with the therapists and to develop important skills such as regulation. However, the children described in the interviews were also being helped with another task, which was to think about and perhaps come to terms with current or past events. This will be thought of in terms of dealing with or processing life events. The other events which the data showed the therapists and dyads dealing with were events that occurred during sessions and contemporaneous events that occurred outside of the therapy sessions. As such the final key objective that emerged from the data was dealing with events.

Influences for dealing with events

Clinical Experience

One therapist described being influenced by previous experience of couple counselling. This influenced how the therapist thought about approaching the work:

'[W]hen you're working with couples where one might have [...] had an affair so then the other can't trust [them], then they'll come back into the relationship and decide to give it another go, now how do they move forward from this injury [...] to their relationship [...] and actually that's the sort of thing when you're working with the children: there's been some kind of injury somewhere you know that's what I'm looking for, where's the trauma, where's the bereavement, what's occurred, what injury's happened and how do we let this injury be without it destroying all what's to come' T6

Colleagues and Supervision

In terms of how the therapists themselves responded to session events, clinical supervision and peer supervision with colleagues was seen as a place to reflect on and possibly modify this:

'I suppose in my own reflections, supervision and stuff like that I've been able to say, oh well I could have maybe said something different there or I could have dealt with that in a different way so supervision obviously always helps to think about those things' T2

Steps for dealing with events

This section explores the steps the therapists described taking in response to significant events, be they: events that had happened within the session; events that were happening in the child's life at the same time as therapy, but outside of sessions; or past events that continue to have a troublesome impact on the child and caregiver. As such the steps the therapists described taking related to: Responding to events in the sessions; Processing past events; Thinking with the dyad about current events. The interviews indicated that the first part of any of these steps might be to open up a discussion of events and check the child's understanding of events. These areas have been discussed in detail in the steps *'Facilitating reflective discussions'* and *'Explaining and Educating'* and so will not be re-iterated here.



Responding to events in the sessions

The therapists described responding to within-session events. Sometimes the therapists seemed to be describing quite an active response in which they had to manage or contain events. At other times the therapists were taking a more reflective role, watching events and then helping the dyad to think about what had happened and to arrive at a shared understanding of these events.

Directive responses

Sometimes the therapists described quite active responses to events that occurred in their sessions. There appeared to be a spectrum of active responses which spanned from asking direct questions or setting tasks to focus the content of the sessions through to actively stepping in to collaboratively make images or, perhaps the most 'active'

response, which was to step in to halt an interaction or even terminate a session or a piece of work which was proving iatrogenic.

In terms of giving direction, some therapists described asking questions and setting tasks to get the ball rolling, reduce anxiety, or focus the dyads attention on a specific area:

'I think some of our kids that we see struggle when you give them a blank piece of paper and so I might set the materials or I might sort of say at the beginning: "Can you draw me your house? And who lives there? And, let's find out a bit more about you" [...] I might suggest we use clay or a particular medium if they're struggling with something' T1

The most active or directive response that emerged was to step in to halt activities or sessions. A few of the therapists described having to do this when they saw that the session's events were having a negative impact:

P: I think sometimes you've just got to stop it [...] He was getting aggressive with his child, they were playing a ball game and he was grabbing the ball off him [...]

I: Right so what did you say?

P: [...] I said I think you're getting wound up and he's getting upset and I think we ought to stop T4

Reflective responses

At other times the therapists' responses to events that occurred in the sessions were more reflective than directive. The therapists described reflecting with the dyad on the process of the sessions and on the making of the art and the final images:

'[T]his is a time [...] for us to try and understand and [...] for us to think about maybe what's happening in the room with the child and [...] y to think about what they're expressing emotionally through the art materials.' T4



Processing past events

The therapists described helping children to think about and make senses of past events in their life, particularly those which had been very difficult or traumatic for the child.

If, until coming into therapy, the child's response to the trauma was to try to bury their feelings, and not to think about what had happened, the therapists might try to open up discussions and help the child to respond in a more adaptive way by processing the events. The importance of this step was summarised by one therapist:

'I guess for me, hopefully, that middle bit [between the beginning and ending phases] would be the bit where they would be able to use the art making as a way of processing trauma, that would be the bit, that for me, is one of the key aims' T5



Thinking with the dyad about current life events

The interviewees provided a number of short clinical vignettes illustrating how sometimes the dyads used the sessions to think about and perhaps begin to make sense of difficult events that were going on in their lives at the same time as the therapeutic intervention. Examples included day-to-day conflicts or difficulties between the caregiver and child, or the challenge of settling in to a foster placement, or bumping into a frightening and unsafe family member in the street:

P: 'by very chance that morning they'd bumped into this person in town and this little fellow you know, [Mum] said first thing she knew was his hands were shaking and it was a really traumatic incident so [...] it was a live incident she came straight in here and spat it out really.

I: And the child was with her then?

P: Yes. T3

Helpers for responding to events



Art as a record of events

In the interviews the therapists described how images could act as a record of an event, be that a life event or an event within the therapeutic encounter. An image can be made as a kind of child friendly contract or agreement:

'[W]e'll often do a little working agreement picture. make a picture at the beginning about what's going to be okay and what's not going to be okay and ... when we're going to see each other and this is where we'll be and this is how long we've got... we'll all sign at the bottom and put the date on' T5.

The therapists might use imagery in narrative life story work or as a way of recording the therapeutic encounter, perhaps by making a book with photographs to show the art-making journey. The therapist who described doing this said it was important for the child to have something tangible at the end of therapy:

'I want them to have a record of what they've done. Of what they've worked through and of, of a success I guess, because you hope don't you that by the end of it something will have shifted on some level for them in a positive way' T5.



Art as a way of communicating, regulating, containing and processing feelings

Therapists described how art can help the caregiver to understand the emotional life of the child, which can to some degree be facilitated by reflective discussions about the images produced in dyadic art therapy.

The therapists also spoke about how using the materials could help children regulate their emotions:

'You see her just kind of go like that "aaah" [...] and then she's chattering away as she's making, you know whatever she feels like on that day, lots of pictures of country houses and beautiful girls and flowers but she goes back out then looking calmer, feeling calmer I think' T5.

There was also an idea that the art materials can be helpful as containers for difficult feelings:

'I think the art making process helps contain some of the very difficult feelings that are emerging and you know and if something's kind of.... if something can't be said if I can see that it's quite symbolic that you know is presenting itself you know it might be a painful thing that can't be spoken about but actually it's being held in that way you know it feels like and at some point you can bring it back and maybe they are ready when we're further down the line.' T6

Finally, as well as understanding and regulating emotions, art was also seen as able to help the child process their emotions. One therapist outlined how following the early

stages of safety and alliance building, the art materials could be used to help the child process trauma:

*'I guess for me... that middle bit would be the bit where they would be able to use the art making as a way of processing trauma'*T5.

Challenges for dealing with events

One of the challenges that emerged was the demand put on the caregiver and the child to be thoughtful and reflective about difficult events and issues. Low reflective functioning and the impact of trauma could make this process very demanding for them. These issues have been explored earlier in the challenges *Demands of work on caregiver* and *Demands of work on child*.

Outcomes for dealing with events

Outcomes relating to the way in which the therapists responded to session events may be seen in terms of their ability to build trust and foster engagement. Some of these outcomes have been discussed in the outcomes for *Engagement*.

The therapists' case examples also illustrated how helping the adult and child process events together could lead to new ways of viewing or understanding events. Sometimes this might mean coming up with new ways of responding or even reframing the difficulty. This is illustrated in the final vignette:

P: [T]his child's [who is] normally sat there with his shoulders hunched and [...] his hood up [...] started to sort of come alive [...] his head had popped out of his body almost because he kind of stretched up and his eyes were wide and he was looking at his mum and looking at his dad and he was smiling and [when] we came out of the session you know he put his arms round his mum and really hugged her and that was the first time I'd actually saw that interaction with his mother [...] I think the child felt validated [...] This is not just about me and my anxiety this is about you and what you're saying and what you're doing and [...] that's why I could see his little eyes getting wider. T6

Finally, by focusing on the emotional world of the child and helping the child to process trauma, there may be other unexpected 'knock-on effects'. One therapist described growth in other areas, both educational and physical:

'I think for those children where you know they don't have a learning disability but something is getting in the way of their learning and I think [...] I'm seeing that more and more that actually you pay attention to the emotional wellbeing and the trauma and they do, they start to grow, they start to learn, it's that sense isn't it of all these things being interrelated really [...] by paying attention to their brain and their mind you're supporting other areas of growth and development aren't you? T5

6.3.10 Final theme: The manual

As discussed above, this theme was not included within the actantial analysis as it was not part of the data relating to the operationalisation of dyadic art therapy. Instead this theme looks at responses to questions that were asked relating to the development of a dyadic art therapy manual.

Not all the interviewees were asked directly about their views on the development of a manual because the topic was not included in the first iteration of the interview topic guide. The suggestion of adding in a probe question about the pros and cons of a manual came during a supervision session in which we were looking at the transcripts of the first two interviews. The data in this theme therefore comes only from interviews with participants interviewed after that point, i.e. T3, T4, T5, and T6.

A manual could enhance clinical practice

Some of the therapists thought that manualising dyadic art therapy could be potentially helpful in thinking about the best way of working with each dyad. They felt that a manual could: give therapists insight into what parents and children are experiencing as helpful; help articulate the part that art can play in dyadic work; provide a skeleton structure; describe some of the challenges; and suggest new ways of working:

'[I]t's nice to have a bit of structure and a framework to be thinking about and to be guiding your practice so I think it would be helpful to have something' T5

A manual could help with confidence and professional credibility

Some therapists also felt that a manual might give art therapists the confidence to move away from the traditional model and adopt a dyadic approach. As such they felt that there could be something quite reassuring about having a manual to provide credibility

and scaffolding for the therapist:

'I think a manual would be a good thing [...] if something's in a manual it's a bit more, what's the word? A bit more official isn't it? So you know because it's quite a flexible way of working isn't it and I think for a therapist, for an art therapist, for an individual therapist, that's I think that's quite a big thing actually to deviate from you know the models, the model that most of us have been taught.' T3

As well as providing individual therapists with confidence and credibility, one interviewee outlined that manualised interventions could be useful to the profession as a whole in the current commissioning climate:

'[M]anualised approaches and shorter therapy I guess is on the agenda for the NHS you know shorter treatment times and I think anything that has some manualised approach to it you know is helpful because it helps us also to think about outcomes and in this day and age in terms of NICE guidelines and outcomes and [...] payment by results and all of those things that's attached to the NHS but they're attached to [...] charities and all sorts of people now, or anybody that's bidding for a pot of money' T6

A manual needs to be flexible not prescriptive

There were some worries that a manual might be too rigid and at odds with a flexible way of working. They said that they couldn't imagine there being 'a blueprint' for the approach as every relationship is different and what will arise in each session is unpredictable. They emphasized the importance of being able to think on one's feet and respond in the moment, all of which could be at odds with their conceptions of a manualised approach:

'I think the manual bit leads you to think it's a very prescriptive process but if you could construct something that had flexibility within it and stressed the need for flexibility within it and the need to be responsive to that individual situation I think that would be helpful' T5

Advice that might be given in a manual

The interviewees were asked about how they would advise a therapist who was starting out with dyadic art therapy, and from this emerged a list of both desirable and

proscribed factors. The interviewees recommended that therapists beginning dyadic work should: spend time completing a thorough assessment and appropriate preparation; gain an understanding of the parents' or carers' strengths and limitations; continue to give carers support as needed throughout the work; have confidence in their own skills and abilities; understand the unique contribution of the art materials; have an awareness of the counter-transference, of what's activated within themselves about the relationship.

The proscribed elements were: inappropriate settings in which the sessions could be interrupted; rushing into dyadic sessions without adequate preparation; continuing with dyadic work with parents who are not able to think about the child or are too preoccupied with their own difficulties; taking sides or becoming overly identified with one half of the dyad; and letting sessions start with a rundown of negative events.

6.4 Discussion

6.4.1 Summary of findings

The actants identified from the data are presented in Table 6.2

Table 6.2: Actants identified in therapists' interviews

Actant	Finding from therapists' interviews
Micro-objectives	Assessing what is needed and what is feasible Taking a flexible needs-based approach Preparing Engaging with the dyad Joining up people, ideas and actions Developing skills Dealing with events.
Steps	Observing and formulating Determining dyad specific goals Reviewing work and gauging goals Structuring the intervention and sessions to meet the dyads needs Adopting the most appropriate approach Preparing themselves Preparing parents or carers Preparing the system Balancing the needs of the dyad Safety building Facilitating joint engagement Helping carers to see for themselves Facilitating reflective discussions

	<p>Explaining and Educating Modelling and practising skills with the caregiver Modelling and practising skills with the child Responding to events in the sessions Processing past events Thinking with the dyad about current life events</p>
Helpers	<p>Seeing the dyad making art together can help the therapist assess and formulate ideas Experiential art therapy tasks for parents and carers can give parents and carers a taste of art therapy and a space to think about their own life experiences Building a sense of safety and trust between the therapist, caregiver and child can help facilitate the work Art materials can act as a bridge, helping with engagement and connecting people and ideas. Art and art making can help with regulating, containing and processing feelings Images can be helpful as a way of recording events Good supervision and a supportive workplace and colleagues are a great help</p>
Challenges	<p>Workplace issues may have an impact on what the therapist is able to offer Families may be wary of a new way of working, particularly the shift in focus from the individual child to the dyad Both the caregivers and the children may find the process challenging A good deal of preparation may be needed There may be complex therapeutic dynamics</p>
Influences	<p>Traditional models Clinical experience Training and training material Colleagues and supervision Workplace</p>
Outcomes	<p>Establishing therapeutic alliances and building trusting relationships with service users Building up a picture of the child's internal and external world which can be shared with caregivers during the therapy. Building a picture of the caregivers and their strengths. Caregivers gaining new insights and understanding. Children's emotional (and maybe even physical) growth Reduction in child's confusion and sense of blame Child becomes more relaxed Child's emotional regulation and articulation increased Child's ability to tolerate potentially stressful situations increased Caregiver and child gain greater understanding of each other Changes occur within the primary attachment relationship(s)</p>

The therapists interviewed were offering dyadic art therapy for two key reasons: for some there was an expectation within their work setting that they would offer dyadic sessions; for others the decision to work dyadically was a pragmatic practice-based

initiative based on experience and thinking about what might be most helpful. All the therapists had developed their practice by seeking skills and knowledge from colleagues, supervisors, experience or relevant literature.

According to the therapists a dyadic approach to art therapy helped them to achieve therapeutic goals such as joining up thinking, developing children and caregivers' skills and working with them to process events and feelings. In order to achieve these goals the therapists had a number of preliminary objectives or goals which they sought to achieve first, namely: assessing, formulating and preparing. They also discussed aspects of the work which they found challenging which included: workplace constraints; the caregivers' and children's feelings about the process and their ability and willingness to engage; the level of preparation needed; and the complex therapeutic dynamics which may be present. However, therapists were supported in their work by supervision and colleagues and said that art making could be a key helper in the therapeutic process including: the role of the image as a bridge connecting people either to communicate ideas or internal states or in joint making activities; the role of images to record events; the role of image making in processing difficult feelings.

6.4.2 Putting the findings in the context of other research

Concurrently with my research, a group of arts therapists at Central and North West London (CNWL) NHS Foundation Trust have been working together using a repertory grid method to look at what therapists do in sessions. They have interviewed arts therapists and then analysed the data to identify personal constructs. A key assumption of the repertory grid process is that people have multiple internal constructs based on (cognitive) opposites that determine their actions. The constructs and their opposites are represented on the grid and actions are rated on an ordinal scale from one extreme to the other.

I have had some conversations with the group who were originally calling the things the therapists do 'interventions'. We discussed how they might be called mini-interventions, to distinguish them from the overall intervention, and I told them how I was thinking in terms of the 'steps' a therapist takes towards their goal or objective. The group then re-named their interventions 'dynamic interventions'. The 'dynamic interventions' they identified relate specifically to work with adults who have a

diagnosis of borderline personality disorder. As yet they have not categorised the interventions although, as the results of their analysis are intended for inclusion in the manuals which they are starting to develop, they see this as a next step.

The group have shared their results with me and although the analysis of their interviews and mine have been conducted very differently, the constructs and their opposites are interesting as they shed some light on the steps the therapists might be taking in their sessions. This is shown in Table 6.3.

Table 6.3: Results of CNWL Repertory Grid

Construct	Opposing construct
Be attuned	Take a contrasting position
Adapt boundaries to the patient's presentation	Establish and maintain boundaries
Regulate affect	Take a neutral position
Give a contrasting response	Respond using mirroring
Collaborating stance	Directive stance
Have a therapeutic focus	Be openly curious
Focus on the therapeutic / group relationships	Focus on external, past or future relationships
Be challenging	Be supportive
Use verbalisation to make contact	Use arts media to make contact
Focus on past and present relationships	Explore relational patterns
Use a structured exercise	Use arts based improvisation / non-directive approaches
Discourage reflecting on self-other states of mind	Encourage reflecting on self-other states of mind
Use arts based interventions	Use verbal interventions
Make explicit what's happening in the arts form	Leave meaning in the implicit
Encourage embodiment of experience	Thoughtful verbal reflection

Although the client group is different, similarities can be seen in terms of focus on reflective functioning; the range and flexibility of possible responses and stances; the

thought given to which approach will be most suitable for which client; the mix of arts based and verbal interactions; the focus on relationships and relational patterns. However, perhaps the most important resonance is the aim of trying to clarify what it is therapists do in sessions and how they respond to the individual's therapeutic needs.

There is a discussion of how these findings relate to the existing literature on dyadic art therapy, in particular the work of Proulx (2003), in Chapter 9.

6.4.3 Strengths and limitations

Assessing quality

Assessing the quality of qualitative research is not a simple or straight forward process, it is however an important one. Pope and Mays (2006, p.83) argue that 'qualitative research can be assessed with reference to the same broad criteria of quality as quantitative research, although the meaning attributed to these criteria may not be the same and they may be assessed differently'. They discuss some ways of improving validity which include: triangulation; exposition of methods, data collection and analysis; and reflexivity. Issues about the quality of the stakeholder study will be included in the discussion at the end of the next chapter following the results of the analysis of the other two components of this stakeholder study. The remainder of this section will cover issues specific to the therapist interviews: saturation; the emic perspective; and the use of the actantial framework.

Saturation

'There always is that potential for the "new" to emerge. Saturation is more a matter of reaching the point in the research where collecting additional data seems counterproductive: the "new" that is uncovered does not add that much more to the explanation at this time. Or, as is sometimes the situation, the researcher runs out of time, money, or both' (Strauss & Corbin, 1996)

The sample size of six therapists was chosen for pragmatic reasons, and it was not envisaged that data saturation would be achieved through interviewing this small number of therapists. The rationale for the small sample size was to achieve a balance between the number of participants and the depth of the analysis within the limitations of available time, resource, and available participants. Depth within the interviews was

particularly important to counterbalance the other elements of the project i.e. the questionnaire and the Delphi which had sought to address issues of relevance, consensus and context rather than depth and detail. As such, although the interviews provide a good starting point for the content of the draft manual, it is hoped that beyond this doctoral thesis, the manual will evolve further. It has an online format (see Chapter 9) and dyadic art therapists will be invited to continually update and enrich the content.

The emic perspective

I am a practising art therapist engaged with dyadic work. In the therapist interviews I was speaking to colleagues who either knew me or knew of me, professionally. As such, this part of the study has been conducted and written about from an ‘insider’ or emic perspective. Emic is a term coined by Pike (1967), who described the emic viewpoint as resulting from studying behaviour from the inside of a given system, as opposed to the etic view point which studies behaviour from outside of that system.

Blythe et al (2013) discuss the issue of conducting qualitative research from an ‘insider’ position and identify a number of challenges which can arise: assumed understanding, ensuring analytic objectivity, and dealing with emotions and participants' expectations. However, they conclude that the use of an insider researcher can aid recruitment, rapport, collaboration and the generation of rich stories. McEvoy (2001) also describes some of the issues which can arise when practitioner-researchers interview colleagues for research purposes. He describes how participants might typically finish off statements with ‘you know’ or ‘haven’t we’ and leave him to fill in the detail himself. In one of the case-examples he gives, he follows up with a probe question to try to get the participant to unpack a ‘haven’t we?’ but reflects that this may have been experienced by the participant as threatening or sarcastic. In this study my own emic position impacted on the recruitment, the data collection and the analysis. These impacts are discussed below.

Recruitment

In terms of recruiting the therapists for the interviews, I may have been at an advantage as an insider. I was already a member of the professional association and the special interest groups through which recruitment took place. Not only did I ‘know the ropes’ and have access to the relevant forums, I was also known by other art therapists and so perhaps viewed with less suspicion or caution than an outsider might have been.

Data collection

When I was conducting the interviews my insider position became more of a double edged sword. The issue which Blythe et al (2013) call ‘assumed understanding’ may have led to certain themes or topics remaining tacit and never being made explicit which is potentially problematic in terms of using the data as the back bone for drafting the manual. For example, during the therapists’ interviews there was an emphasis on understanding the experience of delivering dyadic art therapy from the therapists’ perspective, and this included some of the session-by-session objectives and some of the moment-by-moment ones too. However, there was very little explicit discussion of the primary objective of dyadic art therapy. This may indicate an implicit assumption that, as a fellow art therapist, I would share with the interviewees a broad understanding of the reasons why children are offered therapy and as such is potentially one of the drawbacks of having a fellow art therapist conduct the interviews. Also, there was a sense that because both myself and the interviewee were trained art therapists we would share a language, a knowledge-base and possibly certain assumptions or values. To some degree this might have led both myself and the interviewees to use some elements of jargon or verbal shortcuts and I may not have always explored the meaning of some issues that another researcher would, assuming I understood what was meant.

Another way in which my emic position may have impacted is in the dynamics between interviewer and interviewee. I had to negotiate my relationship with participants who I shared a profession with. Perhaps because art therapy is a relatively small profession, I had mutual professional contacts with all but one of the therapists I interviewed. It is likely that there was a mutual awareness of our commonalities, shared acquaintances and also our differences. For example, two of the interviewees were relatively newly qualified and in their first post-qualifying post and I felt that, to some degree in each of these interviews, there existed a power differential. For example one participant’s responses were quite often couched as questions with suffixes such as *isn’t it*, or *don’t you?* Almost as if the interviewee were checking out with me whether that was an acceptable action or thought, as a newly qualified therapist might be tempted to do with a supervisor. Although I aimed to stick to the topic guide, my supervisor noted that I asked that particular interviewee more about positive outcomes than I did the other newly qualified interviewee. I wonder, in retrospect, whether I had unconsciously

shifted to a more supervisory role, trying to create some balance or draw out a different side of that therapist.

The other four interviewees had as much, if not more, experience than I did, although not necessarily in dyadic work. I found some of them spoke confidently about what they perhaps felt was an area of expertise while others still seemed uncertain about what they were describing, almost as if they were deferring slightly to what they imagined was my greater knowledge.

Analysis

The data I was analysing related directly to a way of working that I am very interested in and that I, as a clinician, practice. I did not use data from any of my own clinical cases as I wanted to have a greater degree of separation and if possible objectivity than I might have had if I was thinking about work with my own clients. However, in the analysis I was organising data and thinking about the themes in an area that I had a vested interest both as a researcher and a clinician. While my own prior knowledge and experience may have helped me to some extent in the analysis it will of course also have had an impact and influence on my thinking.

The issue of my emic view point will be discussed further in the reflexivity section of the final discussion chapter.

Using the actantial model as a conceptual framework for analysis

The idea of using the actantial model to structure the analysis of the therapists' interviews developed from my thematic analysis. I had no knowledge or awareness of the model when I was planning the research or drafting the semi-structured interview schedule. However, once I had come across the actantial model and found that it had been used in modified forms in other health service research, I had to weigh the pros and cons of whether it would be helpful in my own analysis.

Theoretically, the points in favour of using the model were: a tried and tested model or conceptual framework; help with conceptually sorting my data; a method of analysis which, pragmatically, would help me achieve my end point, i.e. suitable content for a manual. However, weighing in against the use of the model was the possibility that not all the data would 'fit' the model; and that the use of a model might cause me to

privilege or over emphasise elements which did fit with the model. In practice, the actantial model did not quite fit with my data – and I found there was one major element or actant missing: this was the steps the therapists took to achieve their goals. As a result I found I needed to adapt the model to fit the data better, specifically the focus on what the therapist actually does. In some ways this felt reassuring, as I was not trying to adapt the data to fit the model, but conversely was adapting the model to fit the data. With the appropriate actants established, I did find the use of a framework helpful in the final defining and naming of themes and equally so in the reporting of these themes.

If I had had the model in mind right from the start then this would have influenced the questions I asked. The final interview took place after I had begun to think about the actantial model, and as such some of my probe questions focussed more on what the therapist's goals were and what steps were being taken, but in the early interviews, without this structure in the forefront of my mind I did not ask some of the questions which, retrospectively, I now see it might have been useful to ask. For example, as has been mentioned above, there was no explicit question about the therapists' primary objectives for the dyadic therapy and so these were only briefly discussed by therapists. Also, although the actantial model felt like a remarkably good fit for the vast majority of the data yielded by the therapists' interviews there were some topics and discussions which did not fall neatly into this conceptual framework. Principally these were discussions that related directly to the process of putting together a manual for dyadic art therapy. These findings were reported in a stand alone theme.

6.4.4 Implications for the draft manual

The use of the actantial model has organised the data in a way that has helped clarify what the therapist actually does; why the therapist does this; what helps the therapist; what hinders the therapist and what the outcomes might be. The dynamic actantial model provides a potential frame work for structuring the contents of the manual.

Starting with the goals or micro-objectives, the manual can outline appropriate steps or measures the therapists might take to achieve these goals. The fluidity of the dynamic actantial model potentially offers the flexibility that the therapists required of a dyadic art therapy manual.

The results from this analysis have been very helpful in terms of thinking about the appropriate content for a dyadic art therapy manual. The Delphi was helpful at identifying the competences and principles (which are also an important element of a manual) but did not produce a thick or rich description of practices. The 'steps' in the actant model fill this gap, providing detailed accounts of what the therapists actually do. The structure was easily transferable and the actants can be mapped directly across to the draft manual. A summary of the findings which can be transferred directly into the manual can be seen in Table 6.2 on page 182.

CHAPTER 7: Stakeholders' perspectives: The service users

7.1 Introduction

As outlined in the previous chapter there are three different aspects to the stakeholders' study:

- Semi-structured interviews with art therapists who currently offer dyadic art therapy
- Semi-structured interviews with caregivers and children who are currently receiving dyadic art therapy
- Longitudinal survey (over a maximum of eight sessions) of parents' or carers' views dyadic art therapy sessions using an adapted version of The Helpful Aspects of Therapy (HAT) (Llewelyn, 1988)

The semi-structured interviews with the therapists were discussed in detail in the previous chapter. This chapter focuses on the semi-structured interviews with the caregivers and children and the longitudinal survey using post-session questionnaires. In the discussion section, attention will be given to bringing together findings from all three data sets.

7.2 Methods

In dyadic art therapy there are two distinct groups of service users: caregivers and children. I wanted to capture the views of the caregivers and the children and to include their reflections on the images produced in therapy too. Two different data collection methods were chosen for this. A qualitative semi-structured interview designed by art therapists with imagery as the focal point was chosen as a tool for in-depth exploration of service users' perspectives (Seidman, 1998). A longitudinal survey using an existing post-session questionnaire was also chosen to elicit service users' impressions of helpful and hindering events in sessions.

Initially I had thought that the interviews could be used to capture the children's views and the longitudinal survey to capture the caregivers' views. I thought the post-session analysis might be daunting or arduous for the children, especially younger ones, and

that they might be happier talking to me. However, I realised that the interviews might also be daunting for the children who would not know me and might not feel comfortable talking, alone, to a stranger. For this reason I decided to have caregivers present during the interviews and to invite them to join in at any point with their reflections.

While the interviews would provide an opportunity to elicit retrospective reflection on the therapeutic process, I also wanted to gather specific details about helpful and hindering events that might get forgotten or distorted over time. A slightly adapted version of an existing instrument was used, namely the Helpful Aspects of Therapy questionnaire (Llewelyn, 1988). The HAT asks the client to describe both the most and least helpful aspects of the therapy session and to rate the helpfulness or unhelpfulness of events. As discussed above I decided to use this with just the caregivers to minimise the demands on the children who agreed to participate.

7.2.1 Qualitative interviews

Semi-structured interviews were chosen as a way of gathering the caregiver and child's views about their experience of dyadic art therapy and what they saw as the most helpful elements for promoting change. I decided to base the interviews on an existing semi-structured interview protocol called the Reflect Interview (RI) which was designed by Neil Springham and the team of art therapists at Oxleas NHS Foundation Trust to specifically 'capture service user views of what changes, and what mechanisms cause change, in the art therapy they have received' (Springham & Brooker, 2013). The RI involves asking participants to bring to the interview images they have made in art therapy. They are asked to choose any two pieces of art, one from early in therapy and one from later on. The participants are then asked to reflect on these images during the interview. The RI is reported as having been used with children of 12 and above (Springham & Brooker, 2013) and grey literature searches indicate that it has also been used with children as young as eight (Wilkinson, 2010). The RI was selected because it uses imagery as well as words and because it is a recognised tool in art therapy research and I wanted to make the research as pertinent as possible to the wider art therapy research community. A copy of the RI topic guide is in Appendix 7.1.

Springham and Brooker (2013) conducted a feasibility study to establish whether the RI could be used to build a credible data set across multiple sites and populations. They included children of twelve and over in this study. They found that the RI had high respondent validity and was unobtrusive to administer in naturalistic settings.

7.2.2 Longitudinal survey

The caregivers recruited to the study were also asked to complete a post-session questionnaire after a maximum of eight sessions. It was explained that these sessions could be all joint dyadic sessions, or could include some caregiver-only sessions if that is what was being offered. The questionnaire used was The Helpful Aspects of Therapy (HAT) (Llewelyn, 1988)

The questionnaire asks a few relatively simple questions. It asks the caregivers to think about the events which occurred during the session they have just completed and from these to identify the most helpful or important event, either for them personally or for their child. The caregiver is then asked to describe what made this event helpful or important. They are also asked to rate the event on an ordinal scale ranging from extremely hindering (1) to extremely helpful (9). They are then asked when the event occurred and how long it lasted. The caregiver is then asked if anything else particularly helpful happened during this session, and to describe and rate any supplementary events in the same way as the first. They are also asked if anything happened during the session which was hindering and once again to describe and rate any such events. The HAT generates qualitative data and numeric ratings and has been used for various research purposes in the UK and abroad (Sales, Goncalves, Fragoeiro, Noronha, & Elliott, 2007). However different studies have analysed the data in different ways (Cahill, Paley, & Hardy, 2013). A copy of the slightly adapted version used can be found in Appendix 7.2.

7.2.3 Sample

Dyadic art therapy is not a mainstream treatment and there is no register or list of service users who are receiving dyadic art therapy. I decided that the best way to find people with direct experience of dyadic art therapy was via therapists who were offering the treatment. I also needed to recruit practicing dyadic art therapists for the therapist interviews, so I decided to recruit art therapists who had active dyadic cases, and to ask

them if any of their clients might be willing to participate in the research. Ethical approval was sought to recruit six dyads with children aged between the age of five and fourteen years. One of the inclusion criteria was the involvement (actual or imminent) of the child and caregiver in regular dyadic art therapy with one of the recruited art therapists.

The children recruited were likely to have relational difficulties e.g. early disrupted or traumatic attachment histories. No specific diagnosis was included or excluded. The setting in which therapy was given included any health service, social care or voluntary setting treating children with emotional difficulties. It was however specified that each child should be in a placement where they had been for sufficient time to have established a stable relationship with their primary carer. The placement could be medium or long term but needed to be unlikely to break down or change within the timescale of the project. Children with co-morbid conditions (such as ADHD, Oppositional Defiant Disorder or Conduct Disorder) were included in recruitment with the proviso that clinical suitability would be discussed with the therapists. Likewise, children with mild to moderate learning disabilities were included in recruitment, however if children had severe learning disabilities decisions about suitability would be made in consultation with the therapist. Children involved in active care proceedings, those in transient care provision, and children currently in abusive environments were not included.

The aim was to recruit children across the age-range, who were receiving therapy in a variety of settings. It was also hoped that of the six dyads recruited two might be in the early stages of therapy, two in the middle, and two might be approaching the end of their therapy. As has been described, the therapists were recruited first and then discussions were held with these art therapists about recruiting suitable dyads from their caseload.

7.2.4 Recruitment

Following preliminary discussions with the therapists about potential dyads, I asked the therapists to approach the dyads directly. If the dyads were interested in participating, the therapists gave both adult and child the appropriate information sheet. More details

about the information sheets and the process of gaining the children's assent is given below and all the information sheets can be seen in full in Appendices 7.3, 7.4 and 7.5.

In reality this procedure was far from straight forward as not all the therapists had suitable dyads on their caseloads and not all dyads identified as potential participants wished to be involved in the research. Those dyads who did express an interest in participating in the study were invited to meet with me to discuss participation and find out more about the project. Although 12 potential dyads were identified by the participating therapists, only three agreed to attend an initial meeting to discuss the project further. All three dyads agreed to participate, however the involvement of one dyad ended early due to unforeseen circumstances related to their personal lives and it was not considered appropriate to include any of their data in the study.

7.2.5 Gaining informed assent

I wanted the children to have as much understanding and control of their involvement in the process as possible, so I created two information sheets aimed at different age groups which I hoped would enable the children to make an informed decision about their own participation. The information sheets used pictures, photographs and simple sentences to explain the research process. Children were told they could choose to participate or not and how much they wanted to tell me. The leaflet for younger children advised:

“You can take a break, have a rest, or spend a bit of time alone with your adult. You don't have to talk to me about anything you don't want to [...] You do not have to take part in this project. It is up to you to say YES or NO [...] If you say YES you can change your mind later and stop at any time.”

7.2.6 Data collection

Both of the caregivers recruited completed the HATs after their sessions (one caregiver completed eight, the other four) and both dyads participated in the semi-structured Reflect Interview. The interviews took place at the clinics the dyads visited for their therapy sessions, each one following on from a therapy session, to cause the minimum possible inconvenience to the participants. The interviews were 36 and 37 minutes respectively. They were recorded and transcribed verbatim.

7.2.7 Analysis

Analysis of the HATs

The HAT generated qualitative data and numeric scores. The original plan was to recruit six caregivers which would have been conducive to a separate analysis of the HATs. However, given that HATs were only completed by two caregivers, I decided to include the qualitative data from the HATs in the thematic analysis of the semi-structured interviews. The range and mean of the numeric scores were calculated and included in tables displaying the data which can be seen in Appendix 7.6.

Analysis of the Reflect Interviews

The semi-structured interviews with child and caregiver were analysed using Thematic Analysis based on the approach described by Braun and Clarke (2006; 2013). As before, this was a recursive process, including: familiarisation with the data; coding; searching for themes; reviewing, defining and naming themes. Each step is described in detail below.

Familiarisation

Once I had completed both interviews I had them transcribed and then I listened back to the audio recording to check the accuracy of the transcripts. This was a difficult process as the interviews had multiple participants, with three people in one and four in the other as the child had asked for the therapist to remain present. In addition, the children's voices were often quiet, muffled and indistinct. At times there were two conversations taking place.

Coding

As I had done with the therapists' interviews, I began by reading through the transcripts, looking for patterns of meaning and thinking about possible coding schemes. I began to code the data into nodes that focused on issues relating to the service users' feelings about therapy; the things they were struggling with inside and outside of the therapy; the therapeutic relationships; and the imagery. Again, I was faced with the 'messy reality' of analysis described by Clarke and Braun (2013, p. 122).

Searching for themes

After this initial coding process I searched for categories which would help convey the service users' views. I started with: the challenges the children were facing in their lives; the challenges the caregivers were facing in relation to the children; the child's experience of dyadic art therapy; the caregiver's thoughts about art therapy. I began the process of writing up, to see if these categories would work as themes.

Reviewing, defining and naming themes

I presented a first draft of my analysis in a supervision session with two of my supervisors and together we reviewed the categories I had begun to write up. Following this supervision session I worked again on the analysis, hoping to reflect a more integrated conceptual analysis of the data. I also made the decision at this time to include the qualitative data from the HATs in the analysis and so the categories were reviewed in light of this additional data. I checked what was not covered by my working categories and found that they did not sufficiently describe the role played by the images in the sessions.

The combination of the interviews and the HATs provided insight into the role the art and the art making played in the sessions, and I thought this might be an important theme if dyadic art therapy is primarily distinguished from other verbal dyadic therapies because of the centrality assigned to the art making process. On the other hand, dyadic art therapy differs from individual art therapy interventions because the two person dynamic between therapist and client is expanded to a three-way dynamic between therapist, caregiver and child (and could be potentially expanded further to include a second caregiver). I found that the interviews and the HATs drew out some of the advantages and challenges of this three way dynamic which is an integral part of the dyadic approach. I therefore decided to take these two defining aspects of dyadic art therapy, the art and the dyadic dynamic, and see if they would work as themes. I also wanted to retain a theme from my earlier schema relating to the aspects and outcomes of the work which the service users valued most.

During analysis of the data I also found that a significant portion of the conversations actually related to the inter-personal process of the interview. This issue will be addressed first prior to reporting the analysis.

7.3 Results

7.3.1 Description of participants

Two dyads were interviewed. Although ethical approval had been sought up to the age of 15, the two children finally recruited were both very young, aged 6 and 7 respectively. Neither child was living with their birth family.

The first child, who will be called Ruby, was living with an interim foster-carer having been removed from her birth family. She was being offered a time-limited piece of work (contracted as 12 sessions with the possibility of a few extra at the end if needed) which had just begun when they entered the study.

The second child, who will be called Jack, lived with his adoptive parents and brother and had recently been given a diagnosis of autism. He was just starting dyadic art therapy, although he was already known to the therapist. He and his mother were being offered an open ended piece of work.

Jack's Mum attended dyadic sessions with him and will be called Mrs B, Ruby's foster carer attended sessions with her and will be called Mrs K. The therapeutic settings included an NHS CAMHS team and a team providing therapy for children in foster-care.

A third dyad, also involving a foster-child, was originally recruited and the caregiver began completing the HATs but, a few weeks after recruitment the placement broke down and the circumstances meant that it was not felt appropriate to include the data in the analysis. No further details will be given to protect the children's anonymity.

7.3.2 The interview process

Some of the data from the interviews related to the process of interviewing the two young children and their caregivers. James (2001, p. 254) writes that semi-structured interviews with children, 'can facilitate a more focused and private discussion than would be possible in the hustle and bustle of the everyday public life' and interviews 'may also prove especially useful for collecting data of a personal and sensitive kind'. However interviews with young children may present too verbal a format, and multi-

methods might have provided more insight (Darbyshire, MacDougall, & Schiller, 2005). Potentially there is a lot to be learnt from this that may be relevant to the manual in terms of how the views of children involved in dyadic art therapy are gathered in the future. Lessons learnt at this stage could help to produce richer more comprehensive data later on.

Engagement

In the initial meetings with the children I tried to engage with them and put them at their ease. In my first meeting with Ruby we made some dot to dot pictures together and in my first meeting with Jack he got out lots of toys for us both to play with, focussing particularly on puppets and a toy phone which he wanted to use to speak to me.

When I returned to interview the children I showed them the recording equipment, recapped on what I was doing and why, and checked that they were still happy to be interviewed. Ruby was quite interested in the recording equipment and at one point towards the end of the interview she began to play with the Dictaphone (which was fine as I had brought two recording devices). Armstead (2011) suggests that handling the research equipment can help to give children a sense of ownership of the research process. She began her interview by hiding behind a sofa and her carer let me know that she wanted us to pretend we didn't know she was there so she could surprise us. The carer and I had a loud staged conversation, along the lines of '*Oh where's Ruby? Couldn't she come today?*' and after a few moments Ruby popped her head up.

When I interviewed Jack, his therapist had shown us into the room, but when I asked if he would be happy for her to leave he looked dismayed. I asked if he would prefer the therapist to stay and he answered: '*I think she's a good little animal player*', so I asked if he'd like her to stay and play with the animals and he said, '*and the telephone*'. These interactions and negotiations felt an important part of trying to put each child at ease and empowering them a little bit in a strange and possibly stressful situation.

Answering questions

Charmaz advises that keeping interview questions open-ended helps enormously (2006, p. 33). However with these two children, open ended questions tended to elicit replies such as 'don't know'. Breaking down the question into fixed choices was not

particularly helpful either as this conversation between Jack and his therapist demonstrates:

Therapist: *What did you have to do to get the splashes?*

Jack: *Err I've forgot how to do it.*

Therapist: *You've forgotten okay. Do you remember what you used? Was it paint or was it a pen?*

Jack: *I still don't know.*

When asked a direct question, Ruby often went through a range of possible answers:

Mrs K: *[Ruby] stopped talking towards the end of the session and barely spoke and that was the Friday at the beginning of the half term holiday so she didn't hardly speak at all for the Saturday and Sunday.*

Interviewer: *Ruby, did you get really upset making that cup for [your brother]*

Ruby: *Yes, I don't know.*

Points at which the child became animated

Jack, having negotiated to have the therapist in the interview, played with her in an intense and animated way throughout the interview. On the occasions when the therapist joined in with the conversation between the interviewer and his Mum, Jack intervened to get her attention back:

Jack: *Are you talking to my mum?*

Interviewer: *I am talking to your mum. Oh do you mean so why is [your therapist] joining in and not playing with you? Okay.*

Therapist: *Yes I think last week and the week before he relaxed didn't he as time went on and became I suppose more amenable to what we were doing.*

Jack: *Can you hear me? Is it Mum and Lizzie talking?*

Interviewer: *Well I'm interested in everybody's opinion, yours, [your therapist's], Mum's, anyone who wants to share their views.*

Therapist: *Lizzie's come all this way to listen to you.*

Although he was quite animated in his play, and in his attempts to keep the therapist's attention, he was quite difficult to engage in the interview process. The points at which he did become chatty were when he was talking about some of his images, notably 'the splashings'. He spoke relatively freely about these as has been described in the section

about images.

Ruby was less animated than Jack perhaps because she did not have someone to play with her other than her carer and the interviewer. She was however a little more engaged in the interview process, although her answers seemed to be cagey, ambivalent and possibly designed to please. However she did come alive at one point when she began to show the interviewer a magic trick:

Interviewer: Ruby, if you stopped coming [to art therapy ... would] you take any tricks away? Have you learnt any tricks about drawing or feelings?

Ruby: I've learnt a really good trick. Not here though

Interviewer: What really good trick have you learnt?

Ruby: One sec... after I've done this. I saw it on TV.

Interviewer: You saw a trick on TV.

Ruby: No, yes, yes and it's really cool. You know if you've got a coin you're not allowed to tell anybody the secret you just have to watch if you've got the coin [...]

Mrs K: Something small.

Interviewer: A little coin you mean. I've got a coin.

Ruby: And then you have to....I don't know I keep forgetting which is the answer. When you've got the coin if you've dropped it you have to try and get another coin that's not there.

Interviewer: Okay.

Ruby: Watch.

Like Jack, Ruby seemed to enjoy having undivided adult attention as she performed the trick.

7.3.3 HAT questionnaires

There were 12 post-session questionnaires collected from the two participating caregivers. Four of the post-session questionnaires were completed following parent only sessions, all by the same caregiver. Eight of the questionnaires had been completed following joint sessions, four by one caregiver and four by the other.

These forms mentioned a total of 16 separate helpful events. The form asks about the most helpful or important event and then also about any additional events which occurred in the session (helpful and then hindering). Respondents were asked to score each helpful event and they assigned ratings which ranged from slightly helpful (6.5) to extremely helpful (9). The scores for helpful events ranged from 6.5 to 9 and the mean score for helpful events was 8.36. Events lasted for five minutes or more and some were described as lasting throughout the session.

There were two hindering events recorded. These were both given a score of 3 which equated to moderately hindering. Both events occurred in joint sessions.

One questionnaire held no details of any events either helpful or hindering, just a brief note that *'Due to recent events the therapist decided to make this more of a fun session so Ruby made cups on the potters wheel'* (Mrs K on HAT form).

The descriptions of the helpful and hindering events and the additional comments were combined with the data from the Reflect Interviews and will be presented in the thematic analysis below. The numeric ratings can be viewed in the tables in Appendix 7.6 with the individual events with respective scores and comments.

7.3.4 Thematic Analysis

Despite the difficulties in recruitment and data collection, a thematic analysis of the two interviews and the qualitative data from the HATs was completed and identified the following themes: the art making; the three-way dynamic; valued outcomes.

7.3.4.1 The art making

Through the interviews a picture emerged of the role that the art making and imagery played in the sessions. The images appeared to be helpful in allowing the children to convey or demonstrate concepts they might not have been able to verbalise. The image-making also seemed to be used to develop the child's skills in terms of creativity, expressive ability and cooperation as well as being used to record events and process feelings.

Showing through doing

The creative art-based activities had given Jack the opportunity to convey something of his experience to his mother and therapist. Jack, the therapist and his mother had chosen to bring to the interview some images of planets and the solar system which had been made in previous sessions. Jack's Mum and his therapist described how in the sessions he had decided to draw some planets and had started to teach them the names. He had been quite bossy and the therapist was able to think with his mother about whether he was actually showing them how hard he found it in school:

Mrs B: He likes to be in charge.

Therapist: He's quite bossy.

Interviewer: So you've both kind of said that that's the thing he likes [...]it's on his terms [...]

Therapist: We have started to wonder just recently whether he's showing us how hard it is to be at school you know.

Developing skills

The data indicated that art activities were used to develop the child's emotional literacy skills, expressive ability and creativity. Mrs K reported on the HAT questionnaire that Ruby and her therapist had been mixing up coloured paint and covering paper in this. Ruby and the therapist had talked about the colours in terms of feelings and Ruby had said the colours she used were scary. She also reported that it had been extremely useful for Ruby to make an image of a door, which had led to discussions about who would be let in.

Another art activity had involved Ruby making cards that showed different feelings and then playing games with these cards which helped Ruby to name and recognise feelings and also allowed the adults to help normalise these feelings:

Mrs K: We have feeling cards which she's done [...] and we pass feeling cards round and we play like a snap game [...] we've turned a sad card over and said what makes you feel sad and we've told her what makes us sad and she's been able to see that we feel sad [...] and we say when something makes us excited or frustrated and all those kind of words. We've given her ideas of how we feel and then she's said ooh I feel like....

Interviewer: Oh brilliant, so you're not just thinking about your feelings you're thinking about understanding that other people have feelings?

Mrs K: That she's normal. These feelings that she's got of frustration and anger everybody has them over different things.

Jack had used some sessions to do self-directed paintings which he had brought to the interview. They were sheets of A2 paper covered in bright splashes of paint and he certainly was at his most expressive and talkative during the section of the interview when he was being asked about these pictures. He described them in terms of their size and seemed proud of them. This might indicate that the self directed imagery he made was developing his creativity and expressive ability:

Interviewer: Would you like to tell me about the pictures you've chosen?

Jack: Some has splashings, some has splashings [...]

Interviewer: Are there some more over here? Shall I take this off so we can see them? Are these more splashings?

Jack: Yes

Interviewer: Yes

Jack: Look, those two are the biggest.

Interviewer: They're the biggest splashings aren't they? [...]

Jack: And here's some more little ones.

Interviewer: There are the little splashings?

Jack: Yes.

Interviewer: Right.

Jack: Those are little teensy weensy ones.

However, not all the art making in Jack's sessions was self-directed. Some of the imagery brought to show the interviewer was jointly made. The joint making activities had pushed Jack slightly outside his comfort zone, as he had had to relinquish some control, but had still managed to join in. This suggests that he might have been developing skills in co-operation and team working: 'Yes I mean well that's why I bought the snail really because it was really hard wasn't it to get Jack involved in that and then he sort of threw himself into it eventually' Jack's Therapist.

Recording Events

Some of the images which Ruby had made in her sessions were used as records of events. She had created an image of the different places she had lived in, which served as a record of the move away from her birth family and into foster care. The picture included depictions of her siblings and information about where they were living at the time. It even included a respite carer's house at which she had stayed for a matter of days, but it is likely that images such as this may have been helpful in terms of recording confusing moves and events in a way that Ruby could make sense of. Ruby had also used imagery to record information about her dyadic art therapy sessions such as the time that she would attend sessions.

Processing events and feelings

For Ruby the art making also seemed to play a key role in helping her to process some of the huge transitions and losses she was going through. She brought to the interview a clay cup she had made for her brother who was about to be adopted. The plan was to give the cup to her brother when they next met, and so Ruby also had a photograph of the cup so that she would have a record herself. In the art therapy sessions she had made a card for her brother too, perhaps the idea being that through making the cup and the card Ruby might be able to begin to process some of her feelings about him being adopted:

Interviewer: 'Oh can we have a look at this one as well, will you show me this one? It's been very carefully packaged in a box hasn't it? Can you tell me a bit about this one? [...] Is there a link between the photograph and what's in the box?

Mrs K: Yes.

Ruby: Yeah.

Interviewer: Because in the photograph you're holding this beautiful cup aren't you? So you've made a cup for him?

Ruby: That's a bit dark

Interviewer: It's darker now is it and you've painted his name on it and are you going to give that to him?

Ruby: Yes when I see him.

Mrs K: We're going to give it to [woman's name] aren't we and she's going to take care of it.

Interviewer: So you've been thinking about your brother whose being adopted and you're a bit uncertain when you're going to see him next?

Ruby: Yes

A while later her carer explained that after the session in which the cups had been made she had been able to talk to Ruby about missing people:

Mrs K: Then we stopped in the car and she'd made the cup and we kind of talked [... The therapist] had asked who she wanted the cups for because she made about five.

Ruby: No six.

Mrs K: Six is it?

Ruby: Yes.

Mrs K: And then she wanted one for [her brother]and..

Ruby: Two others.

Interviewer: Who were the two others for?

Ruby: [Names a friend and a previous carer]

Mrs K also noted on the HAT questionnaire that it had been a great help for Ruby to make a card for her brother and that doing so had helped Ruby to talk about feeling sad. Mrs K saw this as therapeutic because it helped Ruby understand that it's OK to be sad and talk about it.

7.3.4.2 The three way dynamic

The benefits and the challenges presented by the dynamics which arise in dyadic work emerged as a theme within the data. The benefits of having the caregiver present were seen in terms of the caregiver gaining insights and the therapist facilitating helpful conversations and activities. However with three parties present, in at least some of the sessions, the data showed how each person had their own agenda, and how sometimes if these clashed then difficult feelings could arise.

The caregivers' agenda: the child

The caregivers both appeared to have engaged in dyadic art therapy in the hope of getting some help both for themselves, in their capacity as caregivers, and for their

children. In particular, Mrs B wanted help dealing with Jack's challenging behaviour and Mrs K said she wanted help for Ruby so she could think and talk more about her feelings.

Mrs K was an interim carer for Ruby and so there were likely to be other powerful agendas at play. The setting Ruby was being seen in was one which provided therapeutic packages for children in care, and so some of the motivation for bringing Ruby may have been expectations from Social Care and the hope that Ruby could process some of her past trauma in preparation for moving into a permanent foster placement.

Both caregivers described wanting to help their child and the HATs show that, even in the parent only sessions which MRs B had, the focus was predominantly on the child.

The child's agenda

As discussed above, the two children who were recruited were at the lower end of the specified age range, and both had some developmental delays. The format of the research interviews did not really suit these children, who struggled to articulate much about their experiences of dyadic art therapy. Despite these difficulties it was possible to piece together something of the children's agenda.

First it should be said that both children were brought to dyadic art therapy and that the power differential which exists between a caregiver and a young child is such that the children may not have felt they had much choice in this matter. If there was an element of choice, it would be hard to say to what extent that would be an informed choice as neither child professed any knowledge of the reasons for attending. When Jack was asked if he knew why the adults in his life thought that it would be a good idea for him to come for art therapy, he replied:

Jack: *Err I don't know*

Interviewer: *You don't know. Not at all?*

Jack: *No*

When Ruby was asked the same question she also said she did not know why she came. However, both children were regular attenders and Jack at least appeared to enjoy much about the process. Ruby was more ambivalent, which will be discussed later.

Data from the interview with Jack and his mother suggested that the things he liked about dyadic art therapy were that it offered new or different opportunities and activities that it was non-judgemental and child-led:

Mrs B: He can do what he wants and there's no judgement and no 'That's not how you spell it' or whatever so I think that's probably good for him.

Interviewer: So it's not judgemental, it's child-led?

Mrs B: Yes you know it's his picture, it's his model, it's what he thinks and there's nothing to say well that's not right or that's not right, you know, it's very free for him.

When different agendas collide

The data showed that dyadic art therapy was not without its challenges for both caregiver and child. The difficulties identified tended to arise when there was a difference or clash in one or more person's agenda. For example, Jack, who really liked the child-led aspects of the work, did not like it if the therapists declined to join in with him or tried to lead an activity herself. Neither did he like it when his mother and the therapist had adult conversations in the sessions. For Ruby, as has been discussed, there was an agenda about getting Ruby to open up and talk about her feelings. However, this was not necessarily always in line with Ruby's own agenda. Mrs K had noticed that after therapy sessions Ruby could become quite withdrawn, and also that she found it hard going back into school, and there were often incidents on the days she had attended therapy:

Mrs K: When the sessions started her behaviour at school declined the day after the therapy sessions.

Interviewer: So she had a tough day the day after.

Mrs K: Yes the teachers would come out to me in the yard and say to me was it therapy last night they'd say I thought it was because of her behaviour [...] I think she might have been getting a little bit angry and a little bit upset.

This was checked out with Ruby:

Interviewer: Do you sometimes talk about things in art therapy that leave you feeling a bit upset?

Ruby: No

Interviewer: No?

Ruby: Yeah

And slightly later:

Interviewer: And does that mean sometimes its a bit difficult coming to art therapy?

Ruby: Yes.

Interviewer: What's difficult about it?

Ruby: Erm I don't know.

Ruby's carer also thought that Ruby was ambivalent about coming to therapy because it clashed with an after school club which she had wanted to go to:

Mrs K: The first few sessions she liked coming, she actually got excited the night before but then at school they've brought in different clubs so now she has to miss singing [...]

Interviewer: So, she liked it at first then it clashed with something she wanted to do and it got a bit more painful?

Mrs K: Yes

It was not just the children who found it difficult when there were contrasting or conflicting agendas at play. The therapists' agenda for the therapeutic work was discussed in the previous chapter, and the value of using the art materials in creative ways was discussed. While the therapist is likely to feel comfortable with the use of materials and the potential mess that can be created, caregivers may be more wary. Mrs K sounded a note of caution in relation to this:

Mrs K: On a couple of occasions she's done things that she wouldn't be allowed to do at school [...] getting the paints and getting the brushes and just making them all flat and paint everywhere or sprinkling glitter all over the floor is not acceptable at school.

Interviewer: But it is allowed in art therapy? [...] So your worry is that she might think well if it's okay in art therapy maybe it's okay at school but you've not had that report back from school?

Mrs K: It's parents evening next week [...] One of the things she was doing [in sessions] is just getting lots of different paints and not even using them, things like that [...] and coming at me with wet hands.

Interviewer: Painty hands?

Mrs K: Yes knowing that I've said no [...] I have to make it really clear when I've left the building that you don't do those things at school.

The benefits of joining-up

The difficulties in the dynamics, particularly when there were differing agendas, did not seem to outweigh the perceived benefits of having all three parties working together. The presence of the caregiver in the art therapy session allowed the therapist to facilitate ways of being together or talking together which the dyad could continue outside of the sessions. Having the caregiver present also allowed the caregiver to observe their child and gain insights about the child. The next theme, which focuses on outcomes, will explore these benefits in more detail.

7.3.4.3 The valued outcomes

The outcomes which the caregivers reported as having significance or value for them included the insight that they could gain about their children or their interactions with the children; helping the child with emotional recognition, expression and regulation; getting the ball rolling by facilitating or initiating conversations which could carry on outside of therapy; ring-fenced time and space; and support for the caregivers in relation to parenting their child.

Noticing and gaining new insights

Mrs B identified that one of the biggest changes resulting from their coming to dyadic session was that she had started to notice what had got pushed aside in their hectic life in terms of time and attention given to Jack, and also that she could actually do something to change this. She also described on the HAT questionnaire a moment when she became aware that Jack might have memories from past experiences with his birth family.

As well as these insights, Mrs B noted on the HAT questionnaires how helpful it was when the therapist shared insights about situations Mrs B told her about either at home

and at school. In particular she highlighted that in joint sessions the therapist had helped to 'get to the bottom' of some of Jack's behaviours and in parent only sessions it was extremely helpful to go through reports from the consultant and Jack's school with the therapist because this had given her insight into what might be stressful for Jack and how she might respond to this.

Mrs K also described gaining insight through the work, although what she had noticed and gained insight in sessions about was that Ruby was an intentional being with motivations underlying behaviours:

Mrs K: I can see that she's cleverer than she has first let on [...]

Interviewer: Okay so it's giving insight, you've seen a side of her that you might not have known.

Mrs K: Yes, whereas before I might have thought that she didn't know, she didn't understand, I know she knows [...]. She's a clever girl.

Interviewer: Right [...] you've gained a bit of a more rounded picture of her, more dimensions, you've seen different dimensions to her.

Mrs K: Yes there is she has her reasons for her actions rather than that they are coincidental or accidental.

Interviewer: Right so you're getting to see her as an intentional child.

Mrs K: There's a lot more thought going on and I can see that a lot more thought's going into her actions'

Helping the child with emotional recognition, expression and regulation

The caregivers spoke about how therapy was helpful because it allowed the children to express difficult feelings. As described above, Mrs K thought the sessions helped Ruby to talk about her feelings and to put names to those feelings, and it gave the adults the opportunity to let Ruby know that it was normal to have strong feelings.

Mrs B thought Jack was using the sessions to express some of the distress he was feeling at school, and maybe to also begin to regulate some of the stressful feelings:

I think he's telling us you know I mean because he's not very, he's not very keen on talking. He'll come out and it's what've you done today and he's like I don't know. That's generally the response you get every time he comes out and then when you try and draw things out for him it's like, 'Don't want to talk, don't

want to talk, that's enough questions now', but you know we can try and tend to slip them in while he's doing something else and you might get more of an answer. Maybe because it relaxes him a little [...] Mrs B

Both caregivers mentioned a process akin to purging or emptying out feelings:

Mrs K: [T]here's already so many feelings bottled up in there that need to be addressed, adding another one....

Interviewer: You don't want to add another bottled up thing?

Mrs K: No we're never going to get anywhere, we need to help Ruby open up and talk about her feelings. Giving her something else to keep to herself it just feels like sometimes she could probably explode.

Interviewer: So [...] you think, better out than in, and art therapy offers an opportunity to ...

Mrs K: Definitely

Getting the ball rolling

Mrs K highlighted how not all the important conversations happened in the sessions, sometimes the sessions just served to get the ball rolling:

'The stuff that we talk about in therapy means that she can talk about to me if she wants to at home which means I can talk to her at home because it's already out there' Mrs K

This was something Mrs K also highlighted in the HAT questionnaire. She rated as extremely helpful a conversation that took place in therapy in which Ruby had been able to say that she had enjoyed a recent holiday and explained that following this Ruby *'was able to repeat those feelings when asked by someone else the day after.*

Ring-fenced time and space

Both caregivers highlighted the potential dyadic art therapy had offer a unique safe space. Mrs B said that the sessions allowed her and Jack to spend together away from the distractions of a busy family life and Mrs K she said that she thought dyadic art therapy provided Ruby with a separate space where it was possible to think about things in a safe way:

'It's given her a place where it doesn't interfere I think where she can come and

talk about her feelings but then we can leave and it doesn't have to continue at home or at school so if she wants to leave it here she can' Mrs K

Feeling supported

Both caregivers mentioned the support they felt they personally got from the therapists to help them respond appropriately to the child. Mrs K mentioned the support the therapist had given her in dealing with issues outside of therapy such as stealing. Mrs B wrote on the HAT questionnaire that it was extremely helpful in parent only sessions to express her fears and get reassurance from the therapist and several of the helpful events she recorded after parent only sessions related to suggestions, reminders and insights that the therapist had shared with her.

7.4 Integrating the three stakeholder data sets

This chapter and the previous one have reported on three data sets: the therapists' interviews; the HAT questionnaires; and the Reflect semi-structured interviews with service users. Analysis of the therapist interviews was more extensive due to difficulties in recruiting dyads and there were some sections in the therapists' analysis which related to 'behind the scenes' influences on the therapist's practice. To look at how the two analyses might converge or diverge, I took the findings from the service user analysis and looked to see which aspects of the therapist analysis they related to.

The matrix in Table 7.1 displays this information, showing that the therapists were aware of the factors which the service user analysis highlighted. This convergence of issues identified by the therapists and the service users has important implications for the manual as it highlights areas which were seen as significant by both groups.

There were other issues which the therapists identified that were not evident in the data collected from service users, such as what supported and influenced the therapists. Issues such as these would not necessarily be apparent to service users.

Table 7.1: Matrix of findings from each component

Factor	Reflect interviews and text data in HAT	Therapists' Interviews	Relationship
Art making			
Why is it helpful?	Children can show as well as tell The child's creativity and emotional literacy can be developed through the image making	The therapists talked about how using the art materials could help the child to express or communicate their feelings in a direct way to the adults in the room, perhaps better than words alone.	Convergence
What are the challenges	Caregivers might feel uncomfortable about how materials are used	The therapist reported that caregivers' and children's feelings about the process and their ability and willingness to engage can present a challenge	Convergence
The three way dynamic			
Why is it helpful?	Caregiver gains insights from seeing and participating in the process and also from discussions with therapist Discussions and interactions can be initiated between dyad	Therapists took steps to help caregivers to witness significant events at first hand Therapists took steps to facilitate joined-up discussion	Convergence
What are the challenges	Conflicting agendas can arise	Therapists noted that complex therapeutic dynamics which may be present.	Convergence
Valued outcomes	Noticing and gaining new insights Help with emotional recognition, expression and regulation Getting the ball rolling Ring-fenced time and space for caregiver and child Feeling supported	Therapists' goals included developing children and caregivers' skills and working with them to process events and feelings. Therapists took steps to facilitate joined-up discussion Therapists structure the intervention to meet the needs the dyad The therapists noted the importance of engaging the caregiver and creating a sense of trust to facilitate the work	Convergence

7.5 Discussion

7.5.1 Summary of findings from service user data

Analysis of the data from the semi-structured interviews with caregivers and children and the longitudinal post session survey highlights the important role of the image in dyadic art therapy. Art and art making can open alternative channels of communication between the child and carer enabling the child to communicate aspects of their experience through doing rather than explaining. The images were used to help the child develop expressive and creative skills, and they also had a key role to play in recording and processing important events and the feelings associated with them.

Having caregivers present in the sessions was also seen as important by caregivers themselves. Many of the valued outcomes highlighted by the research were achieved by having the caregiver present in sessions. Caregivers gained insights at first-hand and conversations and interactions could be initiated in sessions which the dyad would then continue afterwards in everyday life. As well as having these benefits, the joined-up dyadic approach was also seen as potentially creating a challenging dynamic, particularly if the three key participants had conflicting agendas. Research with the therapists suggested that therapists have an awareness of this issue but it is helpful to understand this also from the service user's perspective.

7.5.2 Putting findings in the context of other research

I was not able to find reports of other interviews or surveys involving dyadic art therapy patients or service users. There is also a paucity of studies reporting on children's views of art therapy, although a recent study looking at the feasibility of using the RI did include children over the age of 12. Therefore I had to consider these findings in the context of qualitative studies of art therapy more generally.

Comparison with qualitative studies of art therapy

There are qualitative studies which consider art therapy from an adult service user perspective. A recent review of these has taken place (Uttley et al, In Press). Eleven of the studies reviewed looked at service users' views reporting on qualitative data from 188 patients. Where age range was reported the ages of the service users ranged from

26 – 82 years. The review suggests that service users find art therapy beneficial, or helpful, when a good relationship with the therapist and other participants (e.g. in group work) is established, and that the intervention can facilitate improved relationships outside of therapy and counter isolation. Service users also thought that it could: facilitate increased understanding of self; provide strength and perspective; distract from pain/illness; provide pleasure and accomplishment; allow for expression of feelings; raise self esteem; promote empowerment; provide a healing experience; and provide comfort, support, encouragement and relaxation. Challenges to engagement that the review identified included: illness or physical restrictions; lack of understanding; and lack of confidence in artistic ability. The potential for harm was perceived if: the therapist was not skilled; the work ended suddenly; emotions were activated but not resolved; and the process caused pain or anxiety.

The service users in the review highlighted the importance of working on relationships and the benefits of making connections. Parallels can be seen with this study in terms of the potential art therapy has to facilitate improved relationships, and the importance of the relationship between client and therapist. The therapist is seen as someone who can offer encouragement and support, something that was mentioned by the caregivers in this study. The findings also resonate with my research in terms of increased understanding of self and the possibility of emotional expression, which overlaps with what I have referred to as emotional recognition, expression and regulation.

Comparison with other studies using the RI or HAT

Some of the findings from the RI and HAT can also be looked at in the context of other research using these tools. As mentioned above, Springham and Brooker (2013) used the RI to investigate what changes are caused by art therapy with adults and children over the age of 12. They found, in line with my research, that it was difficult for the children involved in their study to articulate outcomes and in this respect the authors were not able to fully integrate the children's answers with those from the adult participants. However, they were able to integrate the children's data relating to what causes change in art therapy. The findings were that change was aided by: externalising thoughts and feelings into artwork; making art with others [originally in a group setting but this has been expanded here to look at cross-setting similarities]; the use of art

objects to improve recall of significant others; art objects as a record to reflect on; and containment provided by the structure of regular art therapy sessions.

Although the Springham and Brooker (2013) study relates to individual sessions or group sessions rather than dyadic (three of the six participants had individual work, three had group art therapy), their themes have readily identifiable links with my findings, particularly those I have grouped in the theme *The images*. Within that theme I identified the following sub-themes: showing through doing; developing skills; recording events; and processing events and feelings. Their theme about structure also relates to my finding that both the service users value the protected, bounded time and space.

So there appear to be a number of parallels which seem to cluster around the role of the image and also what people like about the sessions. However it is interesting that Springham and Brooker's (2013) findings relate to just a few aspects of mine, i.e. the imagery and the boundaries. Some of my other findings, particularly those which relate to the interpersonal nature of the sessions, are not so evident in their findings with the exception of the theme called *'Making art in a group setting enriches relating to others'*. This suggests that while dyadic art therapy may share some processes with other forms of art therapy, it may also have unique processes which relate directly to the joined-up interpersonal nature of the work.

The HAT has been used and analysed in diverse ways which makes it difficult to contextualise the findings in terms of related research (Cahill et al., 2013, p. 787). However Timulak (2010) has produced a review of significant events research which identified 41 primary studies that focused on client-identified significant events; 11 of the studies used the HAT as a data collection method. Timulak describes Elliott's (1985) taxonomy of events as pivotal for many of the studies identified. Elliott's taxonomy groups helpful events into two large superclusters. The first is the task supercluster which consists of four clusters: new perspective, problem solution, clarification of problem, and focusing attention. The second is the interpersonal supercluster, which also consists of four clusters: understanding, client involvement, reassurance, and personal contact.

Some of the valued outcomes identified in the service user enquiry in my study can be mapped onto this structure. The aspects which the caregivers value seem to fit predominantly into the interpersonal supercluster. For example, caregiver's noticing and gaining new insights seems to fit in the understanding cluster, caregivers valuing ring-fenced time and space with their child could fit in personal contact, and caregivers reported valuing the therapists' reassurance. The helpful aspect of the art making fit better in the task supercluster as the child's use of the art materials helped the adults to understand the child's perspective, clarifying the issues the children were struggling with and focussing the caregivers' attention or sensitivity to this.

Elliott's clusters of nonhelpful events are: misperception; negative counsellor; unwanted responsibility; repetition; misdirection; unwanted thoughts. The service users' HATs in my study identified two moderately hindering events: the caregiver finding it hard to keep the child on track; and the child becoming agitated when the therapist was not joining in with art making. The interviews identified that Ruby's caregiver found it difficult when Ruby used materials in messy or non-conventional ways. These have been summarised in the analysis as conflicting agendas, but they also resonate somewhat with Elliott's taxonomy. The child, frustrated by the therapist not joining in, may have felt the therapist was uninvolved (a subcluster of the negative counsellor cluster) and the caregivers' difficulties with messy or child-led activities could be seen as an extension of unwanted thoughts, although in these instances it was not the thoughts the therapy initiated that were unwanted, but the activities.

7.5.3 Strengths and limitations of the stakeholder enquiries

Strengths

The stakeholder enquiries provide rich, detailed accounts of dyadic art therapy from the therapists' perspective and from the service users' perspectives. The multiple data sets allow for a degree of triangulation. Pope and Mays (2006) highlight triangulation as a way of improving validity. They also recommend exposition of methods, data collection and analysis. These issues will be discussed below in relation to the three data sets used for the stakeholder enquiries: the therapists' interview; the dyad interviews; and the HAT survey.

Triangulation

Pope and Mays (2006) suggest that triangulation, which at its simplest is the comparison of results from two or more data sources, is generally accepted as a way of making a study 'more comprehensive'.

The integration matrix (see Figure 7.1) shows that some of the therapists' goals, helpers and challenges are highlighted also by users. Although any assumptions or generalisations based on this triangulation would need to be treated cautiously due to the exceptionally small sample size, it is interesting to note where the cross-overs lie. For example the second two data sets confirm that Jack's therapist had indeed spent time observing Jack and his mum making together, noting that Jack became more playful and abstract in Mum's presence. She had also sought to 'get to the bottom' of what was going on for Jack and had shared these insights with his mum, particularly in relation to school, and the HAT shows that Jack's Mum found this extremely helpful. This would seem to serve as a good illustration of the therapist taking the step of observing and formulating, and building up a picture of the child which can then be shared with caregivers and the wider system as appropriate.

Other areas of convergence highlighted across the data sets include examples of :

- The therapists structuring the intervention to meet the dyad's needs, e.g. Mrs B had her own sessions with the therapist which she experienced as helpful.
- The therapists facilitating moments of insight for both caregivers e.g. Mrs B said it suddenly dawned on her that Jack had memories of his time before coming to live with her.
- The dyadic art therapy helping to process current life events e.g. Ruby thinking about the breakdown of her birth family.

However, not all the actants identified by the actantial analysis of the therapist interviews were borne out by the other data sets. This might be because some of the therapists' goals and steps would not be visible to service users, therefore it is perhaps not surprising that some of these were neither illustrated nor contradicted in the latter data sets. Examples of this would include: Observing and formulating; Workplace constraints; Support from workplace, colleagues and supervisors. These steps might not be visible to the service users, who perhaps were focussing more on the outcomes than

the things the therapists had done to achieve these goals. However, given the very small sample size of dyads, it is difficult to draw conclusions about what is not in the dyad interviews.

In at least one instance triangulation of the data sets suggested that the therapists' goals were not always achieved. This was notable in regard to helping the child to understand why they were coming to therapy; neither child could articulate why they were having therapy. However, because of the very small sample size and the lack of diversity within it, this could simply be a function of the extreme youth, or the cognitive challenges, of the two child participants.

Exposition of methods, data collection and analysis

Within the methods sections of these two chapters I have laid out the sampling and recruitment methods and described how the data was collected. I have broken down the analysis into the steps I took which were: familiarisation; coding; searching for themes; reviewing, defining and naming themes. I have also outlined the actantial model which played a key role in the latter stages of the analysis of the therapists' interviews and in the reporting of their results. The methods have been clearly explained, but how appropriate they were will now be discussed.

Limitations

Recruitment

Problems of access and recruitment are known to be major barrier to research with vulnerable or marginal populations (Singh & Keenan, 2010). At the start of this study the aim was to recruit six children and six caregivers. However, the recruitment of the service users, which was mediated by the therapists already recruited, was dependent on the therapists having suitable and willing participants on their caseload. Unfortunately, some of the therapists were unable to identify suitable dyads. Additionally, some of the dyads that were identified were not recruited, either because they did not wish to participate, or in one instance because a foster placement broke down. One dyad which was recruited dropped out of the study because the child's foster-placement broke down and the circumstances meant that it was not appropriate to include the data in the analysis.

Difficulties in recruiting children can compromise case selection (Singh & Keenan, 2010). In this study ethical approval was sought to involve six children aged between five and 14 but only two children were recruited and they were both very young. Jack was seven and had a diagnosis of Autistic Spectrum Disorder and Ruby was only six.

Jack decided that he wanted his therapist to remain present during the interview and so, to accommodate his wishes, the therapist was invited to stay. Jack wanted to play with therapist while I talked to his mother. Having the therapist present may have made him feel more comfortable and less daunted by the interview process, and it also meant that the therapist could chip in with comments and reflections, but it impacted on the dynamics of the interview, with the therapist hearing everything he and his mother spoke about. Potentially this may have influenced what Jack and his mother chose to say during the interview.

Ruby had experienced chronic developmental trauma and was, unsurprisingly, not highly articulate. I was not able to offer her the choice of having her therapist present as the therapist had to leave just prior to the interview. Ruby often struggled to answer the questions I asked her, sometimes running through a gamut of answers: positive, negative, uncertain. I had a sense that she was trying to find the right answer, or at least the one which would get her into the least trouble. As a very young child, who faced enormous uncertainty in her life, it was not surprising that she struggled to verbalise or reflect on her experiences.

Singh and Keenan (2010) highlight that interviews should be age and developmentally appropriate and that children of 8 are at different cognitive levels than children of 12. The Reflect Interview (RI) had been selected prior to the recruitment process because it uses imagery, is a recognised tool in art therapy research and has been used with children aged as young as 8 (Wilkinson, 2010). I had envisaged this would roughly be the average age of the children I recruited. However that was a flawed assumption, and the RI proved too verbal a format for the young children who were recruited.

To try to make the interactions more developmentally appropriate I included some play and art-based interaction with the children during the introductory meetings and the interviews and I noticed that both children became most animated at times when they

could play or take centre-stage in a naturalistic way. For future research with this age group it might be fruitful to explore play-based methods of gathering feedback. If I had conducted a small pilot study I might have been able to identify some of these methodological limitations ahead of time.

A final issue relating to recruitment is that by only interviewing people who were engaged in dyadic art therapy, I missed the negative voice. There will of course be people who have chosen not to engage in dyadic therapy and they may have an entirely different story to tell. The dyads who I recruited were likely to value the process and to have views at least partially aligned with the therapist because they were continuing to attend. Future research could usefully include some dyads who have dropped out of dyadic art therapy. Feedback for these service users could be included into the manual to help therapists to 'right some wrongs' from a service users' point of view.

Methods selected

Arguably the least successful element of the design was the method I chose to collect the views of the children. The RI has been used with children of twelve and above (Springham & Brooker, 2013) and grey literature searches indicate that it has also been used with children younger than 12 (Wilkinson, 2010). However, although the RI asks participants to bring images with them and to reflect upon these images it still has a predominantly verbal format which was not a good match for the children I recruited. A less verbal approach might have been a more appropriate and effective tool for gathering rich data from these children. Given the developmental level of the children I recruited, a combination of multiple methods (Darbyshire et al., 2005) involving imagery and play as one of the primary modes of communication might have been more appropriate.

7.5.4 Reflexivity

Researching art therapy as an art therapist

My position when exploring the therapists' perspective was emic but this was not the case with the service users. I was not an insider in the sense of being a fellow service user, however neither was I an impartial outsider. The information I gave to participants was as transparent as possible, and explained that I was myself an art therapist and that I

was doing some research into dyadic art therapy. As such they would have been able to deduce that I too was, to some degree, a stakeholder in the process we were discussing.

To the two children who participated I may well have seemed like someone who worked alongside their therapist. Both children had met a steady stream of professionals throughout their lives and I wonder whether I seemed any different to them. Certainly I did not feel that either child responded to me differently from how my own clients might respond to me in the early stages of therapeutic engagement, and it seems likely that I adopted a similar manner to that which I would adopt with new clients.

So, while my position as an art therapist may have helped with recruitment (as discussed in the previous chapter) and possibly establishing a sense of trust, it may also have imposed certain restrictions or biases. Specifically, the dyads may have felt that it was more difficult to voice critical thoughts about dyadic art therapy to me than to an impartial researcher who had no links to the profession.

My experience as a clinician may have helped me communicate with the children and would have been a good starting point for visual or play-based methods. Yet, ironically, I chose a tool that used imagery simply as something to reflect upon. In retrospect I have wondered about why I chose this as a data collection method with the children and did not use visual or play-based methods. It is possible that moving from a position of professional confidence as an art therapist to a position as a novice researcher may to some extent have undermined my confidence, particularly in the transferability of my existing skill set. New to health services research, I may have feared that non-verbal data collection would have less credibility or that it would just be too complicated to collect and analyse data. Also, I assumed that the children recruited would be older than they were because as a clinician I tend to be referred children who are eight or above (perhaps due to the culture and referral criteria in my service).

From a personal point of view it was challenging to move from my more familiar role as therapist and take on the role of researcher and to some extent I may have fallen into my familiar therapist persona in some of my responses to the dyad. With my clinician hat on I was to some degree thinking about my own formulation of need. I found the interview with Ruby emotionally challenging because she was in a very uncertain phase

of her life. Her placement was only temporary and her carer told me that they were looking for a long-term foster-placement for Ruby. Ruby then recited a list of what she wanted from such a placement, and I found this heart breaking. I felt a strong desire to offer to foster Ruby myself as I drove away from the interview. If I were working as her therapist I would no-doubt have wanted to reflect on my own response to Ruby's situation in clinical supervision. This powerful projection might have led me to wonder if Ruby was really in a position to engage in therapy given so much uncertainty and the absence of any real permanence or security.

Power relationships

James (2001, p. 253) refers to 'the vexed question of the power differentials that exist between the child and the adult researcher' and reports that to address this some researchers try to be the 'least adult' they can and join the children in play activities. However, James reports that others have questioned this stance contending that children know that adults are different and 'age, size and authority always intervene' (James, 2001, p. 254). When I first met with the children I tried to interact with them in developmentally appropriate ways, speaking clearly and simply at times about the research and at other times using play and art to engage with them. I made some dot to dot pictures for Ruby and used toy telephones and puppets to speak with Jack. In the interviews Jack wanted to play mainly with his therapist, but we set up a system that when he wanted to speak to me he would waggle one of the puppets at me, and he was offered the choice of responding using the play phones. Ruby, began the interviews with a game of peek-a-boo and in the middle of the interview gave us a little magic show. I used these play and art-making to communicate with the children and try to make them feel safe and comfortable, even though it was not an intrinsic part of the interviews.

Another issue which the relative powerlessness of children can exacerbate is the right to withdraw from the process or stop the interview (Twycross, Gibson, & Coad, 2008) and I was aware that for both children the interviews might be emotionally charged and they would not necessarily want to talk about all aspects of their therapy. I think I was very aware of the power differential between me and the children and the sensitivity of the subject matter and proceeded with caution, for example if I picked up that the children were reluctant to talk about something I tended to focus more on the caregivers. I did

not feel comfortable using probing questions with the children but hoped instead that they would contribute when they wanted to. I tried to check out the caregivers' answers with the children from time to time so the children did not feel they were having words put in their mouths, or were at least given the opportunity to respond and put forward their point of view.

7.5.5 Implications for the manual and future research

Although this study had a very small sample size, the data produced suggests that caregivers can find dyadic art therapy to be a helpful way of working and saw the benefits for themselves and their children.

In relation to the art making, the data suggests that it is not only therapists who see this as a key helper, service users have also rated art making activities as extremely helpful, and this will be noted in the manual.

The data from the therapist interviews showed that they were aware that the dynamics involved in dyadic work could be complex, but when they unpacked this they focussed on a number of issues such as feeling exposed and the difficulties of working with punitive or hostile caregivers. Analysis of the service user data highlights how conflicting agendas can also set up tensions and make the work feel frustrating or disagreeable. An awareness of how this can feel from the service user's point of view will be an important component of the manual.

Finally, the outcomes which the service users valued can be highlighted in the manual. This is a very important aspect and one which more work could usefully focus on, so in the future dyadic art therapists can strive to achieve the outcomes which are most important to service users or at least have an awareness of times when their own therapeutic agenda might be at odds with the caregivers' agenda. Of course the small sample size means that the list is by no means exhaustive and may in fact be idiosyncratic, so a larger body of research will need to be established. It should also be borne in mind that the needs of each dyad will vary, and so too may the outcomes which they value.

It is important that the content of the manual is shaped by input from the service users and the findings from this study serve to highlight the aspects of therapy which service users find most helpful as well as the more challenging aspects. If an evidence-base is going to be established in the future, then more data will need to be collected from service users. Future research involving young children could usefully employ more age-appropriate methods of data collection.

Although some of the findings from this study were similar to other research into individual and group art therapy with older children and adults, the study suggests that dyadic art may also have unique aspects which relate directly to the interpersonal nature of the work. This will need to be identified in the manual.

CHAPTER 8: Drafting the manual

8.1 Manual development

The purpose of psychotherapy treatment manuals is to specify interventions in ways that facilitate favourable clinical outcomes for clients (Henggeler & Schoenwald, 2002).

However manuals may also, among other things, be used to: facilitate objective comparisons of different interventions; set standards for training and evaluation of delivery; link treatment processes to outcomes; define treatment goals; establish standards; and reduce variability in outcomes due to therapist effects (Carroll & Nuro, 2002).

Until about forty years ago the nature of psychological treatments was usually identified by asking therapists to identify the theoretical constructs that guided their work. However, self-identification of theoretical alliance is a poor indicator of practice (Beutler, 2002).

As highlighted in Chapter 2, Carroll and Nuro (2002) have published a paper outlining a stage model of manual development which potentially provides a framework for developing manuals (Henggeler & Schoenwald, 2002). They argue that there are challenges inherent to manual development, such as reduction in therapist flexibility, but that these challenges can be addressed by adopting their proposed stage model of development which parallels the “stage model” of behavioural therapies development (Onken, Elaine, & Battjes, 1997). They argue that manuals should meet the needs of therapists implementing the treatment, whether that is in highly controlled efficacy trials or in diverse clinical settings.

They propose Stage I manuals for preliminary evaluation of feasibility and efficacy such as would take place in a pilot or feasibility trial. They specify that a Stage I manual should be an initial specification of treatment techniques, goals, and formats. They propose Stage II manuals for efficacy trials such as randomised control trials, and Stage III manuals for use in effectiveness trials to investigate the transportability and dissemination of interventions into the clinical community. They state that ‘a bare-bones stage I manual should cover the overview, description, and theoretical justification of the treatment; a conception of the nature of the disorder or problem the treatment targets; the theoretical mechanisms of change; the goals of the treatment; a

description of how the treatment may be similar to or different from other existing treatments for the disorder (as a means of highlighting its unique elements); and specification of the treatment's defining characteristics' (p.398)

Essentially Carroll and Nuro offer a meta-manual, or a manual for manualisation (Westen, 2002). However there appears to be an implicit assumption of a 'unidirectional model of treatment development and knowledge generation, in which knowledge flows from researchers to clinicians, with some room for feedback toward the end' (Westen, 2002). Westen argues for a more transactional view, in which clinical practice is seen as a resource, and he suggests the involvement of clinicians much earlier in manual development. Westen (2002) further highlights the *uncommonly differentiated factors paradox* in which the investigators' desire to distinguish clearly between different interventions conflicts with the demands of clinical practice in the real world. He suggests that for treatments that target highly specific symptoms session-by-session, specification of techniques is likely to be an appropriate form of manualisation. However treatments that target generalized affective states or interpersonal patterns and ways of regulating negative emotions, are less likely to be amenable to session-by-session prescriptions.

The tension between the researchers who develop manuals and the clinicians who implement them is also highlighted by Chorpita (2002) who argues that researchers should pilot and initially test a treatment using the therapists and the clients that the application is ultimately meant for. He writes that while Carroll and Nuro's model very helpfully highlights some of the important ingredients for early and more developed manuals it begs the broader question of where they should be built: 'If we want to build manuals *for* the real world, we should build them *in* the real world.' (p. 433)

8.2 Appropriate formats

There is general consensus that manuals should be clear, well presented and user friendly (Duncan et al., 2004; McCulloch & McMurrin, 2007). It felt important to me that it was not just the content of the manual that was creative and flexible, I also wanted a flexible and creative format for the manual. I looked for other manuals with innovative formats.

Open source online manuals, such as the Mentalisation Based Therapy with Families (MBT-F) manual, allow for continual feedback so improvements can be ‘shared, compared and integrated with other ideas from teams around the country and existing evidence, which constantly improves effectiveness’ (Guardian, No date). From an art therapist’s perspective the MBT-F manual is interesting because mentalisation is a flexible way of working which, like art therapy, is used with many different client groups. The mentalisation-based therapies have developed a network of manualised interventions which share the core mentalising stance. The ‘open source treatment approach radically improves knowledge sharing across NHS and voluntary sector teams working with the most vulnerable, disadvantaged youth’ and the manuals provide ‘an internet/smartphone app with guidelines that each team adapts, refines and improves, based on local expertise.

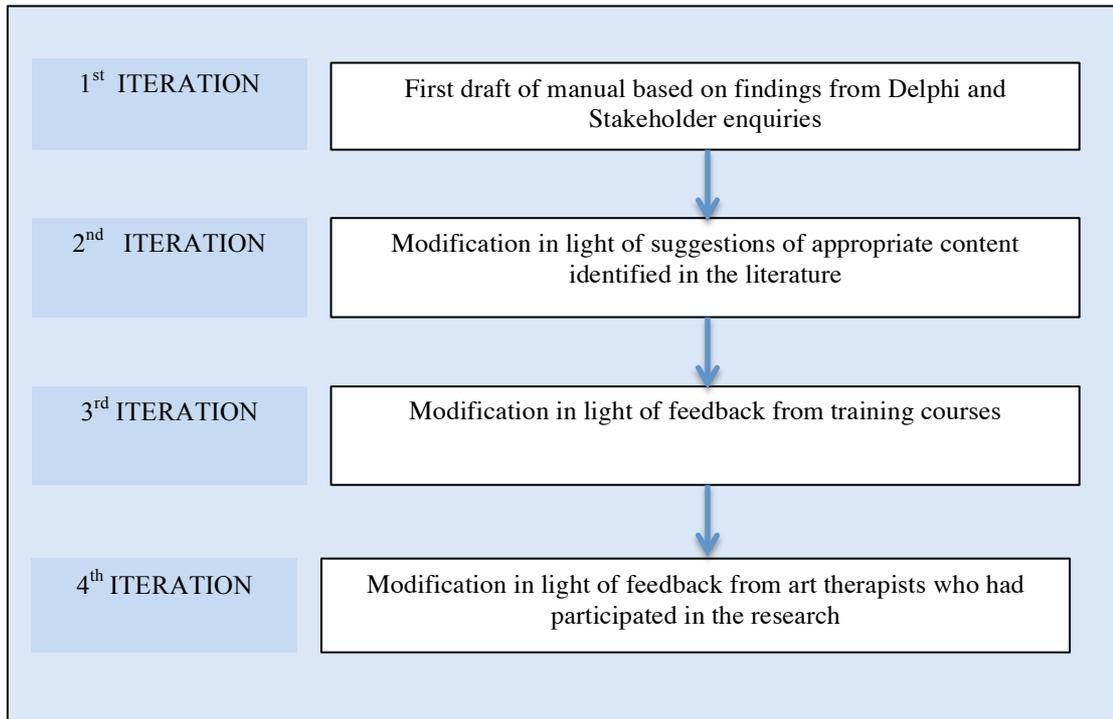
I decided that I wanted the manual to share many of the qualities of the MBT-F manual, and so determined it would have an on-line format that was flexible enough to have the potential to evolve iteratively in response to feedback from clinicians and researchers.

8.3 Method of development

Although aware of Carroll and Nuro’s (2002) model during my research, I did not use their suggestions of content as a list to work through in order to identify appropriate content for the draft manual. This was because the Stage I manual they outline is intended primarily for research purposes, specifically for use in feasibility and pilot studies. Although I wanted the manual to have this potential, I also wanted it to be useful to practicing clinicians. Also, I did not want to employ a top-down ‘unidirectional model’ as critiqued by Westen (2002). I chose instead a more transactional process which drew on clinical practice and involved clinicians in the development process. I designed empirical studies which involved art therapists and service users and used the findings to begin developing possible content for a manual. By sticking close to the data I hoped to create a manual that reflected clinical practice as the therapists and service users experienced it.

The first draft of the manual was therefore based on my empirical findings. However the manual was then modified in a series of iterations. Table 8.1 shows the iterative phases of the manual construction.

Figure 8.1: The iterative phases of construction



8.3.1 The first iteration

Thematic analysis of the therapists' interviews led to the dynamic actantial model outlined in Chapter 5, and this proved helpful as a skeleton structure for the manual. With the 'skeleton' in place the bones were easily fleshed out with the findings from the survey, the Delphi and the service user enquiry. Each component, the sources of the data it was derived from, and a summary of the details given are displayed in Table 8.1. There is also a link for each element to the place it can be seen in the appendices and the online manual (The website is best viewed using up-to-date systems and browsers such as: Internet Explorer 10; Google Chrome; and Mozilla Firefox. It is not compatible with older browsers such as Internet Explorer 9).

Table 8.1: Sources and detail of manual components

Component	Source	Detail	Additional Sources	Link
Guiding Principles	The Delphi Principles	<ul style="list-style-type: none"> • The therapeutic work aims to develop the carer’s capacity for reflective functioning • The therapeutic work addresses how the carer’s own internal working models are enacted in the relationship with the child • The therapeutic work promotes carer-child relationships characterized by both connectedness and autonomy • The therapeutic work includes discussions of attachment and emotion regulation • The therapeutic work seeks to enhance the carer’s sensitivity to the child’s emotional and behavioural signals • Great flexibility is employed in the planning of the treatment programme, respecting diversity of family history, culture and individual experience • Therapeutic work creates links with the present and past, in a historical, developmental and social context • Within the safe, bounded space of art therapy the child is encouraged to expand their ability to recognise his/her own feelings in the context of being together with the carer • Focusing on moments of attunement when warmth and playfulness emerge is at the heart of the work • Therapeutic work aims to enhance the carer’s capacity for openness, working with experiences as they occur within the session 	Link to a description of the Delphi study	Appendix 8.1 OR http://www.dyadic-art-therapy.com/intervention/

Client Groups	Survey and the therapists' interviews	The expected client group is children in middle childhood (5-15) with relational or attachment disturbances and children who have unresolved trauma. These children may be living with birth families, adoptive families, or foster families and they may have other conditions such as ADHD or autism.	Links to literature about dyadic art therapy with younger children	Appendix 8.1 OR http://www.dyadic-art-therapy.com/intervention/
Contra-indications	The therapist interviews	A thorough assessment and an appropriate level of preparation with the parents or carers is an important element of dyadic art therapy and that during this process, the therapist may on occasion decide that the presence of the parent or carer in art therapy sessions will not be helpful for the child, and may even be detrimental. In such cases a different approach should be sought, and the therapist should assess whether further action, such as safeguarding or signposting, is needed.		Appendix 8.1 OR http://www.dyadic-art-therapy.com/intervention/
Goals	The therapist interviews	The focus of the therapist's goals may shift during different phases of therapy. They are given below in a loosely chronological order: <ul style="list-style-type: none"> • To assess what is needed and what is feasible • To take a flexible needs-based approach • To ensure adequate preparation takes place • To engage therapeutically with the dyad • To join up people, ideas and actions • To enhance the caregiver and child's skills • To deal with events (links are provided to pages which go into each goal in detail)		Appendix 8.2 OR http://www.dyadic-art-therapy.com/goals/

Steps	The therapist interviews and Delphi Practices	<ul style="list-style-type: none"> • Observing and formulating • Determining dyad specific goals • Reviewing work and gauging goals • Structuring the intervention and sessions to meet the dyads needs • Adopting the most appropriate approach • Preparing themselves • Preparing parents or carers • Preparing the system • Balancing the needs of the dyad • Safety building • Facilitating joint engagement • Helping carers to see for themselves • Facilitating reflective discussions • Explaining and Educating • Modelling and practising skills with the caregiver • Modelling and practising skills with the child • Responding to events in the sessions • Processing past events • Thinking with the dyad about current life events <p>(links are provided to pages which go into each step in detail)</p>		Appendix 8.3 OR http://www.dyadic-art-therapy.com/steps/
Helpers	The therapist interviews and the service user	<ul style="list-style-type: none"> • Seeing the dyad making art together can help the therapist assess and formulate ideas • Experiential art therapy tasks for parents and carers can give parents and carers a taste of art therapy and a space to think about their own life experiences 		Appendix 8.4 OR http://www.dyadic-art-therapy.com/helpers/

	enquiry	<ul style="list-style-type: none"> • Building a sense of safety and trust between the therapist, caregiver and child can help facilitate the work • Art materials can act as a bridge, helping with engagement and connecting people and ideas. For example, art making enables the child to communicate aspects of their experience through doing rather than explaining and dyads can become more attuned to each others thought and feelings through joint engagement tasks. • Art and art making can help with regulating, containing and processing feelings • Images can be helpful as a way of recording events • Good supervision and a supportive workplace and colleagues are a great help 		
Challenges	The therapist interviews and the service user enquiry	<ul style="list-style-type: none"> • Workplace issues may have an impact on what the therapist is able to offer • Families may be wary of a new way of working, particularly the shift in focus from the individual child to the dyad • Both the caregivers and the children may find the process challenging, particularly if there are conflicting agendas • A good deal of preparation may be needed • There may be complex therapeutic dynamics 		Appendix 8.5 OR http://www.dyadic-art-therapy.com/challenges/
Advice on what to do and what not to do (proscribed	The therapist interviews	<p>Here are some tips from practicing dyadic art therapists:</p> <ul style="list-style-type: none"> • Careful preparation and assessment is essential • Get to know the parent or carer and their strengths and limitations • Be aware of the counter-transference • Understand the unique contribution of the art materials 		Appendix 8.6 OR http://www.dyadic-art-therapy.com/advice-and-help

elements)		<ul style="list-style-type: none"> • Have confidence in your own abilities and don't be frightened to give it a go • What to avoid: • Inappropriate settings. Find a protected space where you're not going to be interrupted • Rushing into dyadic sessions without adequate preparation • Starting or continuing with dyadic work if the parent isn't able to think about the child and is too preoccupied with their own difficulties • Taking sides or becoming overly identified with one half of the dyad • Starting sessions with the parent or carer giving a rundown of the past week's negative events 		
Outcomes	The therapist interviews and the service user enquiry	<p>Analysis of data from research involving caregivers and children highlights the important role of the image in dyadic art therapy. Art and art making can open alternative channels of communication between the child and carer enabling the child to communicate aspects of their experience through doing rather than explaining. The images were used to help the child develop expressive and creative skills, and they also had a key role to play in recording and processing important events and the feelings associated with them.</p> <p>Having caregivers present in the sessions was also seen as important, many of the valued outcomes highlighted by the research were achieved by having the caregiver present in sessions. Caregivers gained insights at first-hand and conversations and interactions could be initiated in sessions which the dyad would then continue afterwards in everyday life. As well as having these benefits, the joined-up dyadic approach was also seen as potentially creating a challenging dynamic, particularly if the three key participants had conflicting</p>		<p>Appendix 8.7 OR http://www.dyadic-art-therapy.com/service-user-feedback/</p>

		<p>agendas. Research with the therapists has suggested that therapists have an awareness of this issue but it is helpful to understand more about it from the service user's perspective.</p> <p>Interviews with dyadic art therapists highlight some of the changes they have seen in their work. These include:</p> <ul style="list-style-type: none"> • Establishing therapeutic alliances and building trusting relationships with service users • Building up a picture of the child's internal and external world which can be shared with caregivers during the therapy. • Building a picture of the caregivers and their strengths. • Caregivers gaining new insights and understanding. • Children's emotional (and maybe even physical) growth • Reduction in child's confusion and sense of blame • Child becomes more relaxed • Child's emotional regulation and articulation increased • Child's ability to tolerate potentially stressful situations increased • Caregiver and child gain greater understanding of each other • Changes occur within the primary attachment relationship(s) <p>There is currently no agreed or formal evaluation tool for Dyadic Art Therapy. However, interviews with dyadic art therapists indicated that it might be the helpful and illuminating to evaluate the following outcomes:</p> <ul style="list-style-type: none"> • Outcomes relating the quality of the attachment relationship between the primary caregiver and the child 		
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		<ul style="list-style-type: none"> • Stability of family or placement • Changes in caregiver sensitivity • Changes in caregiver stress levels • Child's ability to make links with current behaviours and past events • Child's ability to manage relationships; • Reflective functioning • School attendance • Attachment behaviours • Emotional literacy • Regulation and arousal and stress levels (including trauma symptoms) • Cognitive gains • If goal based outcome measures are used the outcomes might relate to progress in meeting individually established goals. 		
Therapist Competences		<p>Therapists should have an understanding of:</p> <ul style="list-style-type: none"> • Developmental trauma and the impact this has on the child's development • Post Traumatic Stress Disorder symptoms and sensitivity to the child's ability to tolerate traumatic memories being exposed • How the nervous system is impacted by trauma and stress including how to help it calm and whether a child is being activated into a stress response (fight, flight or freeze) or whether they are able to manage higher level reflective functioning • The difference between therapy with a birth parent and their child and therapy with a fostered or adopted child • Parenting strategies particularly those for children with disturbed 	Link to a description of the Delphi study	Appendix 8.8 OR http://www.dyadic-art-therapy.com/competences/

		<p>attachment behaviours so the therapist can help the carer understand behaviours and to respond to them</p> <ul style="list-style-type: none"> • Child development including stages of a child's art development • Attachment theory • Psychotherapeutic ideas of how the self is built up and strengthened • Alternative theoretical frames and an openness to many ways of working <p>Therapists should be able to:</p> <ul style="list-style-type: none"> • Use within-session events to address carer's affective responses and understanding of child's behaviour. • Maintain an intersubjective stance • Help carers think about the impact of their own history on their current parenting • Make a broad assessment of adult and children's attachment styles, recognising unresolved trauma in the adults. • Develop an understanding of the child for the carer and for the child, so that the child's feelings can be seen and acknowledged, and so the child can begin to regulate his/her own feelings and the carer can help to soothe and contain them • Recognise contra-indicators to Dyadic Art Therapy. 		
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8.3.2 The second iteration

Using the results of the mixed methods studies helped me create a structure that was linked to and had grown out of accounts of clinical practice. Once I had populated the manual with the empirical findings I was able to compare what I had with recommendations of what an early stage manual should contain (Carroll & Nuro, 2002). This identified the following gaps: mechanisms of change; rationale; a conception of the nature of the disorder or problem the treatment targets; and clinical examples and vignettes. I also discussed the first iteration in supervision where it was suggested that it might be helpful for illustrative purposes to include a draft of an adherence rating scale and to include information on who might use the manual.

I therefore went back to my data to try to understand whether any of the participants had spoken, even indirectly, about these issues. In doing so I was challenging my analysis to see if there was data relating to these elements that had not come to light in my previous analyses.

Rationale

There were findings relating to rationale in the initial survey and also in the interviews with the therapists. Both studies shed some light on the rationale therapists have for adopting a dyadic approach but I had not as yet integrated the findings into a summary of the rationale. The survey had supplied a list of potential reasons which participants were asked to score. They were also asked to add in further reasons not included the original list although analysis of the additional responses did not provide additional motivations for dyadic work beyond what was included on the list. 80% or more of therapist responding to the question said they sometimes involved caregivers in sessions for the following reasons:

- To observe the relationship between the child/young person and the parent/carer
- To enhance parent/carer observation, sensitivity and reflective functioning
- To offer the child/young person and the parent/carer a shared creative/playful experience
- To work directly with the relationship between the child/young person and the parent/carer

- To reduce any anxiety the child/young person might feel when first engaging
- To share therapeutic skills or model a way of interacting with the child/young person

In the interviews the therapists were asked why they adopted a dyadic approach. For some therapists there was an expectation within their work place that joint sessions would be offered, while for others the dyadic sessions grew out of an assessment of what would be most helpful for each family referred. Although neither of these two reasons really equate to a *rationale* for dyadic work, some of the other responses did make more explicit reference to what might be seen as a rationale. These reasons tended to be framed as what the therapists hoped to achieve by working dyadically. As such the rationale can be seen underlying some of the therapists' objectives or goals (and the steps they took to achieve these). Particularly:

- To assess what is needed and what is feasible.
- To engage with the dyad
- To join up people, ideas and actions
- To develop skills
- To deal with events

An overlap can be seen in the findings from the survey and therapist interviews. This is shown in the integration matrix in Table 8.2.

Table 8.2: Matrix of findings relating to Rationale

Factor	Survey	Therapists' Interviews	Relationship
Assessment	Caregivers invited to join in with sessions so therapists can observe the relationship between the child/young person and the parent/carer	Therapist aims to assess what is needed and what is feasible	Convergence
Engagement	To reduce any anxiety the child/young person might feel when first engaging	To engage with the dyad therapist takes the step of building a sense of safety for the child	Convergence

Caregiver sensitivity, understanding and attunement	Caregivers invited to join in with sessions to enhance parent/carer observation, sensitivity and reflective functioning AND To share therapeutic skills or model a way of interacting with the child/young person	To develop skills therapists take the step of modelling and practicing skills with the caregiver.	Convergence
Facilitating joint engagement activities	Caregivers invited to join in with sessions so therapists can offer the child/young person and the parent/carer a shared creative/playful experience	To join up people, ideas and actions therapists take the step of facilitating joint engagement.	Convergence
Facilitating reflective (mentalizing) conversations between caregiver and child	Caregivers invited to join in with sessions so therapists can enhance parent/carer observation, sensitivity and reflective functioning	To join up people, ideas and actions therapists take the step of facilitating reflective discussions	Convergence
Helping the child process past events		Therapists aim to help dyad deal with past events	Complementary
Process current events	To work directly with the relationship between the child/young person and the parent/carer	Therapists respond to events in the sessions and think with the dyad about current life events	Convergence

Integrating the findings from these two studies led to a summary of the rationale which was included in the manual:

- To observe the relationship between caregiver and child at first hand
- To facilitate joined up creative and playful activities between caregiver and child
- To enhance caregiving skills
- To facilitate reflective discussions between caregiver and child
- To work directly with the relationship between the child and caregiver
- To help the child to engage and feel safe during the therapy

Mechanisms of change

Another element recommended by Carroll and Nuro is hypothesised mechanisms of change. I did not specifically ask about this in any of the studies but I looked back at the data to see if it might be possible to identify potential, theoretical mechanisms of change. I found that it was possible to do so using the Delphi PPCs. For example, one of the Delphi principles is: *'Within the safe, bounded space of art therapy the child is encouraged to expand the ability to recognise his/her own feelings in the context of being together with the carer'*. So, development of the child's ability to recognise internal states may be tacitly understood to be a hypothetical mechanism of change. In a similar way, other PPCs can be used to elucidate tacit hypothetical mechanisms of change. This is shown in Table 8.3.

Table 8.3: Elucidation of hypothetical mechanisms of change from Delphi PPCs

Examples of therapeutic action based on PPCs	Underlying or tacit mechanisms of change	Potential outcomes
<p>Within the safe, bounded space of art therapy the child is encouraged to expand the ability to recognise his/her own feelings in the context of being together with the carer.</p> <p>The therapist develops an understanding of the child for the carer and for the child, so that the child's feelings can be seen and acknowledged, and so the child can begin to regulate his/her own feelings and the carer can help to soothe and contain them.</p>	<p>Child learns to recognise internal states, feelings and emotions and caregiver helps acknowledge and contain these feelings and can continue to do so outside of therapy</p>	<p>Increase in child's emotional understanding and regulation</p> <p>Increase in caregiver sensitivity and attunement</p>
<p>The therapist is alert to the carer's own affect and helps the carer to recognise, contain and eventually understand this.</p> <p>The therapist helps carers think about the impact of their own history on their current parenting and how the carer's own internal working models are enacted in the relationship with the child.</p>	<p>Caregiver learns to recognise own internal states, and gains a conscious understanding of own internal working models</p>	<p>Increase in caregivers' emotional understanding</p>
<p>The therapist encourages carer-child relationships characterized by both connectedness and autonomy.</p> <p>Focusing on moments of attunement when warmth and playfulness emerge is at the heart</p>	<p>Joint engagement activities and joined-up discussion</p>	<p>Increased theory of mind/empathy</p>

of the work.		
<p>The therapeutic work aims to develop the carer's capacity for reflective functioning</p> <p>Within-session events are used to address carer's affective responses and understanding of child's behaviour.</p> <p>The therapeutic work seeks to enhance the carer's sensitivity to the child's emotional and behavioural signals.</p> <p>Therapeutic work aims to enhance the carer's capacity for openness, working with experiences as they occur within the session. The therapist explores parenting strategies particularly those for working with children with disturbed attachment behaviours (it is not enough to understand disturbed behaviours, a carer also has to respond to them).</p> <p>The therapeutic work includes discussions of attachment and emotion regulation</p>	Enhancing caregivers' sensitivity to child's internal states and behavioural signals	More reflective and sensitive parenting including understanding of child's attachment needs
Therapeutic work creates links with the present and past, in a historical, developmental and social context.	Co-constructing shared narratives.	Narrative coherence

The following summary of these hypothetical mechanisms of change were included in the manual:

- Enhancing caregiver sensitivity
- Enhancing caregiver insight into impact of their own history on their parenting
- Facilitating joint engagement activities
- Facilitating reflective (mentalizing) conversations between caregiver and child
- Co-constructing shared narratives
- Enhancing child's affect recognition and regulation

Status of the manual

The manual seeks to present a developing and evolving description of dyadic art therapy rather than a definitive one. The content of the manual is based on therapists' and service users' accounts of dyadic art therapy. The research which led to the development of the manual did not focus on mechanisms of change.

Uses of the manual

As highlighted by Carroll and Nuro (2002) there are many possible uses for a manual. The art therapists involved in the research described it in terms of a clinical resource, offering information and support for therapists and the opportunity to share ways of working. The manual might also be suitable for further research, providing a description of the intervention for both process and outcome-based research.

Conception of the nature of the disorder or problem the treatment targets

When I began the research process I was interested in exploring dyadic art therapy for children who had attachment difficulties. However, the results of the survey indicated that attachment was more often an underlying difficulty than the presenting difficulty and so dyadic art therapy might be being offered to children with a range of presenting problems. This might be understood in terms of the referral criteria of the services that the art therapists worked in, or it could be understood in light of variations in diagnostic practices and terminology. There is a lack of clarity about attachment related difficulties: ‘[t]he terms attachment disorder, attachment problems, and attachment therapy, although increasingly used, have no clear, specific, or consensus definitions’ (Chaffin et al., 2006). Chaffin et al point out that the terms differ from the ‘more tightly defined, and better accepted diagnosis of Reactive Attachment Disorder or RAD’ . However it is ‘difficult to diagnose RAD accurately’ and they advise that ‘the label should be viewed cautiously.’ They go on to say that:

‘Recognizing the limitations of the formal RAD criteria, alternative diagnostic criteria have been proposed to describe broader disorders of attachment [...] In the absence of consensual and officially recognized diagnostic criteria, the omnibus term attachment disorder has been increasingly used by some clinicians to refer to a broader set of children whose behavior is affected by lack of a primary attachment figure, a seriously unhealthy attachment relationship with a primary caregiver, or a disrupted attachment relationship.’

The lack of consensus and confusion around attachment as diagnostic category led me to question how helpful it would be to specify this as the primary application.

Additionally, the survey indicated that art therapists were working dyadically for a variety of reasons. The interviews with the therapists also indicated that dyadic work

was helping with a number of issues. Some could be seen as specifically relational (such as seeing changes within the primary attachment relationship, or the caregiver and child gaining greater understanding of each other) while others (such as increases in child's emotional growth, regulation and articulation) were focused on emotional recognition and management.

This led me to wonder whether in early iterations of the manual it would be more pragmatic to leave a degree of flexibility about the potential applications. Although for clinical trials greater specificity about applications would be needed, at least in the short-term, the manual would be used for training and practice. I therefore decided to describe the application broadly as potentially helpful for children who have emotional and relational difficulties.

There is a body of literature describing the effects of developing young peoples' capacity to identify, manage, and recover from painful emotions. Pisani et al (2013) report that using internal strategies and support from key adults to manage emotional distress, may be critical in disrupting trajectories toward suicide and maladaptive emotion regulation processes have been linked to depression, (Forbes and Dahl 2005; Jacobson et al. 2010; Silk et al. 2003), anxiety (Carthy, Horesh, Apter, Edge, & Gross, 2010) antisocial behaviour (Beauchaine, Gatzke-Kopp, & Mead, 2007) and borderline personality disorder (Gratz & Roemer, 2004). It seemed therefore that the value of this application for emotional difficulties would demonstrable, and that the application itself was broad enough to cover a significant proportion of clinical practice while also offering the potential of further refinement down the line.

Adherence

I received feedback from one of my supervisors that since one of the intended uses of the manual was for research it might be helpful to include a draft of a treatment fidelity adherence rating scale. This is in-line with Luborsky and Barber's (1993) recommended content of manuals. I therefore drafted an example of a possible adherence rating scale based on the therapists' goals identified from the interview data. This preliminary draft is untested and for illustrative purposes only. This can be seen in Table 8.4.

Table 8.4: Draft adherence scale

SCORING: 0 = NOT EVIDENCED; 1 = POORLY EVIDENCED;
2 = ADEQUATELY EVIDENCED; 3 = STRONGLY EVIDENCED

A	WITHIN RECORDS SCORE EVIDENCE FOR:	SCORE 0-3
A.1	Thorough assessment and formulation The therapist ensures an adequate assessment has taken place, arriving at a formulation of what is needed and what is feasible.	
A.2	A flexible needs-based approach Goals have been discussed and agreed with the relevant people and the structure of the intervention and approach taken reflects the therapeutic needs and goals	
A.3	Adequate preparation The therapist has prepared for the work, and taken steps to prepare the caregivers and system as appropriate	
B	WITHIN SESSION SCORE EVIDENCE FOR:	SCORE 0-3
B.1	Therapeutic engagement with the dyad The therapist balances the needs of both halves of the dyad ensuring that the perspectives and needs of both are recognised. The therapist creates a sense of safety for both parties.	
B.2	Joining up people, ideas and actions Art making activities and joined up reflective conversations are facilitated. Through these activities the therapist facilitates an exploration of other people's minds and perspectives.	
B.3	Enhancing the caregiver and child's skills The therapists models and/or explains skills and ideas that may help the dyad.	
B.4	Responding to events in the sessions The therapist uses reflective responses to encourage an exploration of the session's images and interactions and directive responses to contain and manage the session appropriately	
B.5	Processing current and past events The therapist helps the dyad to use art materials and reflective dialogues to explore and process current and past events.	

Issues such as inter-rater reliability and the threshold for deciding whether or not treatment is sufficiently faithful to the model have not yet been explored. Testing of the adherence scale would need to take place before it could be used in further research. Although I have no immediate plans to do this, it is something other researchers could do.

Clinical Examples and vignettes

The interviews with the therapist were a rich source of detailed clinical descriptions and I found some of the cases they described compelling. Carroll and Nuro (2002) recommend that Stage I manuals include clinical examples and vignettes so I extracted

some directly from the therapists' accounts, and put them into the manual. I also added in two more from my own clinical practice which I had written for training purposes and which I thought might add useful illustrations.

8.3.3 The third iteration

As I came towards the end of my research I decided to co-facilitate two training courses in dyadic art therapy for the British Association of Art Therapists. Thinking about the content of the training with another highly experienced art therapist helped me review the content of the manual and think about helpful ways of presenting the information I had gathered. Although the training was not explicitly based on the manual I did present some findings including the Delphi PPCs, and elements of the actantial analysis. The training courses were attended by 44 art therapists working in range of settings. Delivering this training provided informal feedback on the relevance and comprehensiveness of the material presented. It also helped identify gaps in the material. The training used a number of role-plays so that the participants could practice their new skills, and feedback from the first course was that participants had found the role-plays very helpful but would value seeing videoed role-plays for illustrative purposes. In preparation for the second course, my co-facilitator and I role-played and recorded three dyadic sessions and one preparatory session. We played these at the second course and received very positive feedback. For this reason I decided to include them in the third iteration of the manual.

8.4 Feedback from stakeholders

In September 2014 a hyperlink to the manual was sent out to the Delphi panel and the therapists who had participated in the interviews, accompanied by a request for feedback and a feedback form (see Appendix 8.9). A link and a feedback form was also sent to a small number of art therapists who had expressed interest or supported the research along the way. I did not ask service users to review the manual as it is designed to be a tool for clinicians and I wanted feedback from the potential end-users of the manual.

Nine of the fourteen therapists who had participated in either the Delphi or the stakeholder enquiries responded with feedback within the specified timeframe. Of these nine reviewers, four responded using the feedback form and five responded less

formally by email. Feedback was also received from four art therapists who had been involved in the research in other ways such as piloting or sharing their own experiences of drafting manuals. In this process some technical difficulties were identified possibly caused by filters on work-based computers or lack of software compatibility.

The feedback was collated and can be seen in Appendix 8.10. A thematic analysis of the reviewers' comments took place and identified the following themes: initial impressions; charting new territory; a clinical resource; a resource for evaluation and research; a reflection of participant's views; improvements. These themes will be discussed in detail below.

8.4.1 Results

Initial impressions

The reviewers commented favourably on the format and characteristics of the manual, particularly on the power of the images, the layout of the manual and its clarity. Some reviewers also commented that it might take time to become accustomed to the layout and that people who were unfamiliar with computers might prefer a hard copy. All these issues will be now be explored in more depth.

Quotes will be identified by a letter and then a number. P1-P9 are art therapists who participated in either the Delphi or the therapist interviews; N1- N4 are other art therapists who had expressed a particular interest in the manual.

The power of the images

A number of the people who gave feedback on the draft manual commented favourably on the use and range of images. Some people commented on individual images, for example the image of the family in the boat was described as "extraordinary". Other viewers commented on the power of the images overall to promote and illustrate the visual communication possible in dyadic art therapy:

"I really loved the images which are an integral part of the manual, really good in themselves and for promoting art therapy through images, and letting people take in information visually" P9

Layout

There was also favourable feedback given about the layout which was described as “lovely” and “easy to read”. One person commented on the way the material was broken down into separate sections but had links to related sections:

“ [I] feel it is really well put together and so informative. Particularly like the way it is broken down into different headings and the useful links to more info on a subject or research etc. Really looks good and reads well” N2

Clarity

Feedback indicated that reviewers valued the clarity of the manual. The information was seen as being and presented in a concise way which would give art therapists interested in dyadic art therapy enough information to begin, and would also signpost people to relevant research:

“I like the clarity - for instance observing and formulating. This is clear, informative and helpful. Similarly [sic], Structuring the Intervention and Sessions is concise and helpful with an important comment on being aware of the carer's own past and how this might impact on dyadic work. The joint engagement research is also extremely interesting and relevant.” P7

Usability

The feedback indicated that the reviewers generally thought that the manual flowed well and was easy to navigate:

“An extremely useful, user friendly and interactive manual. Really well written with great images, aesthetically pleasing and smooth to navigate.” P1

However, there were a few qualifiers given by reviewers in terms of the usability. One said that although it became quite easy to use with a great deal of readily available information, it had initially seemed cumbersome to use. Another reviewer suggested that although people who are computer literate would love the manual, those who were less capable with computers might find it harder to engage with. This reviewer wondered if it might be possible to produce a hard copy for those who were less comfortable with technology. A final qualification was that it might be possible to miss material if people did not follow the links provided:

“Perhaps because the hyperlinks seem to take you into deeper levels if further information is required. This is helpful but I initially read it through and then went back to follow the links afterwards.” P4

Charting new territory

Feedback indicated that reviewers thought the manual broke new ground. The manual was seen as providing inspiration and as an achievement both for the profession and for me as a doctoral student.

Different

Feedback indicated that the reviewers saw the manual as a “refreshing change”, an improvement on what had come before and different from what they expected:

“I didn’t have much idea what an online manual for art therapists would be like. The word manual sounded a bit dry. What you have created far far exceeds any expectations I had and it is definitely not dry” P2

Descriptive

Criticisms of psychotherapy manuals sometimes focus on highly prescriptive formats. However, reviewers described the manual as providing a descriptive rather than prescriptive account of the aims, purposes and different aspects of the work:

“It provides a descriptive context of dyadic work taking into account how a person functions emotionally and intellectually” P6

Inspiring and motivating

Two reviewers described feeling inspired or motivated by the manual. One reviewer described feeling excited and motivated by the work and another cited parallel efforts to produce a draft manual:

“The adherence scale was also inspiring. We’re hoping to have a draft manual for November.” N4

A professional and a personal achievement

As well as commenting on the importance of the manual as a resource for the profession, reviewers also framed the manual as a personal achievement for me:

“I think it is a great website and so useful, it explains everything so well. You’ve put so much work into it! What a fantastic gift to the profession.” N2

One reviewer described the balance achieved between the personal and the communal nature of the enterprise:

“It is [...] lovely that it has been partly a collaborative project but completely held together by your energy and creativity.” P9

A clinical resource

Many of the reviewers described the manual as a “helpful”, “excellent” and “invaluable” resource for art therapists.

Insight and understanding

Feedback was given to say that the manual would give art therapists insight into supporting children and families with emotional difficulties, highlighting the importance of interactional issues including the parent’s ability to work in this way:

“I think the manual is excellent and gives insight into the complex nature of relationships between a child and their caregiver” P6

Reviewers also said that the manual helped to signpost people to ways of developing their clinical practice further: “[I]nformation and signposting to further ways to learn is brilliant” P9.

A framework

The manual was seen as having the potential to provide a framework for art therapists to deliver a relational intervention:

“Whilst we understand attachment framework and theory this does not always provide a framework in which to work with these difficulties.” P6

The manual was also seen as having the potential to provide a framework of knowledge and competences for dyadic art therapists:

“The manual enables the clinician to understand what competence and level of experience they require in order to work in this way which is important. It demonstrates a level of skill needed in understanding the effects of trauma and the needed for safety and containment” P6

A learning resource for art therapists starting to work dyadically

The manual was described as a learning resource for art therapists who have not done dyadic work before to help them think about the ways it can be used and how to deliver it in a safe way:

“For art therapists who have neither done dyadic work before nor had any training it will also be a really amazing resource particular [sic] to help them get started in a safe way and begin to open their minds to the potential uses of a dyadic approach” P2

Reviewers also seemed to think that the manual might help to reassure art therapists perhaps particularly those who were feeling anxious about starting up dyadic art therapy:

“I think assessing and considering starting up dyadic work can be anxiety provoking and guidance/tips/reassurance and links to vignettes are very helpful.” P4

However, concern was expressed by one reviewer that referring to the manual might influence a new therapists' spontaneity:

“For those who are about to do so, it might make the intervention seem too complex, which it is, but needs to be tried first, with some trial and error for the therapist to learn.” P3

A resource for evaluation and research

Some of the reviewers considered the manual from the perspectives of other potential users, such as dyadic art therapists wanting to write case studies or conduct research and evaluation. Reviewers commented that the manual demonstrates the complexity of the work and could serve to highlight to others the potential use of dyadic art therapy when working with emotional and relational issues between children and caregivers. The manual was seen as having use as a framework for writing individual case studies and for other studies which might develop the evidence base for art therapy:

“I am so pleased this piece of work has evolved. It feels like a laying down of some much needed foundations in this area of work and research, a good solid base for art therapists to consider and share” P1

A reflection of participants’ views

Feedback from the therapists who participated in the research and completed the formal feedback sheet unanimously confirmed that the content of the manual reflected the ideas they had shared during the research process.

Improvements

Important issues that should be covered

A comment from one reviewer highlighted that the sections pertaining to safeguarding needed to be made more visible:

“I was uncertain or may have missed safeguarding issues and what may need to happen if a parent is unable to demonstrate emotional warmth to a child. Referral to other agencies including Children's Services may play a part in the dyadic work and in itself can be an intervention.” P6

Building on what is already there

Some reviewers gave ideas for additional material that could be developed for inclusion in future iterations of the manual. Ideas included: a downloadable leaflet for service users; links to Dan Hughes’ Dyadic Developmental Psychotherapy literature and videos; information about future BAAT dyadic art therapy trainings; information about evaluation tools that dyadic art therapists have been using ; useful journals/books/articles/tools that may help the clinician to talk with the parents about these issues (psycho-education); and links to YouTube clips or lectures that people have found helpful for use with caregivers.

Changes

A few reviewers mentioned specific changes they would like to see in the content. Changes suggested included greater clarity that the “helpers” section referred to things which could help the process rather than what the process can help deal with (e.g. outcomes or benefits). The reviewer suggested a change in the title to clear up the ambiguity. A different reviewer took issue with a statement that sometimes more than

one primary caregiver is involved, stretching the concept of “dyadic”. The reviewer felt that stretching the concept could result in a lack of clarity about the intervention and boundary issues in sessions.

Finally one reviewer feedback that one of the images was not as sharp as the others:

“I think the first image in the "about the manual" section could be stronger and more in focus. I love the idea of the go gos lining up, they look ready for action and about to start to sort themselves out but I think it is not as strong as the other photos in terms of the lighting and sharpness.” N1

8.4.2 The fourth iteration

After receiving the feedback I made some changes. The image of the “go gos” had been mentioned twice, one comment was very favourable, but the other suggested it was not sharp enough. Both reviewers had seemed to like the symbolic value so I decided to keep the image but to enhance the lighting and sharpness.

The issue about the ambiguity of the helper page was addressed by changing the explanatory wording to: *Research with art therapists and service users suggests that there are some things which aid or enhance the process of dyadic art therapy.*

The issue of stretching dyadic work to include more than one caregiver was carefully considered. The feedback from the reviewer said:

“The therapist stretching the dyad art therapy concept may have boundary problems and in [sic]unable to set strong rules with the parents about this process” P3.

I replied by email to the reviewer saying it was an interesting point and that the issue had arisen in the Delphi, as one of the suggested PPCs began “Sessions include only one parent”. However when the panel voted on this principle it did not achieve consensus as appropriate. Comments from the panellists who disagreed indicated that they thought it depended on the case and that flexibility in planning the treatment was important. The reviewer wrote back to me saying that flexibility was important and dyadic work could include family sessions and parental meetings but the reviewer still

felt it was confusing to say the dyad could be stretched to include more than one caregiver.

I decided that it could be confusing and that it would be best if the statement on the page entitled *About the Intervention* were as clear and simple as possible. As details about who attends which sessions are given in the body of the manual, I changed the opening statement to *Dyadic art therapy is a joined up approach to art therapy involving children and their parents or carers in joint art therapy sessions at least some of the time. The make-up of the dyad varies with different children and different family set-ups, but usually involves the child and an adult with whom the child has a significant and enduring relationship.*

8.5 Summary

The manual went through a number of iterations the last of which incorporated feedback from art therapists who had participated formally or informally in the process. The feedback identified positive responses. However, the reviewers were people who already had an interest and possibly an investment in dyadic art therapy and in my research so their feedback is unlikely to be fully representative of the wider professional body. It will be important to widen feedback sought in future iterations.

CHAPTER 9: Discussion

The aim of this thesis was to develop content for a dyadic art therapy manual for use in research, clinical practice and training. The manual is now ready for testing and further iteration by clinicians and researchers. In this discussion key findings are summarised and strengths and limitations of the research process are discussed.

9.1 Summary of findings

9.1.1 Relevance of manual

The survey of art therapists in the UK identified that 60% involved parents and carers in art therapy sessions with some degree of frequency. Respondents reported interest in parent-child work but few had specialist knowledge or training in dyadic approaches. This identified the relevance of the manual to contemporary art therapy in the UK and also the potential usefulness of a manual that could be used in training and sharing practice.

9.1.2 Empirically based content

The manual was based on empirical studies involving experts, practicing dyadic art therapists and service users. The content includes: guiding principles; competences; goals and the steps the therapists take to achieve them; challenges; helpers; and outcomes (from both the therapists point of view and the service users' point of view).

9.1.3 Findings which resonate across the data sets

There were some themes which resonated across three or more data sets. These were:

- Enhancing caregiver sensitivity to the child's thoughts and feelings
- Facilitating reflective conversations and interactions between the caregiver and child
- Developing the child's emotional recognition, expression and regulation
- Ring-fenced time and space in which the dyad can be playful and creative together
- The role of art making in the therapeutic process
- Observing the dyad's interactions

Some findings, such as ring-fenced creative time, draw out the therapeutic potential of a joined-up approach and therefore elucidate the distinction between dyadic art therapy and individual art therapy. Other findings, such as developing emotional recognition and expression and regulation, may not be unique to a dyadic approach to art therapy but may be enhanced by the presence of the caregiver.

9.1.4 Feedback

The therapists who participated in the study either formally or informally (e.g. in piloting) were invited to critique an iteration of the manual and give feedback. Thematic analysis of the feedback indicated that initial impressions were positive although some reviewers thought the web-based format might be a little difficult for some users to get used to at first. The manual was seen as charting new territory for the profession, providing a valuable clinical resource as well as a resource for evaluation and research. Those who had been research participants confirmed that the manual reflected the views they had shared in the research process.

9.1.5 The web-based manual

The web-based manual can be viewed at www.dyadic-art-therapy.com . The website is best viewed using up-to-date systems and browsers such as: Internet Explorer 10; Google Chrome; and Mozilla Firefox. It is not compatible with older browsers such as Internet Explorer 9. Selected pages of the manual are shown in the Appendices 8.1- 8.8.

9.2 Strengths and limitations

9.2.1 Strengths

The content for the manual was initially developed through empirical research involving over 100 participants including: 85 art therapists who participated in the survey; 8 experts who took part in the Delphi study; and 6 therapists, two caregivers and two children who were interviewed. As such the manual represents many stakeholder views and has established a degree of consensus from within the professional community and incorporated feedback from that community.

The dynamic actantial model I developed and used in the analysis of the therapists' interviews provided a useful structure for the manual. The idea of the therapists taking

steps which could be choreographed into a sequence that is unique, needs-based but also identifiable helped me find a balance between specification and flexibility identified in the interviews as important to art therapists. As UK art therapists move towards recognition of the need for greater specificity and clarity about art therapy interventions this manual can be seen as breaking new ground, as a descriptive but flexible, web-based manual.

The content of the manual was developed from studies that sought to capture something of the service users' experience. Although I was not able to recruit as many service users as I had hoped to, my reflections on the difficulties I encountered, particularly the problem of how to capture very young children's views, can be used to inform more appropriate ways of incorporating their views in future iterations of this manual or in the construction of other art therapy manuals. In the past this has not necessarily been a standard part of the development of psychological therapy manuals or clinical guidelines, something which has been highlighted as a shortcoming (Springham, Dunne, et al., 2012).

Research participants were invited to help iteratively refine the content to check accuracy and, because they were practicing art therapists, relevance to clinical work. Feedback from therapist participants reviewing the manual indicated that from their point of view the manual content and characteristics were appealing to art therapists and achieved a satisfactory balance between specificity and creativity.

9.2.2 Limitations

Design

Reviewing my research I can see that each component could have been improved and that the methods selected had some inherent limitations for the purposes I was using them. I can also see that the design of the whole study relies on stakeholders' descriptions and accounts of the intervention and does not directly explore the process to understand the mechanisms of change. The focus on stakeholder accounts rather than observable process was selected because I found so few descriptions of dyadic art therapy with older children that it seemed to me I needed, as a first step, to establish a description of the intervention. It would have been premature to focus my main research on mechanisms of change, however I can see that if I had inquired at each stage of the

work about mechanisms I could have gathered valuable data and begun the process of understanding the mechanisms.

The survey

The survey was an efficient way to find out about prevalence of dyadic art therapy in the UK and shed light on its rationale and theoretical influences but, had the survey been conducted later, I could have included questions about potential applications and asked about hypothesised mechanism of change.

The Delphi

The Delphi panel could also have specifically focused on mechanisms of change and rationale. However, other inherent limitations of the Delphi method would still have had an impact. Using a consensus method if there is a lack of consensus is clearly problematic and this means that it might not have been the best method to choose. Also, the small field of experts in dyadic art therapy meant that I included people with related expertise, which is likely to have impacted on the findings as the small panel size meant that the weight of each panellist's scoring was considerable. In retrospect I wonder whether I could have omitted the Delphi and gathered more relevant data by adapting the other studies.

The stakeholder interviews

The interviews with service users could have been designed differently to focus on mechanisms of change and more successfully capture the children's views. It proved more difficult to recruit dyads than I had envisaged and for future research I would acknowledge this and allow more time. I would also change the format of the interviews. I chose the Reflect Interview, which involves images which the participants are invited to discuss, but with hindsight I think it might have been more appropriate to have used a multi-method format for interviewing the children which had play and art-making as part of the data collection process. Also, I chose joint interviews because I thought that it might be too daunting for vulnerable children to meet a stranger and review difficult and potentially painful material without a safe and known adult present. However having the caregivers present, and in one case at the child's request, also the therapist, will have had an impact on the dynamics of the interview, and I wonder in retrospect if there might have been other ways to create a sense of safety for the children.

Clarity about applications

At the start of my research I was interested in exploring dyadic art therapy for children who had attachment difficulties. However, the results of the survey suggested that dyadic art therapy was being offered to children with a range of presenting problems. I also found that there was a lack of consensus and confusion around attachment as diagnostic category and I therefore began to question whether the manual should specify attachment difficulties as the primary application. I decided to leave a degree of flexibility and to describe it broadly as applicable for children who have emotional and relational difficulties.

Clarity about mechanisms of change

Carroll and Nuro (2002) suggest that an early stage manual should include a conception of the disorder or problem and an explanation of theoretical mechanisms of change related to that disorder. However, my decision to keep the potential applications flexible made it difficult to identify specific mechanisms of change. Although attachment theory and attachment-based therapies were relevant to dyadic art therapy, it was clear from my research that other models were also relevant.

It is a limitation of the research that it does not posit or seek to identify clear mechanisms of change. The manual provides a description of Dyadic Art Therapy which is based on therapists' and service users' accounts of Dyadic Art Therapy, and one of the next steps could be to engage in process research to identify mediators and mechanisms of change.

Theoretical thematic analysis

Braun and Clarke (2006) distinguish between inductive and theoretical thematic analysis. Inductive analysis is 'bottom up' with the coding process strongly linked to the data and not driven by the researcher's interest, whereas theoretical thematic analysis is driven to a greater degree by the researcher's theoretical or analytic interests. Analysis of the therapists' interviews started inductively but was most similar to the description of theoretical thematic analysis because it was driven by my clinical and theoretical interests in how therapists delivered dyadic art therapy.

Theoretical thematic analysis tends to provide less rich descriptions of the data but more detailed analysis of specific aspects of the data (Braun & Clarke, 2006, p. 84). My theoretical analysis of the therapists' interviews gave rise to a helpful structure for the manual and within that structure specific details are given about goals, steps, challenges, helpers, outcomes and influences. However, by opting for a more theoretical analysis I sacrificed the greater degree of depth which an inductive analysis might have provided.

Multi-purpose manual

The primary aim of the research was to identify content for a manual of dyadic art therapy for school aged children who have emotional and relational difficulties. At the outset I wanted to construct a manual that would be useful for treatment, training and outcome-based research. On reflection I can see that one of those aims became overshadowed by the other two. As I became immersed in the Delphi and the therapist interviews I began to be pulled, emically, towards the art therapists' perspective. I began to understand the value which they placed on freedom and flexibility, and when I began to construct the manual it was with the hope of producing something which art therapists would find helpful and acceptable. I had been pulled towards seeing the therapists as the primary users, and images of future researchers who might use the manual began to fade into the background. This tipping of the balance, which was at first unconscious, is evident in the feedback process which was designed to collect the therapists' views, but not the researchers' views. Future iterations could be improved by incorporating feedback from researchers and perhaps commissioners.

However, the question arises of whether it was feasible to produce a single manual that serves both functions. A manual for outcome research would need to have observable competences that could be rated. However competences agreed between practitioners, such as those derived in the Delphi, will not necessarily be observable in sessions, so it may not be possible to reliably rate treatment. Open, flexible competences favoured by clinicians may be seen by researchers as fuzzy and hard to rate. There may also be a tension between the current format of the manual which can be iteratively refined by stakeholders and the need for a more fixed manual to be used by researchers. If the manual is going to be used in outcome research then a modified version may need to be produced for that purpose. The competences would need to be reviewed to filter out non-observable ones, and comprehensive scales of adherence and competence

developed and tested. In addition greater specificity of the client group that the manual is aimed would be needed. Also the manual would need to become fixed at that the start of the research, with a single iteration being used.

One potential explanation for the tipping of the balance in favour of therapists as end-users rather than researchers lies in my growing appreciation of the complexity of running clinical trials. While completing the research I was asked to be a clinical advisor for a systematic review of the clinical and cost-effectiveness of art therapy for people with non-psychotic mental health disorders (Uttley et al., In Press). I noted that of the four trials identified which involved children, three were in time-limited group formats, and the conditions addressed had more straightforward aetiologies, resolution and outcomes than the complex interpersonal issues identified in my research. So, as I began to think about putting together a proposal for a trial of dyadic art therapy I was struck by a number of hurdles, not least the heterogeneity of the population. I realised that it would probably be better to cut my teeth on a more straightforward art therapy intervention with a more homogenous client group.

9.3 Transferability

9.3.1 Transferability of manual beyond the original purpose

The manual produced is specifically intended for use by art therapists working dyadically with children in middle childhood, and so transferability may be limited beyond this population. However, some aspects of the findings may have relevance to other populations. For the profession of art therapists as a whole there may be interest in an example of a creative and user-friendly manual developed by empirical research. During the project I made links with other art therapists who were thinking about manualising different art therapy interventions. I shared with them some findings about the steps therapists take to achieve their goals. They fed back that this has helped them think about their manualisation projects, and a request was made that I help the art therapists in a London trust engage with the process of manualising their arts therapy interventions. Feedback from this group also stated that the adherence scale I drafted was ‘inspiring’.

9.3.2 Transferability of skills I have developed

In the future I will be able to use the skills and knowledge I have acquired to construct manuals for other art therapy interventions. As discussed above, I have made links with other art therapists thinking about manualising and I have already shared with these people some of my findings and ideas about manual construction. I have published a paper in the professional peer reviewed journal about creative manuals (Taylor Buck & Dent-Brown, 2014) (see Appendix 1.1) in which I present the idea of a linked network of wiki-type manuals for different art therapy interventions and I could use some of the skills I have developed during my PhD to help people construct this network.

Additionally, shortly after I designed the Delphi study I was asked by a group of art therapists to help them use consensus methods to develop principles of best practice. I did this and have since had requests from two more special interest groups for guidance.

9.4 Relevance

9.4.1 Relevance to art therapy research

There may be interest in the findings about the use of the RI with children under the age of twelve, as this is an area that does not yet appear to have been reported on. More research is needed into how younger children perceive art therapy, even though, as the discussions in this thesis indicate, careful thought will be needed about the best way to gather those views. Additionally the views of caregivers may be a useful starting point for more a formal gathering of the views of parents and carers whose children are receiving art therapy interventions of any variety. The elucidation of potential theoretical mechanisms of change may be seen as a contribution to the growing body of literature concerning the agents of change in art therapy.

Additionally the protocol I developed for constructing the manual may be of interest to other art therapy researchers who wish to construct their own manuals. Westen (2002) coins the phrase ‘a manual for manualisation’, and it may be the case that the protocol I used can be transferred for use on future constructions of art therapy manuals.

9.4.2 Relevance to clinical practice

During my research I have co-facilitated two training events for the British Association of Art Therapists (BAAT) with over twenty participants at each event. Three more BAAT training events are planned for 2015. A local hospital trust has also asked me to

provide clinical supervision for their entire art therapy group who have been asked to provide dyadic art therapy for children with attachment issues who were being held on a waiting list for a different, over-subscribed, intervention. Dyadic art therapists who attended the training are already seeing promising results, as suggested by this recent email message I received:

“I just said goodbye to my current dyadic AT family and in last feedback session I had asked them to fill in the PSI (Parent Stress Index) and ERC (Emotional regulation checklist) again and we compared the results. It was so good as this had recorded a lowering of dysregulation behaviours and increase in emotional regulation. Mum's PSI scores had levelled out and she had also noticed child's stress symptom had reduced. It was such a great visual source to see the scores and be able to discuss the positives. [...] They were really complimentary about the approach and were really happy for me to use their work to help inform others about dyadic AT”.

9.5 Reflexivity

I became aware during the process of times when my subjectivity impacted to a greater or lesser degree on the research. As discussed in the individual chapters, there were interpersonal power relationships to be negotiated. Interviewing the art therapists was complicated because I shared a profession and professional contacts with them. The interactions were characterised by subtle power relations based on length and depth of professional experience. During the interviews with the children the power dynamics were also complex because of the combined presence of the child, the caregiver, and in one instance the therapist. Additionally, because I am an art therapist this may have impacted on how freely they felt able to speak to me.

My research began from a specific perspective which was my own interest as a clinician in dyadic art therapy and I recognise that I cannot be entirely objective. My professional experience as an art therapist may have meant I was inclined to privilege the therapists' perspective which is reflected in my decision to allow the dynamic actantial model which I developed during analysis of their interviews to shape the content of the manual. Originally I had seen the client interviews as feedback rather than having equally important status in shaping the manual. Discussions in supervision helped me to

see the role of the client interviews more clearly and develop the first iteration of the manual based on their views.

Also, sharing the therapists' perspective may have led to me being emically drawn to their position as end users of the manual. As discussed above, the manual was intended for use both as a clinical and a research resource. As someone who has worked as an art therapist for two decades I am likely to have identified far more readily with the therapists who might use the manual than with the people in the field of research which I have entered much more recently.

Throughout the project I continued to develop my clinical practice, informed by my reading and my research findings. I also co-facilitated two training courses, which drew on and explicitly referred to my research findings. I have tried to keep an awareness of the distinction between my clinical work and the research, and notice the degree to which my clinical work has influenced the development of the manual. However I must own the impact of my clinical practice and my clinical learning. I have added into the manual two vignettes from my own clinical work and some role-plays produced for the trainings and I have been explicit about this.

9.6 Findings in the context of other research

9.6.1 Research into dyadic art-therapy

The most comprehensive account of dyadic art therapy to date is provided by Lucille Proulx (2003) in her book *Strengthening Emotional Ties through Parent–Child-Dyad Art Therapy*. Whereas the manual I have constructed (referred to henceforth as ‘the manual’) focuses on a treatment intervention for children in middle childhood involving individual dyads, Proulx states that her approach focuses on work ‘in the prevention field’ (p.19) with the early childhood population, and is predominantly delivered in a group format. Although Proulx does provide some information about work with individual dyads and older children, and some of the case-studies she presents describe more than just preventative work, these case-studies and scenarios appear to be given as additions or adaptations of the dyadic infant and preschool groups which are the main focus of the book.

Proulx describes the specific aims of the intervention as:

- Including the parent as a participant
- Providing a window to monitor progress in the parent-child relationship
- Permitting therapeutic input

These aims can be compared to the therapists' goals outlined in the manual, which are:

- To assess what is needed and what is feasible
- To take a flexible needs-based approach
- To ensure adequate preparation takes place
- To engage therapeutically with the dyad
- To join up people, ideas and actions
- To enhance the caregiver and child's skills
- To deal with events

Proulx's aim of including the parent as participant clearly has some common ground with the aim in the manual of joining up people, ideas and actions. Proulx mentions the therapist's role as a facilitator and in the case-examples and commentaries the emphasis appears to be on facilitating joint creative activities and helping the caregiver to follow the child's lead. This potentially resonates with two steps the manual highlights, namely facilitating joint engagement and helping the caregivers to see for themselves. However the manual also describes other steps which the therapist takes towards the aim of joining up, one of which is facilitating reflective discussion. Feedback from the service users indicated that caregivers valued the role the therapist could have in 'getting the ball rolling' in terms of discussions. Proulx does not focus on reflective or mentalizing conversations; this is probably because her work is predominantly with the pre-school age group in which reflective conversations between caregiver and child are not feasible because the child's reflective function and verbal ability is not yet developed sufficiently.

The manual describes one goal as the assessment of what is needed and feasible, and detail is given about the steps the therapists described taking to achieve this goal, namely: observing and formulating; determining dyad specific goals; reviewing work and gauging goals. Proulx's second aim of providing a window to monitor progress in the relationship is not given explicitly as relating to assessment or formulation, but it does appear to be describing a continuous process of review. Proulx does not elucidate

extensively on the formal assessment process used. She simply provides an appendix with references for assessment tools, at the beginning of which she states that it is important for the art therapist to get as much information as possible when working with the infant and preschool population, including a family history, a pregnancy and a birth history.

Proulx's final aim of permitting therapeutic input is tacitly unpacked throughout her book. Proulx provides a lot of information about the theories which have influenced her work and the symbolic quality of specific art materials. For example, she writes that the texture and quality of sandpaper and chalk 'stand for impermanence' and flour 'symbolizes germination and growth' (p.70). With each of the activities which Proulx suggests there is a specification of the symbolic meaning and developmental potential. For example for an abstract collage activity she writes: 'Within a boundary created for the child and the parent to interact, sticking objects to the surface becomes a concrete attachment symbol [...] The dyad becomes stimulated by the color and texture of the paper, and by shaking of the material onto the collage' (p.119). Some art therapists might find this a little over generalised or prescriptive. The findings of my research suggest that art therapists tend to value a case by case approach that would preclude hermeneutic generalisations such as those given by Proulx.

The importance of taking a flexible needs-based approach was highlighted in the empirical studies used to develop the content of the manual. This is not something which Proulx explicitly identifies as an aim of the work, however a flexible needs-led approach is more possible when working with individual dyads than it is with groups when there may be a range of different needs pertaining to the different dyads who make up the group. As such Proulx's groups are perforce more prescriptive and less focussed on the particular needs of each individual dyad. However, she does tailor her approach when working with individual dyads, allowing more client-led activities and only suggesting a task if the dyad appears stuck.

One of the focuses of the manual is the challenges the work presents for the therapists and the dyads. Proulx discussed transference and countertransference issues, highlighting that the dynamics may be overwhelming for the beginner and stresses the importance of personal therapy and supervision. However, there is little discussion of

other challenges, particularly from the child or caregiver's perspective, which are covered in my manual.

In summary, Proulx's book represents a single expert's views and practice whereas the manual has been developed through empirical research involving over 100 participants. Proulx's book also focuses on group work with the pre-school age range whereas the manual focuses on work with individual dyads and comprised of caregivers and children in middle childhood. Proulx's book emphasises theoretical orientation and prescribed activities rather than broad principles and goals. Competences are not explicitly given, challenges are not greatly elucidated and the service users' voice is not represented. However, Proulx does provide greater detail about the therapeutic qualities of the art making, although these qualities are not necessarily substantiated by empirical research.

9.6.2 The wider research context

Some of the findings from my empirical studies are not specific to dyadic art therapy as they relate to other types of parent-child or relational therapy or to other types of art therapy. For example: the importance of observing caregiver-child dyads, making a formulation of need and then tailoring the intervention for each dyad's needs is highlighted by Circle of Security (Pazzagli, Laghezza, Manaresi, Mazzeschi, & Powell, 2014); helping the caregiver gain insights about the child's inner world is highlighted by approaches such as Watch Wait and Wonder (Muir et al., 1999); the ability to build a trusting relationship with clients, is seen as a generic competences or requirement of all psychological therapies (Lemma et al., No date); and the findings that art materials can create interpersonal connections, record events and process feelings have been identified by other art therapy researchers (Springham & Brooker, 2013). However there are some findings which may be unique to an art-therapy based relational approach such as creative joint engagement, seeing the art-making process at first hand and co-constructing meaning with images and words. These are discussed below.

Creative joint engagement

Dyadic art therapy offers the dyad the opportunity to jointly engage in art making activities. Recent research has shown the impact that symbol-infused joint parent-child engagement has on the acquisition of theory of mind: 'periods of symbol-infused joint

engagement may provide children with opportunities to interweave symbols into shared activities in ways that have been shown to facilitate the development of theory of mind' (Nelson et al. 2008, p.848). The study indicates that when engaged in joint parent-child activities the toddlers are not only in a position to compare their own feelings about an event with the adult partner's emotional reaction to it; they can experience their adult partner as an intentional being, able to react to the toddler's actions and also to initiate new actions. The researchers conclude that:

'Both observing a partner's actions on and reactions to shared objects during periods of coordinated joint engagement and discussing shared objects during symbol-infused joint engagement may provide vital information about other people's mental states.' (Nelson et al., 2008, p.851)

Although this research focuses on the joint engagement of parent and toddler in shared task it seems likely that joint making activities with older children and their parent or carers could also foster important and potentially therapeutic processes in the child and also perhaps in the adult. The findings indicate that dyadic art therapy has the potential to offer the parent and child opportunities for joint engagement tasks and encourages discussions of the task as well as an appreciation of the other person's perspectives. This finding is not one likely to be shared by research into individual art therapy or other relational therapies that do not include creative joint making.

Seeing the art-making process at first hand

When caregiver and child paint, design, build or draw an image together or in each other's presence, each of them (and indeed the therapist) has the chance to see things they might otherwise not be privy to. One of the therapists highlighted how helpful it was as part of an assessment to see the dyad engaged together in a joint making activity, which could give a sense of the relationship between the child and the parent and highlight things which had not been immediately apparent.

Watching their children carry out art-based activities, noticing their actions, responses and feelings may give the caregivers fresh insights. The data provided examples of caregivers seeing their children in a new light and gaining greater understanding. In the more traditional individual art therapy model, these insights would be noted by the therapist and maybe shared in review meetings with caregivers, but they would be

reported second hand, and caregivers would miss the opportunity to see for themselves and gain their own insight and understanding.

Co-constructing meaning with imagery and words

Dyadic art therapy, like other relational approaches, offers the adult and child the opportunity to co-create meaning around specific events. However, the data illustrated how in dyadic art therapy this can be done non-verbally, using imagery to communicate thoughts and feelings in a way that may be easier for the child to express. For many children, making and showing may be an easier and less daunting way of communicating complex thoughts and feelings. This is clearly illustrated by the example given by one of the therapists of the child who struggled verbally, but over the course of a number of sessions wrote names on paper until he was able to get his name and the names of all his birth family and foster family onto one piece of paper. The therapist who described this concluded that this creative process had helped the child express complex feelings, in the presence of his foster carers, in a way which he had not been able to do verbally, and this in turn had given the carers insight into his inner world.

9.7 Implications

The manual which has been constructed is based on empirical research into the practice of dyadic art therapy with children in middle childhood. It can be used in clinical practice and for training purposes and be refined for use in research.

9.7.1 Clinical practice

Art therapists working with children and families who wish to set up dyadic sessions can use the manual as an aid to clear, effective and transparent practice. It may also be a means through which art therapists can help commissioners, referrers and service users to make informed decisions about dyadic art therapy provision. The manual is not intended as a finished product, instead in its current form it is intended to be one of a series of iterations and it is hoped that it will evolve alongside the practice of dyadic art therapy, edited by the community of dyadic art therapists who use it.

9.7.2 Training

In the last year of the research project I co-facilitated two training courses on dyadic art therapy. Over forty students attended these trainings and a significant proportion of the

curriculum was based directly on my research. Trainees requested a ‘Level 2’ training in which they could go into the intervention in greater depth and also be introduced to the manual and learn how to use it. The ‘Level 1’ and ‘Level 2’ trainings are likely to become regular events which I will run for BAAT. Once the manual is up and running, there will be potential for others to also use it as a training tool.

9.7.3 Research

The manual provides a description of dyadic art therapy that can be used in future research and evaluations into the intervention. The current iteration of the manual has been left deliberately inclusive to reflect current practice, but it would be possible to adapt it to more specific purposes. The manual would need to be honed and refined for outcome-based research purposes. Adherence and competence rating scales would need to be developed and tested and a relatively homogeneous client group identified. Before designing a trial it would also be necessary to identify appropriate outcome measures.

However, thoughts of immediate use of the dyadic art therapy manual in feasibility and efficacy trials may be premature. If UK trials of art therapy with children are to be run it might be pragmatic to begin with the children who have conditions with relatively straight-forward aetiologies and outcomes. In which case the description of how this manual content was developed may help researchers construct manuals for these other more straight-forward art therapy interventions.

9.8 Recommendations

A summary of the recommendations is presented in Figure 9.1

Figure 9.1: Recommendations

- The manual can be used to facilitate clinical practice and to train people who want to learn about dyadic art therapy
- The manual should be seen as a developing resource that will change over time
- More research is needed on service-user views which can be used to shape future iterations
- More effective ways to gather and represent the voices of the children involved in dyadic art therapy need to be found
- Feedback should be sought from researchers about modifications needed for use in future outcome-based research
- The format and method of construction can be used to inform the development of other art therapy manuals for use in treatment and research

9.9 Conclusions

The unique contribution of this thesis is the construction of an expert-informed, research-based manual of dyadic art therapy for children in middle-childhood who have emotional and relational difficulties. It is useful for clinical practice and training. It is also a resource which can be developed for research purposes in the future and may serve as a model for the construction of other art therapy manuals.

APPENDICES

Appendix 1.1: Publications emanating from this research

The results of the survey (Taylor Buck, Dent-Brown, & Parry, 2012) have been published in the International Journal of Art Therapy, 18(1), 20-28. doi: 10.1080/17454832.2012.749293

The Delphi study (Taylor Buck, Dent-Brown, Parry, & Boote, 2014) has been published in The Arts in Psychotherapy, 41(2), 163-173. doi: <http://dx.doi.org/10.1016/j.aip.2014.01.004>

I have published a paper on creative art therapy manuals (Taylor Buck & Dent-Brown, 2014) which stemmed from this research project in the International Journal of Art Therapy, 19(2), 82-87. doi: 10.1080/17454832.2014.906475

Appropriate permission relating to the use of these papers in my thesis has been sought.

Appendix 4.1: Questionnaire

Investigation into Parent-Child Art Therapy

The aim of this questionnaire is to discover to what extent Art Therapists working with children and young people involve parents and carers in the therapy and the rationale behind this approach.

Thank you for agreeing to complete this questionnaire. Please read each question carefully. If you have any additional comments please write them in the box at the bottom of each page.

Setting

Tick the box or boxes most appropriate to you:	CAMHS - Inpatient	CAMHS - Outpatient	Education	Private Practice	Other (please specify)
Please describe your work setting					

Client Group

Please write your answers in the box next to the question:	
How would you describe your client group? (e.g.: Children with special needs; Asylum seekers...)	
What is the age range of the children or young people you work with? (e.g.: 5-12years)	

Any additional comments:

Involvement of Parents/Carers

Please tick only one box

When offering art therapy to a child/young person, how often do you:	Never	In some cases	In many cases	In almost all cases
Have direct contact with the parents/carers				
Meet separately with the parents/carers				
Include the parents/carers in the initial assessment session				
Include the parents/carers in all the assessment sessions				
Have regular separate sessions just with the parents/carers				
Offer parents/carers their own regular separate sessions with another therapist				
Include parents/carers in art therapy sessions				
I include parents/carers in art therapy reviews				

Please answer the following questions about past and present art therapy groups:	No	Yes – in the past	Yes - currently
Do you ever offer art therapy groups for children/young people with a parallel group for parents/carers?			
Do you ever offer art therapy groups which parents/carers and children/young people attend together?			
Do you ever offer art therapy groups just for children/young people without any parent/carer involvement?			

Any additional comments:

Involvement of Parents/Carers (continued)

Please answer the following questions about what happens if parents/carers are involved in art therapy sessions or reviews:	No	Occasionally	About half the time	Often	Almost always	N/A
If parents/carers are included in an art therapy sessions do you also arrange separate meetings just with the parents/carers?						
If parents/carers are included in art therapy sessions do they join in the image making						
When parents/carers are included in review meetings do they join in with the image making?						

Reasons for involving Parents/Carers

If you do invite parents or carers into art therapy sessions, please rate how often is it for the following reasons:	Never	Occasionally	Sometimes	Often	Almost always	N/A
To reduce any anxiety the child/young person might feel when first engaging with you						
To observe the relationship between the parent/carer and the child/young person						
To work directly with the relationship between the parent/carer and child/young person						
To enhance parent/carer observation, sensitivity and reflective functioning						
To share therapeutic skills or model a way of interacting with the child/young person						
To offer the child/young person and the parent/carer a shared creative/playful experience						

Please specify any other reasons for inviting parents/carers into an art therapy session and rate how frequently you do this:	Never	Occasionally	About half the time	Often	Almost always	N/A
1)						
2)						

Any additional comments:

Referrals

Please tick the box which most accurately completes the sentence:	Increased	Stayed about the same	Decreased	Don't know
In recent years the number of children/young people referred to me with attachment issues has...				

Please tick the box that is most appropriate for you:	Never	Occasionally	Often
I am referred children/young people with attachment as the presenting difficulty			
I am referred children/young people with attachment as an underlying difficulty			
Within my team art therapy is seen as an appropriate intervention for children or young people with attachment difficulties			

Any additional comments:

Helpful Interventions for Children with Attachment Difficulties

When referred a child or young person with attachments difficulties, how frequently do you personally offer the following interventions?	Never	Occasionally	About half the time	Often	Almost always	N/A	I do not offer this – but it is available in
Individual art therapy with the child/young person as the sole intervention							
Individual art therapy for the child/young person in conjunction with separate work with the parents/carers							
Support and training to the parents/carers as the sole intervention							
Art therapy sessions which include both the child/young person and the parent/carer as the sole intervention							
Art therapy sessions which include both the child/young person and the parent/carer in conjunction with parental support and training							
Art therapy group for parent/carer and child/young person to attend together							
A children/young people's art therapy group and a parallel separate group for parents/carers							
A children/young people's art therapy group with no parent/carer involvement							
Systemic Family Art Therapy							

Helpful Interventions for Children with Attachment Difficulties (continued)

Please specify any other interventions you personally offer to children/young people with attachment difficulties and rate how frequently you use this approach:	Never	Occasionally	About half the time	Often	Almost always	N/A
1)						
2)						
3)						

Any additional comments:

Theoretical Background

Please tick the box that is most appropriate for you

My work with children/young people and families is informed by:	Not at all	Slightly	Moderately	To a great degree
Attachment Theory				
Psychoanalytic Theory				
Object Relations				
Jungian Psychology				
Systemic Family Therapy				
CBT				
Solution Focussed Therapy				
These other following theories/therapies:				
1)				
2)				
3)				

Any additional comments:

Related Interventions

Please rate your knowledge/awareness of the following interventions:	Not aware of this approach	Aware of this approach but no practical experience	Use elements of this approach but no formal training	Training or expertise in the use of this approach
Circle of Security				
Watch Wait and Wonder				
DDP				
Filial Therapy				
Theraplay				
Webster Stratton				
The Parent Child Game				
Relationship Play				
Mentalisation-Based Therapy				
The Solihull Approach				

Professional Background

Please write your answers in the box next to the question:	
Are you currently a member of the British Association of Art Therapists?	
When did you qualify as an Art Therapist?	
Where did you train as an Art Therapist?	
Do you have additional professional qualifications? (Please specify)	

Any additional comments:

Specialist Knowledge/Interest

Please tick the box that is most appropriate to you:	No	A little	Yes	Don't know
Do you have experience of providing parent-child art therapy?				
Do you have experience of combining art therapy and attachment based therapy?				
Would you be interested in finding out more about an attachment based approach to parent-child art therapy?				

Any additional comments:

Appendix 5.1: The Round 1 Delphi Questionnaire

<p style="text-align: center;">SECTION A Principles informing Dyadic Art Therapy</p>	<p style="text-align: center;">Validity How appropriate is the suggested principle?</p> <p>Please rate from 1- 9 by placing a cross in the box underneath the number you have chosen.</p> <p style="text-align: center;">1 = not at all appropriate 9 = very appropriate</p> <p style="text-align: center;">Not at all Moderately Very</p>																		
A1. The therapeutic work is psychodynamic	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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Comments:																			
A2. The therapeutic work includes discussions of attachment and emotion regulation	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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A3. The therapeutic work aims to develop the carer's capacity for reflective functioning	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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A4. The therapeutic work addresses how the carer's own internal working models are enacted in the relationship with the child	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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A5. The therapeutic work includes periods of child-led activity	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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A6. The therapeutic work seeks to enhance the carer's sensitivity to the child's emotional and behavioural signals	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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A7. The therapeutic work promotes carer-child relationships characterized by both connectedness and autonomy	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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Comments:																			
<p>Please describe any further principles that you believe to be important when offering dyadic art therapy:</p>																			

<p align="center">SECTION B Practices involved in the delivery of Dyadic Art Therapy</p>	<p align="center">Validity How appropriate is the suggested practice? Please rate from 1- 9 by placing a cross in the box underneath the number you have chosen. 1 = not at all appropriate 9 = very appropriate Not at all Moderately Very</p>																		
<p>B1. The therapist takes charge of the interaction during the session and guides the carer to do the same</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>B2. The carer observes the child's behaviour and interactions and reflects on the child's inner world and relational needs</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>Comments:</p>																			
<p>B3. The therapist uses touch to enhance his or her interpersonal connection with the child</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>Comments:</p>																			
<p>B4. The therapist is alert to the carer's own affect and helps the carer to recognize, contain and eventually understand this</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>B5. The therapist meets alone with the carer to establish a therapeutic alliance characterized by safety and trust</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>Comments:</p>																			
<p>B6. The therapist provides sensory-motor stimulation and rhythmic movement and guides carers to do the same</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>Comments:</p>																			
<p>B7. The story of the relationship between carer and child is retold with emphasis on emotional meaning of shared events</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>Comments:</p>																			
<p>B8. Carers are helped to engage with their child through creative activity, non verbal attention and child-directed descriptive speech (tracking comments)</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>Comments:</p>																			
<p>Please describe any further practices that you believe to be important when offering dyadic art therapy:</p>																			

<p align="center">SECTION C Therapist competences required for the delivery of Dyadic Art Therapy</p>	<p align="center">Validity How relevant is the suggested competence?</p> <p>Please rate from 1- 9 by placing a cross in the box underneath the number you have chosen.</p> <p align="center">1 = not at all appropriate 9 = very appropriate</p> <p align="center">Not at all Moderately Very</p>																		
<p>C1. Ability to use within-session events to address carer's affective responses and understanding of child's behaviour</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>Comments:</p>																			
<p>C2. Ability to maintain an intersubjective stance, communicating verbally and non-verbally the personal impact of the process</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>C3. Ability to help carers think about the impact of their own history on their current parenting</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>C4. Understanding of attachment theory</p>	<table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	1	2	3	4	5	6	7	8	9									
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<p>Comments:</p>																			
<p>Please describe any further competences that you believe to be important when offering dyadic art therapy:</p>																			

<p>Please write any additional comments in the box below:</p>

Appendix 6.1: Schedule for Interviews with Therapists

Section	Potential Questions	Potential probe questions
Background	How did you become interested in dyadic art therapy?	What were your reasons for originally deciding to start involving parents/carers in sessions?
		Can you tell me about any relevant training that has helped you develop this way of working?
		How long have you been working in this way?
	Can you give me some (anonymised) examples of the kinds of cases you have worked with in this way?	Do you work in this way mainly with one specific client group?
		Do you work with individual dyads or groups?
		Broadly speaking what might be your goals?
Can you describe the setting you work in?	Is there something about your setting that has made dyadic art therapy possible?	
Practical details and examples of operationalisation	What are the reasons or indicators that would prompt you to work in this way with any given case?	Who do you think this intervention is suitable for?
		Who might it not be suitable for?
	Can you describe any structures you have developed for the delivery of dyadic art therapy sessions	Do you have separate sessions sometimes just with the carers?
		Do you have separate sessions sometimes just with the child?
		How long does each session typically last?
		Can you say something about who leads or structures the sessions and whether they are directive or non-directive?
		Can you describe the shape or structure of a typical dyadic session?
Do you offer dyadic work on your own or do colleagues join with you for these cases?		

		Can you tell me about any special facilities needed for working in this way?	
		How frequent are sessions?	
	Can you tell me a bit about the duration of therapy?	How long might you expect to be working with a dyad for?	
		Are there distinct phases in the therapy?	
		How do you handle endings and breaks?	
	Can you tell me about the more problematic aspects of dyadic work?	How do you handle difficulties that arise?	
		In what ways do you find your clinical supervision supports this work?	
	Have you used measures any outcomes?	Which measures did you use and would you recommend them?	
		What measurable outcomes or goals do you think are most likely to be seen following a piece of dyadic art therapy?	
	Reflections and observations	Does working in this way have an impact on you personally?	Do issues of transference and counter-transference arise in the same way they do in individual work?
			Can you describe the therapeutic relationships that you make with the child and the carer?
		What are the disadvantages to working dyadically?	What would you consider to be the most important contraindications for dyadic art therapy?
What advice would you give to an art therapist who is just beginning to offer dyadic art therapy?		What would you say were the three most important things to do?	
		What would you say were the three most important things to avoid?	
		What would be the pros and cons of having a manual?	
Can you tell me about a particular case in which you noticed positive change?		Can you describe any bearing that you think art therapy had on this change?	
		What elements or mechanisms within the art therapy might have prompted the change?	
Can you tell me about another case when you think dyadic art therapy was less effective?		What was it about this situation that meant dyadic art therapy has a less positive impact?	

Appendix 7.1: The Reflect Interview schedule

Pre-interview instructions: *Before coming to record the interview please choose any two pieces of art that you have made in your sessions. These can be anything you like that is important to you. If you don't have pictures, models or photos to bring please try to remember an activity or a game that you played in a session. Choose one picture, model or memory from early on in your therapy and one that is from later on.*

The Interview

Section of the interview	What we are trying to find out	Potential questions
The patient's narrative of their experience of dyadic art therapy	The biographical context: start of therapy	Can you say a bit about why you think the adults in your life thought art therapy might be helpful for you? What was going on in your life just before you started art therapy?
	Apperception of psychological change between art work 1&2	Could you say something about the first picture/model/memory? When did you make it? What was it like making this in art therapy? Could you say something about the second picture/model/memory? When did you make it? What was it like making this in art therapy?
	The biographical context: end of therapy	Can you tell me what is going on in your life at the moment? Do you think coming to art therapy has changed anything or helped in any way?
The patient's perception of agents of change	How dyadic art therapy works	What is it about dyadic art therapy that you think made those changes happen?
	Comparison to other psychological therapies	Have you had any other sort of therapy How was that different from dyadic art therapy?
Overarching reflection	Check to see if an open question reveals relevant information	Is there anything else you would like to mention?

This is a modified version of the Reflect Interview. Original copyright: Neil Springham – British Association of Art Therapists, 24-27 White Lion Street London N1 9PD

Appendix 7.2: Modified HAT

HELPFUL ASPECTS OF THERAPY FORM (H.A.T.)

1. Of the events which occurred in this session, which one do you feel was the most **helpful** or **important** for you personally or for your child? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist said or did.)
2. Please describe what made this event helpful/important and what you or your child got out of it.
3. How helpful was this particular event? Rate it on the following scale. (Put an "X" at the appropriate point; half-point ratings are OK; e.g., 7.5.)

HINDERING	<----- Neutral ----->								HELPFUL
1	2	3	4	5	6	7	8	9	
E	G	M	S		S	M	G	E	
X	R	O	L		L	O	R	X	
T	E	D	I		I	D	E	T	
R	A	E	G		G	E	A	R	
E	T	R	H		H	R	T	E	
M	L	A	T		T	A	L	M	
E	Y	T	L		L	T	Y	E	
L		E	Y		Y	E		L	
Y		L				L		Y	
		Y				Y			

4. About where in the session did this event occur?
5. About how long did the event last?
6. Did anything else particularly **helpful** happen during this session?
 YES NO
 a. If yes, please rate how helpful this event was:

_____ 6. Slightly helpful
_____ 7. Moderately helpful
_____ 8. Greatly helpful
_____ 9. Extremely helpful

 b. Please describe the event briefly:

7. Did anything happen during the session which might have been **hindering**?

YES NO

a. If yes, please rate how hindering the event was:

- _____ 1. Extremely hindering
- _____ 2. Greatly hindering
- _____ 3. Moderately hindering
- _____ 4. Slightly hindering

b. Please describe this event briefly:

This form is a modified version of the original HAT developed by Llewelyn (1988) (Copyright © 2000 NREP)

Appendix 7.3: Younger child's information and assent sheet

Art Therapy Research

Would you like to take part in a research project?

My name is Lizzie and I am doing a project about what children and young people think about art therapy and how it feels to have their adult in the session with them. I am asking you to join because you regularly have art therapy with your adult.



What will you do in the project?

This project will take place at the same place you normally have your art therapy. I will make a special appointment to meet with you and your adult. I will ask you some questions about the things you have made in art therapy and about what you like about art therapy and what you don't like. I will record what we both say. If you want me to I can put a recording of our conversation on to a disk with photos of your pictures and give it to you.



What things may bother you about the project?

You might feel a bit shy of meeting me and talking to me but if you do you can take a break, have a rest, or spend a bit of time alone with your adult. You don't have to talk to me about anything you don't want to.



What's good about this project?

This project is good because you can say what you like and what you don't like about your art therapy. The things that I learn from the project may help other children in the future.

Who will know what you say?

This project will be written up like a report and Lizzie may put in some of the things you say, but she will never tell people your name or say who said what. If something you say worries Lizzie about your safety or about someone else's safety she might have to tell other people to make sure you are kept safe. Lizzie will talk about this with you first before she talks to someone else.

Do you want to take part or not? - YOU DECIDE!

You do not have to take part in this project. It is up to you to say YES or NO. No one will be cross or upset if you do not want to. If you say YES you can change your mind later and stop at any time.



Before deciding to help with this project?

Take time to think. Talk about this project with your adult, family, friend, or someone you can trust before you say YES or No.

Do you have any questions?

Ask as many questions as you like at anytime. For more information or if you have more questions about this project you can ask your art therapist or e-mail me (or ask your adult to) on e.taylor-buck@sheffield.ac.uk

If you decide to say YES to take part in this project you will be asked to sign an OK form.

Some useful contact numbers

If you would like to speak to one of the art therapists involved, you can call If you are unhappy about any part of this project and you would like to tell someone else about it you can e-mail Lizzie's supervisor on ...

OK FORM

I have read the information letter.

I understand what Lizzie is asking me to do.

I will talk to Lizzie about what it is like to have art therapy.

Lizzie will record my voice on a tape when I talk to her.

Lizzie won't use my real name when she writes the report.

If I don't want to do this I don't have to.

I can stop doing this if I want to.

I get to keep a copy of the information letter and this box that gives my permission.

Your Signature

Date

Appendix 7.4: Older child's information and assent sheet

Art Therapy Research

Would you like to take part in a research project?

My name is Lizzie and I am doing a project about what children and young people think about art therapy and how it feels to have their adult in the session with them. I am doing this project as part of my work for The University of Sheffield where I study. I am asking you to join because you regularly have art therapy with your parent or carer.



What will you do in the project?

This project will take place at the same place you normally have your art therapy. I will make a special appointment to meet with you and your parent or carer. When we meet I will ask you some questions about things you have made in art therapy and also about what you like about art therapy and what you don't like. I will record what we both say. If you would like I can put a recording of our conversation on to a disk with photos of your pictures and give it to you so you can listen back.

What things may bother you about the project?

You might feel a bit shy of meeting me and talking to me - but you can let me know if at any time you would like to take a break, have a rest, or spend a bit of time alone. You don't have to talk to me about anything you don't want to.



What's good about this project?

This project is good because you can say what you like and what you don't like about your therapy. Also you could be helping other people, because the things that I learn from the project may help other children in the future.

Who else will know what you say?

I will not report the things that you say to your therapist or anyone else who knows you. However, this project will be written up like a report which may include some of the things you say. The report will never mention your name or say who said what. There will be nothing written down or discussed with anyone else that would mean they could identify you or the things you have said.

However, if something you say raises concerns about your safety or about someone else's safety I might have to tell other people. This is not part of the project and is just normal procedure to keep all children safe. It is exactly what would happen if you told something worrying to a teacher or a doctor. I will talk about this with you first before I talk to anyone else.

Do you want to take part or not? - YOU DECIDE!

You do not have to take part in this project. It is up to you to say YES or NO. No one will be cross or upset if you do not want to. If you say YES you can change your mind later and STOP AT ANY TIME.

Before deciding to help with this project?

Take time to think. Talk about this project with your family, friends, or someone you can trust before you say YES or NO.



If you decide to say YES to take part in this project you will be asked to sign a consent form.

Do you have any questions?

Ask as many questions as you like at anytime. For more information or if you have more questions about this project you can ask your art therapist or e-mail me on e.taylor-buck@sheffield.ac.uk

Some useful contact numbers

If you would like to speak to one of the art therapists involved, you can call If you are unhappy about any part of this project and you would like to tell someone else about it you can e-mail Lizzie's supervisor on ...

ASSENT FORM

I have read the information letter.

I understand what Lizzie is asking me to do.

I will talk to Lizzie about what it is like to have art therapy.

Lizzie will record my voice on a tape when I talk to her.

Lizzie won't use my real name when she writes the report.

If I don't want to do this I don't have to.

I can stop doing this if I want to.

I get to keep a copy of the information letter and this letter that gives my permission.

Your Signature

Date.....

Appendix 7.5: Caregivers' Information Sheet

Participant Information Sheet for Parents and Carers about The Dyadic Art Therapy Research Project

Invitation

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you and your child. Talk to others about the study if you wish. (Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study). Ask us if there is anything that is not clear.

The research project is focusing on the use of parent-child dyadic art psychotherapy. "Dyadic" means involving both parent/carer and child together in the sessions. The researchers would like to hear about how you and your child feel about being involved in dyadic art therapy.

What is the purpose of the study?

The study is to find out more about parent-child dyadic art psychotherapy. We want to hear first hand from people who are involved in dyadic art therapy. Their thoughts and opinions will be used to draft some practical guidelines for other art therapists who are interested in working in this way.

Why have I been invited?

You have been invited because you and your child have been direct experience of dyadic art therapy. We would like to ask you some questions about your experience.

Do I have to take part?

Involvement in the project is entirely voluntary and it is up to you to decide to join the study. Your regular therapy will not in any way be affected by whether or not you decide to take part in the project.

We will describe the study in this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

Both you and your child will be invited to take part. Below is a break down of what will be asked of your child and then what will be asked of you:

Child	There will be at least one meeting with the child and you, their parent or carer, before the start of the research to give information, answer questions and ask you to sign the consent form. There will also be one other meeting when the researcher will ask you both some questions about your child's experience of therapy. Audio recordings of the second meeting will be made, and you will be offered a copy of the recording.
Parent or carer	As well as attending the meetings with your child and the researcher which were described above, you will also be asked to complete a simple questionnaire on eight separate occasions. You may also be

	<p>contacted towards the end of the project and asked to give some feedback. All the meetings will take place where you normally have your therapy. The project will take place over a period of approximately six months, although your involvement may be shorter than this.</p>
--	--

Expenses and payments

The researcher will travel to the place where you normally have therapy and will try to schedule the meetings to suit you. Therefore there should not be additional costs to you. If you need to travel solely for the purpose of attending a meeting with a researcher, or pay for parking during the meeting, then you will be able to claim your travel costs back.

What will we have to do?

You and your child will need to attend an initial meeting with the researcher. This will allow you and your child to ask any questions you have. If you want to be part of the research then you and your child will be asked to sign a consent form. This meeting should take about half an hour. You and your child will both need to attend another meeting with the researcher at which you will both be asked about the child's experience of dyadic art therapy. You will be asked to fill out eight short questionnaires after eight consecutive art therapy sessions. It will take about ten or fifteen minutes to fill out the questionnaire each time.

What are the possible disadvantages and risks of taking part?

You and your child will be asked about your experience of therapy. Therapy can be quite a private process, and so there is a possibility that you might feel that the questionnaires or interviews are a bit intrusive. You might also feel that the extra time needed to complete the questionnaires and interviews is not very convenient.

What are the possible benefits of taking part?

We do not think there is likely to be any direct clinical benefit in taking part, because the research does not involve any alterations to your actual therapy sessions. However, you may feel it is useful to reflect on the therapy that you and your child are involved in. You may also value the extra space to be listened to by a researcher who is interested in your opinions. Finally, if you do choose to participate, we hope that you will feel that you and your child have participated in a useful piece of research that could help other people in similar circumstances.

What happens when the research study stops?

The research should not affect the course of your therapy, and future sessions will be planned with your therapist as normal. This is something you can talk to your therapist about.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You can choose at any time to leave the study. However, if you do withdraw from the study we would still like to use the data collected up to the point of your withdrawal. If you are unhappy about this arrangement please let us know at the time.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you do have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions [Tel: 0114 2220753]. If you remain unhappy and wish to complain formally, you can contact the researcher's supervisor Dr Kim Dent-Brown [k.dent-brown@hull.ac.uk].

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the therapy setting will have your name and address removed so that you cannot be recognized by this.

However, if something you or your child says raises concerns about anyone's safety then the researchers may need to talk to other people. This is not part of the project and is just normal procedure to keep all children safe. It is exactly what would happen if you or your child discussed something worrying with a teacher or a doctor

What will happen to the results of the research study?

This study is part of a doctoral research project and the findings will be written up as part of the doctoral thesis. The results of the study, including the information gathered from you, will also be used to draft a manual with practical guidelines for other art therapists who want to use a dyadic approach.

Who is organising and funding the research?

This research has been funded by the National Institute for Health Research, and is being hosted by The University of Sheffield. Your therapist will not be paid for including you in this research.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NRES Committee Yorkshire & The Humber – Sheffield.

Further information and contact details

You can contact the researcher on e.taylor-buck@sheffield.ac.uk, or on 0114 2220753

Appendix 7.6: Summary of helpful and hindering events

Appendix 7.6.1: Helpful events in parent only sessions

How helpful?	Extremely	Rating	Description of helpful event	What caregivers said made this event helpful	When during session	How long it lasted	Session number
		9	Catching up with what's been happening in relation to child	Good to express fears and get reassurance and ideas from therapist	-	-	-
		9	Going through feedback from consultant and school	Insight into what might be stressful for child, how this is displayed in art therapy and discussion of ways forward	-	-	-
	Greatly	8.5	Discussing frustrations about school and home life	Explaining events and getting the therapist's take on situation	Through-out	Through-out	3
		8	Reminder help available for school issues	Had forgotten about accessing this help	Towards end		1

Appendix 7.6.2: Additional helpful events in parent only sessions

How helpful?	Extremely	Rating	Description of additional helpful event	Session number
		9	Suggestions for dealing with issues relating to sibling	3
	Moderately	7	Reminder of normal behaviour	1

Appendix 7.6.3: The main helpful events in joint sessions

How helpful?	Extremely	Rating	Description of helpful event	What caregivers said made this event helpful	When during session	How long it lasted	Session number
		9	Getting child to talk about recent holiday	Child able to talk about feelings when asked about holiday the day after	Near beginning	15 mins	1
	9	Therapist helping to 'get to the bottom of' recent behaviours	Discussing with the child what might be stressing child. Working as well as talking	Towards beginning	All session	5	
	Greatly	8.75	Child making card for absent family member and talking about feeling sad	Helps child to understand it's OK to be sad and talk about it	At start	Most of session	-
		8.25	Child did not want to work together but therapist helped negotiate with child		Towards the beginning	About 20 mins	4
	Moderately	7.75	Child mentioned a memory parent was not aware of	Made parent think child may have memories from previous experiences with birth family or foster family	Towards the end of the session	5 mins	2
		7.25	Looking through child's art work	Child happy to watch – may have been tired	-	-	6
	Slightly	6.5	Child was painting and therapist and child talked about how the colours looked like feelings	Child said that some of the colours she had used were scary	-	-	2

Appendix 7.6.4: The additional helpful events in joint sessions

How helpful?	Extremely	Rating	Description of additional helpful event	Session number
		9	Drawing a door and talking about who child would let in: all the time; sometimes; never.	1
	9	Therapist agreeing to work alongside dyad	5	
Greatly	8	Child likes to lead play and has a chance to do this as well as discussions	2	

Appendix 7.6.5: Hindering events in joint sessions

How hindering?	Moderately	Rating	Summary of hindering event	Session number
		3	The child likes to lead the play and can become centred on one activity. The caregiver finds it hard to get child on track.	2
	3	Child is used to therapist working alongside and became agitated when the therapist was not doing so	4	

(- denotes no response entered on questionnaire)

Appendix 8.1: About the intervention (manual page)

DYADIC ART THERAPY

Dyadic art therapy is a joined up approach to art therapy involving children and their parents or carers in joint art therapy sessions at least some of the time. The make-up of the dyad varies with different children and different family set-ups, but usually involves the child and an adult with whom the child has a significant and enduring relationship.



RATIONALE

Art therapists may decide to offer dyadic sessions for a variety of reasons. For example:

- To observe the relationship between caregiver and child at first hand
- To facilitate joined up creative and playful activities between caregiver and child
- To enhance caregiving skills
- To facilitate reflective discussions between caregiver and child
- To work directly with the relationship between the child and caregiver
- To help the child to engage and feel safe during the therapy

MECHANISMS OF CHANGE

Joined up dyadic art therapy sessions offer a number of potentially therapeutic opportunities such as:

- Enhancing caregiver sensitivity, understanding and attunement. [For information about research relating to caregiver sensitivity click here](#)
- Enhancing caregiver insight into impact of their own history on their parenting
- Facilitating joint engagement activities. [For information about research relating to joint engagement click here](#)
- Facilitating reflective (mentalizing) conversations between caregiver and child. [For more information about research on mentalization with parents and children click here](#)
- Co-constructing shared narratives. [For more information about research into building coherent narratives click here](#)
- Enhancing child's affect recognition and regulation

GUIDING PRINCIPLES

The therapeutic work aims to:

- Be flexible, respecting diversity of family history, culture and individual experience
- Create links with the present and past, in a historical, developmental and social context.
- Encourage children to expand their ability to recognise their own feelings in the presence of their carers.
- Focus on moments of attunement when warmth and playfulness emerge is at the heart of the work.
- Promote relationships characterized by both connectedness and autonomy.
- Enhance the carer's capacity for openness, working with experiences as they occur within the session.
- Develop the carer's capacity for reflective functioning.
- Address how the carer's own internal working models are enacted in the relationship with the child.
- Enhance the carer's sensitivity to the child's emotional and behavioural signals.
- Include discussions of attachment and emotion regulation

[If you would like more information about how these principles were developed please click here](#)

DYADIC ART THERAPY CLIENT GROUPS

Dyadic art therapy is used in a variety of settings across the country. It may be considered when children have emotional and relational difficulties.

Dyadic art therapy is used with fostered and adopted children as well as children who live with their birth families. It can be used with children with diagnoses such as a learning disability, autism or ADHD.

There are already some rich descriptions of dyadic art therapy with infants and toddlers, so this manual will focus on children between the ages of 5 and 15. [For information about dyadic art therapy with pre-schoolers click here](#) and [for information about work with infants click here](#).



CONTRAINDICATIONS

A thorough assessment and an appropriate level of preparation with the parents or carers is an important element of dyadic art therapy. Occasionally during this process, the therapist may decide that the presence of the parent or carer in art therapy sessions will not be helpful for the child, and may even be detrimental. In such cases a different approach should be sought, and the therapist should assess whether further action, such as safeguarding or signposting, is needed. Information about safeguarding can be found by clicking the button below

SAFEGUARDING

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Appendix 8.2: Goals (manual page)

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THERAPIST GOALS FOR DYADIC ART THERAPY

The focus of the therapist's goals may shift during different phases of therapy. They are given below in a loosely chronological order. Please click on any goal to get more details:

- [To assess what is needed and what is feasible](#)
- [To take a flexible needs-based approach](#)
- [To ensure adequate preparation takes place](#)
- [To engage therapeutically with the dyad](#)
- [To join up people, ideas and actions](#)
- [To enhance the caregiver and child's skills](#)
- [To deal with events](#)

[Details about the steps the therapists take to achieve these goals can be found by clicking here](#)



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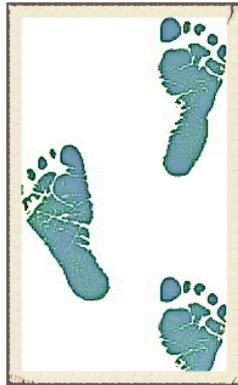
Appendix 8.3: Steps (manual page)

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THE STEPS THE THERAPISTS TAKES TOWARDS ACHIEVING THEIR THERAPEUTIC GOALS

CLICK ON ANY STEP BELOW TO FIND OUT MORE:

- Observing and formulating
- Determining dyad specific goals
- Reviewing work and gauging goals
- Structuring the intervention and sessions to meet the dyads needs
- Adopting the most appropriate approach
- Preparing themselves
- Preparing parents or carers
- Preparing the system
- Balancing the needs of the dyad
- Safety building
- Facilitating joint engagement
- Helping carers to see for themselves
- Facilitating reflective discussions
- Explaining and Educating
- Modelling and practising skills with the caregiver
- Modelling and practising skills with the child
- Responding to events in the sessions
- Processing past events
- Thinking with the dyad about current life events



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Appendix 8.4: Helpers (manual page)

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HELPERS

Research with art therapists and service users suggests that there are some things which can aid or enhance the process of dyadic art therapy:

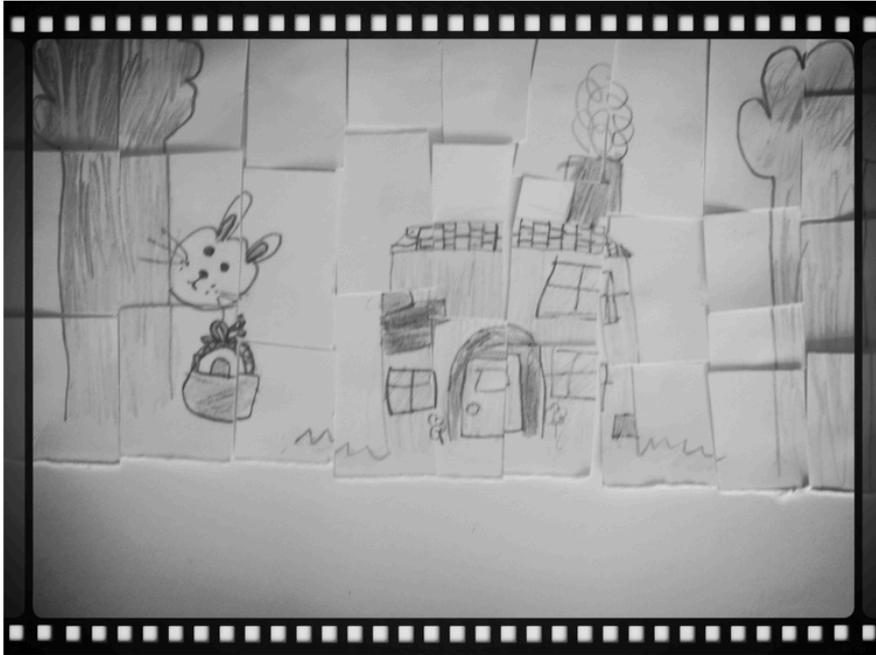
- Seeing the dyad making art together can help the therapist assess and formulate ideas
- Experiential art therapy tasks for parents and carers can give parents and carers a taste of art therapy and a space to think about their own life experiences
- Building a sense of safety and trust between the therapist, caregiver and child can help facilitate the work
- Art materials can act as a bridge, helping with engagement and connecting people and ideas. For example, art making enables the child to communicate aspects of their experience through doing rather than explaining and dyads can become more attuned to each others thought and feelings through joint engagement tasks.
- Art and art making can help with regulating, containing and processing feelings
- Images can be helpful as a way of recording events
- Good supervision and a supportive workplace and colleagues are a great help

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Appendix 8.5: Challenges (manual page)

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CHALLENGES

Offering Dyadic Art Therapy can be challenging. Research with practicing art therapists and service users has highlighted the following challenges:

- Workplace issues may have an impact on what the therapist is able to offer
- Families may be wary of a new way of working, particularly the shift in focus from the individual child to the dyad
- Both the caregivers and the children may find the process challenging, particularly if there are conflicting agendas
- A good deal of preparation may be needed
- There may be complex therapeutic dynamics

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Appendix 8.6: Tips and advice (manual page)

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HERE ARE SOME TOP TIPS FROM PRACTICING DYADIC ART THERAPISTS:

CAREFUL PREPARATION AND ASSESSMENT IS ESSENTIAL

Therapists stress the need for a thorough assessment and thorough preparation. During the assessment think about the relationship between the parent and the child and whether that relationship would benefit from having a space where the parent is encouraged to think about the child's emotional world. Also, if you can, spend some time with the parent or carer finding out about the child's early years and developmental history. If possible, before you start the joint sessions, prepare the parent or carer for those sessions, discussing the various roles and thinking through what might happen. [For an example of one kind of preparation session click here and listen to the audio file](#)

GET TO KNOW THE PARENT OR CARER AND THEIR STRENGTHS AND LIMITATIONS

Think about parents and carers' own history and their capacity to think because that might change the way that you structure the dyadic work. Continue to give carers the support they need throughout the work.

BE AWARE OF THE COUNTER-TRANSFERENCE

It may be helpful to reflect on what is activated in you about the relationship between the dyad as a way of taking a check on it

UNDERSTAND THE UNIQUE CONTRIBUTION OF THE ART MATERIALS

Let the art materials do some of the work, art may be able to communicate something about the child's experience in more effectively than words. [Click this here for Vignette 5 which illustrates this.](#)

HAVE CONFIDENCE IN YOUR OWN ABILITIES AND DON'T BE FRIGHTENED TO GIVE IT A GO

Be prepared to be a bit flexible let your own practice evolve. Remember there isn't a magic wand and it can be helpful to model that for the parents and carers. Don't put too much pressure on yourself and have confidence in your own skills, which you can quickly develop by reading about the subject and getting appropriate support.

FINALLY, HERE IS A LIST OF WHAT TO AVOID:

- Inappropriate settings. Find a protected space where you're not going to be interrupted
- Rushing into dyadic sessions without adequate preparation
- Starting or continuing with dyadic work if the parent isn't able to think about the child and is too preoccupied with their own difficulties
- Taking sides or becoming overly identified with one half of the dyad
- Starting sessions with the parent or carer giving a rundown of the past week's negative events



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Appendix 8.7: Outcomes (manual page)

OUTCOMES



FINDINGS FROM RESEARCH INVOLVING SERVICE USERS

Analysis of data from research involving caregivers and children highlights the important role of the image in dyadic art therapy. Art and art making can open alternative channels of communication between the child and carer enabling the child to communicate aspects of their experience through doing rather than explaining. The images were used to help the child develop expressive and creative skills, and they also had a key role to play in recording and processing important events and the feelings associated with them.

Having caregivers present in the sessions was also seen as important, many of the valued outcomes highlighted by the research were achieved by having the caregiver present in sessions. Caregivers gained insights at first-hand and conversations and interactions could be initiated in sessions which the dyad would then continue afterwards in everyday life. As well as having these benefits, the joined-up dyadic approach was also seen as potentially creating a challenging dynamic, particularly if the three key participants had conflicting agendas. Research with the therapists has suggested that therapists have an awareness of this issue but it is helpful to understand more about it from the service user's perspective.

FINDINGS FROM RESEARCH INVOLVING THERAPISTS

Interviews with dyadic art therapists highlight some of the changes they have seen in their work, these include:

- Establishing therapeutic alliances and building trusting relationships with service users
- Building up a picture of the child's internal and external world which can be shared with caregivers during the therapy.
- Building a picture of the caregivers and their strengths.
- Caregivers gaining new insights and understanding.
- Children's emotional (and maybe even physical) growth
- Reduction in child's confusion and sense of blame
- Child becomes more relaxed
- Child's emotional regulation and articulation increased
- Child's ability to tolerate potentially stressful situations increased
- Caregiver and child gain greater understanding of each other
- Changes occur within the primary attachment relationship(s)

THOUGHTS ABOUT EVALUATION

There is currently no agreed or formal evaluation tool for Dyadic Art Therapy. However, interviews with dyadic art therapists indicate that it might be the helpful and illuminating to evaluate the following outcomes:

- The quality of the attachment relationship between the primary caregiver and the child
- Stability of placement
- Caregiver sensitivity
- Caregiver stress levels
- Child's ability to make links with current behaviours and past events
- Child's ability to manage relationships;
- Reflective functioning
- School attendance
- Attachment behaviours
- Emotional literacy
- Regulation and arousal and stress levels (including trauma symptoms)
- Cognitive gains
- If goal based outcome measures are used the outcomes might relate to progress in meeting individually established goals.

ADHERENCE

Some forms of evaluation may involve adherence testing. A draft adherence tool is being developed and can be viewed [here](#)

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Appendix 8.8: Competences (manual page)

COMPETENCES

Dyadic art therapy is an intervention delivered by qualified art therapists. In the UK art therapists must be registered with the HCPC and meet the HCPC Standards of Proficiency. [These can be found by clicking here](#)

Therapists should also be able to demonstrate the following specific competences:

Have an understanding of:

- Developmental trauma and the impact this has on the child's development
- Post Traumatic Stress Disorder symptoms and sensitivity to the child's ability to tolerate traumatic memories being exposed
- How the nervous system is impacted by trauma and stress including how to help it calm and whether a child is being activated into a stress response (fight, flight or freeze) or whether they are able to manage higher level reflective functioning
- The difference between therapy with a birth parent and their child and therapy with a fostered or adopted child
- Parenting strategies particularly those for children with disturbed attachment behaviours so the therapist can help the carer understand behaviours and to respond to them
- Child development including stages of a child's art development
- Attachment theory
- Psychotherapeutic ideas of how the self is built up and strengthened
- Alternative theoretical frames and an openness to many ways of working

Be able to

- Use within-session events to address carer's affective responses and understanding of child's behaviour.
- Maintain an intersubjective stance
- Help carers think about the impact of their own history on their current parenting
- Make a broad assessment of adult and children's attachment styles, recognising unresolved trauma in the adults.
- Develop an understanding of the child for the carer and for the child, so that the child's feelings can be seen and acknowledged, and so the child can begin to regulate his/her own feelings and the carer can help to soothe and contain them.
- Recognise contra-indicators to Dyadic Art Therapy.

[If you would like more information about how these competences were developed please click here](#)



Appendix 8.9: Feedback forms

8.9.1 Feedback form for participants

Feedback for Dyadic Art Therapy Manual

A draft of the dyadic art therapy manual can be accessed at:

www.dyadic-art-therapy.com

(If you are having difficulty viewing the site please try using newer browsers e.g. Chrome or Firefox)

I would really welcome your feedback on the manual as it currently stands. If you would like to, please could you look at the manual and then briefly answer the following questions:

Q.1 Does the manual contain the kind of information you would hope to see in a dyadic art therapy manual?

Q.2 Do you think the manual would be helpful for art therapists who are working with parent-child dyads or about to start doing so?

Q.3 Did you find the manual easy to navigate and use?

Q.4 Does the manual reflect some of the ideas you shared during your participation in the development process?

Q.5 Do you have any other feedback you would like to give?

8.9.2 Feedback form for non-participants

General Feedback for Dyadic Art Therapy Manual

A draft of the dyadic art therapy manual can be accessed at:

www.dyadic-art-therapy.com

(If you are having difficulty viewing the site please try using newer browsers e.g. Chrome or Firefox)

I would really welcome your feedback on the manual as it currently stands. If you have time, please could you look at the manual and then briefly answer the following questions:

Q.1 Does the manual contain the kind of information you would hope to see in a dyadic art therapy manual?

Q.2 Do you think the manual would be helpful for art therapists who are working with parent-child dyads or about to start doing so?

Q.3 Did you find the manual easy to navigate and use?

Q.4 Do you have any other feedback you would like to give?

Appendix 8.10: Verbatim feedback

8.10.1 Participants using feedback form

P1 Comment: An extremely useful, user friendly and interactive manual. Really well written with great images, aesthetically pleasing and smooth to navigate. Thanks for all your hard work and commitment to it Lizzie, this will be an invaluable tool and reference space for people.

Q.1. *Does the manual contain the kind of information you would hope to see in a dyadic art therapy manual?* Yes. It is descriptive, informative and its aims and purpose explained very well.

Q.2. *Do you think the manual would be helpful for art therapists who are working with parent-child dyads or about to start doing so?* Most definitely.

Q.3. *Did you find the manual easy to navigate and use?* Very.

Q.4. *Does the manual reflect some of the ideas you shared during your participation in the development process?* Yes.

Q.5. *Do you have any other feedback you would like to give?* I am so pleased this piece of work has evolved. It feels like a laying down of some much needed foundations in this area of work and research, a good solid base for art therapists to consider and share. Thanks for all your hard work and commitment to it

P2: Q.1 *Does the manual contain the kind of information you would hope to see in a dyadic art therapy manual?* I didn't have much idea what an online manual for art therapists would be like. The word manual sounded a bit dry. What you have created far far exceeds any expectations I had and it is definitely not dry.

Q.2. *Do you think the manual would be helpful for art therapists who are working with parent-child dyads or about to start doing so?* Absolutely definitely. I think for art therapists who have done the training that you and I have developed they will immediately recognise the approaches and language and will regular go back to it perhaps for reassurance or to develop their practice. For art therapists who have neither done dyadic work before nor had any training it will also be a really amazing resource particular to help them get started in a safe way and begin to open their minds to the potential uses of a dyadic approach.

Q.3. *Did you find the manual easy to navigate and use?* Yes, really easy and clear.

Q.4. *Does the manual reflect some of the ideas you shared during your participation in the development process?* Yes definitely!

Q.5. *Do you have any other feedback you would like to give?* Lizzie this is really brilliant. I think you have probably lost sight of what a fantastic resource you have put together. It'd really really excellent

P3: Q1. *Does the manual contain the kind of information you would hope to see in a dyadic art therapy manual?* I am of two minds: YES as it is complete and clear, but also NO as it may influence the new therapists' spontaneity

Q 2. *Do you think the manual would be helpful for art therapists who are working with parent-child-dyads or about to start doing so?* I think it would be more useful for Art Therapists who are working with parent-child-dyad art therapy. As it will give them the words and the focus required to write case studies of their work. It could also act as a support for them as they are progressing in the therapeutic situation. For those who are about to do so, it might make the intervention seem too complex, which it is, but needs to be tried first, with some trial and error for the therapist to learn.

Q3. *Did you find the manual easy to navigate and use?* At first I found it cumbersome. But as I went through it more than once, I found it became quite easy with a lot of important information at my fingertips.

Q4. *Does the manual reflect some of the ideas you shared during your participation in the development of the process?* Yes I could see myself paraphrased in many of the statements included.

Q5. *Do you have any other feedback you would like to give?* I do not agree with the following: Sometimes more than one primary caregiver is able to regularly join sessions, so the concept of dyadic is then stretched a little to involve two caregivers. And your Vignette #1 demonstrates how working with both parents puts the child back into the insecurity of the home. More than one caregiver changes dyadic art therapy to Family Art therapy. The concept of the dyad may not be stretched. First the work can be one for several sessions with dyads of one parent and then the other to strengthen the relationships. Several sessions with the parents alone so they can resolve their differences and then a termination session with both parents and the child. I think you should remove both the statement highlighted in blue above and the vignette, as they distort the concept of dyad art therapy. My fears are that art therapist new to this type of work will then put the child in a situation of being pulled between both parents, which

is what dyad art therapy is attempting to discourage. The therapist stretching the dyad art therapy concept may have boundary problems and in unable to set strong rules with the parents about this process. (The request of parents to be seen together with the child usually comes from parents who are separated or divorced and trying to use the child as a pond). I think you have compiled this massive amount of information in a simplified way so that art therapists interested in working with parent-child-dyad art therapy will have the information they need to begin.

P4: Q.1 *Does the manual contain the kind of information you would hope to see in a dyadic art therapy manual?* Yes, very helpful, informative and reassuring.

Q.2. *Do you think the manual would be helpful for art therapists who are working with parent-child dyads or about to start doing so?* Yes I think assessing and considering starting up dyadic work can be anxiety provoking and guidance/tips/reassurance and links to vignettes are very helpful. (I could only find vignettes 5 and 6 but I am guessing that is because it still in draft process).

Q.3. *Did you find the manual easy to navigate and use?* Yes, really easy and clear. Not quite sure about this yet, generally yes - but sometimes felt like I had maybe missed things. Perhaps because the hyperlinks seem to take you into deeper levels if further information is required. This is helpful but I initially read it through and then went back to follow the links afterwards. I suppose it depends on the angle you are approaching the website from, i.e. looking for guidance on a specific element of dyadic art therapy work or as someone new to art therapy trying to get a general feel for what it all means. Or colleagues from different disciplines perhaps trying to understand more about the approach.

Q.4. *Does the manual reflect some of the ideas you shared during your participation in the development process?* Yes certainly.

Q.5. *Do you have any other feedback you would like to give?* Thanks this is a very helpful resource! Ideas for development; Perhaps a section or downloadable leaflet for service users (child and parent friendly) could be a useful addition to be developed in future? Something which gives a brief overview of the manuals content but also what those going to participate in art therapy might expect. Q and A section, ground rules, some images etc. I would be happy to try and contribute to this in future if required. We have begun trying to adapt regular art therapy leaflets in our service to help people understand what to expect. I have personally found Dan Hughes' Dyadic

Developmental Psychotherapy literature and video's useful, maybe this would be something useful to link with? And also any info about the training you have run for BAAT could be a useful link?

8.10.2 Unstructured feedback from participants (i.e. not using form)

P5: I think the layout is lovely. A refreshing change somehow from the norm. I love the go gos on the front page! It looks like it will be really helpful. Well done, you must be delighted and relieved!

P6: I think the manual is excellent and gives insight into the complex nature of relationships between a child and their caregiver. It provides a descriptive context of dyadic work taking into account how a person functions emotionally and intellectually. It is helpful to highlight impairment of emotional functioning and to think about assessing a parents ability to work in this way. Whilst we understand attachment framework and theory this does not always provide a framework in which to work with these difficulties. The manual enables the clinician to understand what competence and level of experience they require in order to work in this way which is important. It demonstrates a level of skill needed in understanding the effects of trauma and the needed for safety and containment. I was uncertain or may have missed safeguarding issues and what may need to happen if a parent is unable to demonstrate emotional warmth to a child. Referral to other agencies including Children's Services may play a part in the dyadic work and in itself can be an intervention. I thought the layout of the manual was very clear. I also liked the images used. I am sorry I have not had time to give more detailed feedback. I feel what you have achieved demonstrates the complexity of the work we undertake in Art therapy and goes a long way in evidencing Art therapy as an approach to working with the complex, emotional and relational issues of children, parents and carers. I am very excited and motivated by your work

P7: I think the website is great. I like the clarity - for instance observing and formulating. This is clear, informative and helpful. Similarly, Structuring the Intervention and Sessions is concise and helpful with an important comment on being aware of the carer's own past and how this might impact on dyadic work. The joint engagement research is also extremely interesting and relevant. This is an important and

useful website. The image of the family in the clay rowing boat is extraordinary too!
I've left it too late to say anything else except hearty congratulations

P8: have done a brief analysis of the manual and find the content and layout easy to read and convincing in their findings. The method should be of real interest to therapist and carers of children who are in need of further support in instigating and encouraging interaction of children in a state of emotional arrest. The graphics are certainly an improvement on other layouts I have seen and lends itself to an easy follow through of the research and practice. Can I congratulate you on this lengthy and well researched manual. I feel sure it will be successful to all those needing practical therapeutic support.

P9: Basically to say what a beautiful piece of work it is, well done! I think it will prove to be incredibly helpful to lots of people, information and signposting to further ways to learn is brilliant. I really loved the images which are an integral part of the manual, really good in themselves and for promoting art therapy through images, and letting people take in information visually. It is really informative and lovely that it has been partly a collaborative project but completely held together by your energy and creativity. Will you be producing it as a hard copy as well? I am thinking of some people I supervise who are really not very capable with computers and might find it hard to engage with it. Others are very capable and will love it. Congratulations, its a great piece of work.

8.10.3 Feedback for non-participant parties

N1: This is fabulous Lizzie. Thank you. Just a small comment on the visuals. I really like the way you have brought in images and that they are wide ranging but I think the first image in the "about the manual" section could be stronger and more in focus. I love the idea of the go gos lining up, they look ready for action and about to start to sort themselves out but I think it is not as strong as the other photos in terms of the lighting and sharpness.

N2: I really love it! It's great, have had another good look tonight and feel it is really well put together and so informative. Particularly like the way it is broken down into different headings and the useful links to more info on a subject or research etc. Really

looks good and reads well. I think it will be an excellent resource for AT's to use. So in answer to the questions I would say " yes definitely " Sorry haven't got form with me at mo as my ipad won't let me open it. But if remember correctly the gist of the questions are about whether it would be useful to AT's and explained dyadic process etc, then yes , a big fat yes!! The only feedback I would suggest in terms of a change was wondering about the section entitled helpers, reading it I assumed it's describing what it is uniquely helpful about dyadic AT and the benefits of it's approach. But was just wondering if a different title might work, as initially was unsure what "helpers " would cover. Would benefits of approach be any good? On just re reading the section again now , wondered if it was perhaps it also about what helps the dyadic work, esp with the last line "good supervision and a supportive workplace and colleagues are a great help" So maybe I have got a little muddled, sorry! But basically just wondering about a different title . I think it is a great website and so useful, it explains everything so well. You've put so much work into it! What a fantastic gift to the profession .

N3: I had a really good read through and followed the links to all the different pages and felt you have done an amazing job of covering so many different aspects of this work. It flows so well and is easy to navigate through. There was nothing that stood out as needing to be altered in my view. I think it will be an invaluable resource to many art therapist and such a good point of reference for clinicians starting out in this work. So much hard work must of gone into this and you can tell this from the site.

I wondered if maybe in the future it might be useful to gain information about the different evaluation tools that art therapists have been using and the success of these. May help point people in the right direction. Also wondered about the different themes that may occur within the sessions with parents/carers and possible useful journals/books/articles/tools that may help the clinician to talk with the parents about these issues (psycho-education). I wondered about possible You Tube links to clips/lectures etc that people have found helpful that they maybe able to use to explain points to carers. In summery, it's brill!! Well done you.

N4: this is such brilliant work! My only thoughts are that people might want more 'how to...' in the steps - as much of this isn't taught on the trainings. Perhaps videos? The adherence scale was also inspiring. We're hoping to have a draft manual for November. Well done!!!!

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