FAMILY ASSESSMENT

and

INTERACTIVE ART EXERCISE:

AN INTEGRATED MODEL

by

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A dissertation submitted in fulfillment of the requirements for the degree of Doctor of Philosophy in the field of Art Therapy.

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I certify that this thesis entitled *Family assessment and interactive art exercise: An integrated model* and submitted for the degree of Doctor of Philosophy is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed ……………………………

Date………………………………..
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This thesis presents research into the development of a family assessment and interactive art exercise that is designed for children between the ages of two to eleven with complex psychiatric difficulties and those who have been exposed to significant abuse, trauma, and neglect and with family relationship problems. An overview of the field of child development, trauma and attachment is presented. Various clinical approaches and tools that have been used to engage and assess children is then explored and analysed including psychodynamic and systemic, such as art therapists, family therapists and family art therapists. These explorations created the framework for the development of the family assessment and interactive art exercise using an integrative model that is a synthesis of theoretical approaches and clinical assessment tools. The family assessment and interactive art exercise was then applied to four families and the findings evaluated and presented through vignettes, observations and discussions. The results demonstrated that when applying an integrative model of assessment to children with complex needs increases child inclusion, multiple levels of information can be effectively and efficiently observed and assessed and first-rate multidisciplinary treatment plans can be created.
CHAPTER ONE

Introduction: The reason for the development: the context and the ‘problem’

Children exposed to significant abuse, trauma, and neglect and with family relationship problems often present a confusing and difficult-to-assess clinical picture. Providing efficient and comprehensive family assessments culminating in first-rate treatment plans are essential for the future wellbeing of these children. The often extreme behaviours of these children and the associated anxiety of being assessed by unfamiliar adults can mean that family assessments quickly become unproductive, because the family assessment is reduced to simply managing the child’s anxiety and challenging conduct. Whilst this information can be useful, it lacks richness and loses the opportunity for a broader systemic understanding of the child’s behaviour.

Furthermore, when assessing multi-generational families the constant demands for attention of younger, toddler age children can collide with the therapist’s need for a more complex systemic understanding of the child’s behaviour within their family relationships and wider contexts. Childrens’ variable developmental capacities and understanding of language also poses problems in family assessments, because their thoughts and contributions are lost in the primarily language based adult process, where a child can easily be held responsible for their behaviours. Children, who feel blamed, do not understand or when excluded, are more likely to become restless, demanding and disruptive. These factors do not provide a favorable family assessment environment that is efficient and conducive to accomplishing a child-inclusive, comprehensive family assessment and do not assist in developing first-rate treatment plans.

Accepting the impact of abuse, neglect and trauma on these children and their families, as well as the need to elicit complex and at times sensitive information at multiple levels, is considered crucial in developing efficient and helpful treatment plans.

Considering ways to provide a more child-inclusive comprehensive family assessment, that was positive and engaging for all family members, becomes essential when working with these children; which also needed to encompass ideas related to working with traumatised children within a multidisciplinary child and adolescent psychiatric hospital. These basic arguments are all supported by the literature (Arrington, 1991; Chasin & White, 1989; Dowling & Jones, 1978; Riley & Malchiodi, 1994; Rubin & Magnusssen, 1974). Yet in an extensive review on child-inclusive family therapy and family art therapy assessments and the various techniques described, a family assessment was not found that was both suitable for these children and their families and congenial to the child and adolescent psychiatric hospital’s demands for efficacy.

What did emerge strongly from the literature was that conducting assessments of traumatised young children and their families’ presents a challenge for a therapist, and requires an integrative model of assessment and treatment (Bentovim, 1998; Berliner, 2002; Crittenden, 1996, 1997; Lebow, 1997). This study therefore adopts an integrative model with the argument being put forward that when assessing traumatised children the approach needs to be informed by a trauma paradigm, which is truly systemic, encompassing social, family, medical, behavioural and psycho-dynamic understanding, including non verbal interventions, with children being active participants of the therapeutic process (Kozlowska & Hanney, 2003). This distinction of adopting an integrative approach when assessing these children and their families, created the framework for the literature review and theoretical exploration.
When faced with children who have been psychologically traumatised the integrative model also stresses the importance of exploring a child’s perceptions of their world and the more hidden stories, which can be expressed through more non-verbal interventions. The use of non-verbal models of working, such as art therapy, as well as other therapeutic approaches, which have sought ways to successfully assess and treat traumatised children, is presented. Whilst these ideas were helpful the integrative approach also recommends an assessment that is truly systemic. An exploration of the systemic approaches that were influential in developing the assessment exercise is also offered.

Emerging out of the literature was a family assessment and interactive art exercise that adopted an integrative approach for assessing traumatised children and their families that was more child-inclusive. Once the family assessment and interactive family art exercise was created it was then incorporated into the child and adolescent psychiatric hospital’s assessment process.

Four families who had been referred to the child and adolescent psychiatric hospital agreed to be video recorded whilst undergoing the family assessment and interactive art exercise. Alongside these video recordings the therapist and multidisciplinary team’s thoughts and discussions behind the one-way screen were recorded in note form. The video recordings were then transcribed in written form, including some brief descriptions of non-verbal physical movement, as well as word for word verbal communications. Evaluating the family assessment and interactive art exercise is through the use of these four family assessment transcripts. Key moments, creating vignettes, have been lifted from the transcripts and are interwoven with the observations and discussions held by the therapist and multidisciplinary team behind the one-way screen. The intention of using the vignettes alongside the therapist and multidisciplinary team discussions is to illustrate the multiple levels of information that can be effectively and efficiently observed and assessed when an integrative approach is adopted. The process and the richness of the family assessment and interactive art exercise, particularly the high levels of child-inclusive practice it accomplishes, are also clearly demonstrated. The therapist and multi-disciplinary team’s diagnosis, formulation and consequent treatment plans are also presented.

The primary aim of this study was to develop a more child-inclusive family assessment using an integrative model as recommended by the literature as the most helpful way of assessing children who have experienced psychological trauma (Bentovim, 1998; Berliner, 2002; Crittenden, 1996, 1997; Lebow, 1997). In appreciating the entirety and the complexity of a family system this integrative approach will seek to bring together diverse theoretical sources into a coherent family art therapy assessment framework that aims to increase child inclusiveness.

In increasing child inclusive practice it seemed crucial to place the child at the centre of the assessment, which led to the first step of developing an understanding of child development. A brief outline is given of child development models, particularly with a focus on language and understanding, alongside consideration of how abuse, neglect and trauma impact on a child’s development and capacity to communicate. The child development models that were reviewed all strongly underlined the importance of children’s ability to form healthy attachment relationships to their future wellbeing. This capacity to form healthy attachment relationships is examined through attachment theory. Incorporated in this is the impact on childrens’ development of trauma, abuse and neglect, as well as parental mental health on their ability to form a healthy attachment. Some of the assessments techniques that have been employed to assess child-parent attachment relationships are presented. These techniques were helpful in placing emphasis on the importance of understanding the interaction between a parent and child and assessment techniques. The attachment theorist’s primarily focus however, on the dyad,
mother-child relationship, limited the range and depth of information required to form a comprehensive family assessment of children suffering psychological trauma. In respect of the integrative model recommended for working with traumatized children a truly systemic approach also needed to be considered.

Family systems theory underlines the importance of all the relationships in the family, where each family member’s relationship influences the other. Including and understanding all of the attachment relationships that children have in their family as well as the impact of the trauma becomes essential. A review of systemic theory is therefore undertaken, including some relevant family therapy approaches. Consideration is then given to engaging children and creating a therapeutic environment safe enough for children to express themselves freely. Various therapeutic approaches that were relevant are presented including psychoanalytic, play therapy and art therapy. The literature review concludes with an exploration of family art therapy, a seemingly comfortable synthesis of psychodynamic and systemic methods of working. Family art therapy seemed to provide a framework for taking an integrative approach to conducting family assessments with children who have been traumatised.

The literature review is followed by a discussion outlining the different therapeutic approaches and previous assessments, describing their contribution and areas that required further development to meet the needs of the children and families in this study. The ideas that were synthesised to create an integrative approach to the family assessment and interactive art exercise are then illustrated. This is followed by a detailed description of the actual tools and methodology of the family assessment and interactive art exercise. This will include the use of the one-way screen, the therapist’s role and role of the multi-disciplinary team. Four families agreed to take part in the study and key moments are taken forming vignettes to illustrate the effectiveness of the family assessment and interactive art exercise. The study concludes that by adopting an integrative approach to the family assessment and interactive art exercise has added to the knowledge on assessing traumatized children and some ideas are briefly presented on further research.

**Context**

The impetus for a family assessment and interactive art exercise arose in the context of an Australian tertiary child and adolescent psychiatric hospital, which provided a service for children between the ages of four and sixteen, presenting with severe emotional and behavioural difficulties.

In the 1990’s the Australian National Health Service provided a three tier treatment service for children with emotional and behaviour difficulties. The system placed children’s emotional and behaviour problems on an escalating scale, culminating with the most complex and severe problems at Tier 3, with the type and intensity of interventions taking place in parallel, beginning with home-based treatment to Tier 3 inpatient child and adolescent psychiatric services.

Tier 1 was focused on early interventions, such as parenting groups, support and advice orchestrated mainly through health visitors, school counselors and general practitioners. Treatment was conducted primarily in the client’s home, nursery, school or local community facility. If these interventions were unsuccessful in improving a child’s difficulties then a referral would be made to the Tier 2 community child and adolescent mental health team.
The Tier 2 community child and adolescent mental health teams were also based in the community but would have serviced a wider population area. The teams were multidisciplinary, including child and adolescent psychiatrists, paediatricians, family therapists, clinical psychologists and child psychotherapists. They would liaise closely with the child’s nursery or school, family and if necessary, the department of children’s social services. Depending on the child’s presenting problem, treatment could have included psychotherapy, cognitive behaviour therapy, pharmacology and a range of psychological assessments, as well as liaison with other agencies. Treatment would be time limited, approximately six to twelve months and usually involve a weekly one to two hour treatment sessions held at the clinic. If the child had been medicated then regular medication reviews would also be held. When children and their families continued to present with ongoing emotional and behavioural difficulties then a referral would be made to Tier 3 services.

The children and families referred to the Tier 3 child and adolescent psychiatric hospital had usually not benefited from simpler interventions at a primary or secondary level, that is, treatment at the local community child and adolescent mental health services, with their paediatrician or other mental health professionals. The children and families often presented in crisis i.e. threat of expulsion from school or family breakdown. The majority of referrals were from community child and adolescent mental health services, with the remainder being referred through the courts and the department of children’s social services.

The child and adolescent psychiatric hospital was set up by the Australian government to provide a Tier 3 child and adolescent psychiatric service for the state of New South Wales. The model of care described was the result of an ongoing change process that commenced in the early 1990’s, when the focus of child psychiatric services shifted from residential and day programmes for individual children to a family focused intervention. The extremely large geographical area of New South Wales, and therefore wide group of service users, meant that some children were on the doorstep, whilst others would need to be able to access the hospital from rural communities, some as far as eight hundred miles away.

As well as providing a day only admission for local children, the psychiatric hospital provided two inpatient family units, which allowed families from the wider geographic area to access treatment. These families would be admitted into their own flat for the five-day family admission programme, which involved assessment and treatment, incorporating a number of structured and unstructured components. The high demand on this assessment and treatment option meant that these families would be admitted to the hospital for a week every three months so as to allow as many families as possible to benefit.

In between the family admissions, the child and adolescent mental health psychiatric multidisciplinary team would work in close liaison via telephone and video-conferencing with the family, as well as the child and families local community mental health teams and other government agencies involved with the child and their family. The family admission process allowed rural families to receive an intensive intervention, which was not available locally.

The majority of the children referred to the child and adolescent psychiatric hospital had such complex and challenging behaviours that they had become too extreme to be managed safely within their local schools. Some of the children would therefore, also be referred to an inpatient school, which was on the hospital site. The children whose families came from rural areas were admitted to the school during their inpatient family admission week. The school had a high staff ratio and small classes and was supported by psychiatric nursing staff. The aim of the school was
to assess the child’s academic and social abilities, contribute to the multidisciplinary assessment and treatment and facilitate and support a managed integration back into mainstream education.

The child and adolescent psychiatric hospital’s multidisciplinary clinical team incorporated a child and adolescent psychiatrist, family art therapist, clinical psychologist and mental health nurses, as well as, the teaching staff.

It was the expectation of the referrer and the child and adolescent psychiatric hospital that every child and family referred were provided with at least a comprehensive child and adolescent psychiatric assessment. A standard child and adolescent psychiatric assessment would consist of the child and family being seen by a minimum of two clinical staff, for a number of one to two hour sessions over several weeks. Along with the referral information, the child’s developmental history, the information gathered during the comprehensive psychiatric assessment would then be formulated into an extensive report, which would make recommendations for treatment and interventions. Given the difficulties and high level of concern surrounding the children referred, there was significant pressure from referrers and outside agencies to produce timely reports and recommendations. If the comprehensive psychiatric assessment concluded that the child and family would benefit from being admitted into the child and adolescent psychiatric hospital, then various treatment options would be part of the recommendations. Treatment strategies were usually complex, requiring multiple treatment modalities and were individualized according to the child and families needs.

The overall treatment approach of the child and adolescent psychiatric hospital encompassed a systemic framework that included a combination of social, family, psychological and biological interventions including: outpatient family therapy; family art therapy (Hanney & Kozlowska, 2002; Kozlowska & Hanney, 1999); pharmological therapies; a week inpatient family work; child and adult individual psychotherapy; group art therapy (Kozlowska & Hanney 2001); marital therapy; parent–child interactive therapy; parenting skills; social skills; and, home visits by nurses. Some children were admitted to the therapeutic school day program to address behaviour problems in the classroom and to pursue remediation of educational difficulties.

The need for a family assessment and interactive art exercise emerged from primarily clinical expectations and requirements of the context described and the difficulties encountered in attempting to respond efficiently and comprehensively to those requirements. Secondly, it developed out of a desire to provide more child-inclusive practice where assessment included families with varying degrees of language and authority.

Although the child and adolescent psychiatric hospital assessed children between the ages of four and sixteen, the primary aim was to facilitate an assessment of families with children (2-11 years) including their younger siblings. The assessment needed to obtain substantial multi-leveled information with the view to formulating an efficient and comprehensive multi-disciplinary treatment plan. The high level of subsequent intervention and necessary degree of commitment from the family, as well as the professionals involved, led to an emphasis on providing an efficient, thorough and comprehensive assessment.

The information that the multi-disciplinary team required included; data related to family relationships and patterns of interaction (including family alliances and coalitions); sequences of interaction both verbal and non-verbal; possible attachment behaviour patterns; coping skills; children and family’s affective states; parenting skills; fine and gross motor skills;
speech/language abilities; cognitive and developmental abilities and any underlying and possible unspoken or unknown narratives and beliefs that could be impacting on the family system.

In respect of assessing a children with severe and complex behaviour difficulties (often extremely distressed with a consequential short attention span), at the same time as attaining multi-layered information, it seemed important to reduce their distress by removing the clinical focus away from them. The assessment needed to be experienced as non-confrontational, particularly by the children as well as the family. The entire family needed to be engaged, regardless of age, language development, and the ability to think abstractedly and sequence temporal events. With these early thoughts in mind, what emerged was a desire to create an environment and experience that was efficient, semi-structured, anxiety reducing and that encompassed verbal and non-verbal communication and stretched over all levels of developmental ability. The assessment needed to help children and families recount their story and therefore promote more child inclusive practice.

The initial inspiration to explore the idea of creating a family assessment, followed three years of observing family assessments through a one-way screen. A therapist would interview the family whilst a therapy team from multidisciplinary backgrounds observed. The multidisciplinary team would often vary depending on availability but could include child and adolescent psychiatrists, clinical psychologists, art therapists, child psychotherapist, family therapists and occupational therapists. Working with a multidisciplinary team creates the opportunity for multiple perspectives to be effectively and efficiently obtained and integrated into a comprehensive treatment plan. In these observations it had become increasingly evident, and at times concerning, that the children were rarely spoken too or at best were encouraged to play with toys in the corner of the room. The children’s play was rarely explored or links made to the adult conversations taking place. Wondering how children experienced these assessments and if given a voice, what they might say led to a curiosity as to why children were not being involved in the sessions and were rarely given the opportunity or appropriate communication tools to partake. The family therapy literature on assessment and child inclusive practice (Cederborg, 1997; Clarke, 1999; Combrinck-Graham, 1991; Wilson, 1998; Zilbach, 1986) would certainly pose similar questions and reflective thoughts.

After an extensive appraisal of child-inclusive family therapy assessment techniques and family therapy literature, an assessment task was not located that was both suitable for the particular client population and congenial to the child psychiatric hospital. As a consequence the family assessment and interactive art exercise was developed with the intention that it would: provide a more child-inclusive practice; be responsive to the requirements of the context; and, be more appropriate for the specific clientele.

The ‘problem’

The family assessment and interactive art exercise owes part of its development from the experience with a number of clinical difficulties that were regularly encountered. Firstly, most families often included children from various stages of language development, different abilities for abstract reasoning, and a variable capacity to sequence temporal experience. Additionally these children would not normally be able to articulate their ideas and feelings using verbal language. Furthermore, the identified child, more often than not, demonstrated either learning or speech difficulties e.g. difficulty with expressive or receptive language skills, or difficulties with internal state language - that is language about their feelings. On some occasions, some members
of the family did not speak English, or it was their second language. Techniques, which rely solely on language acquisition, were not therefore always helpful (Kozlowska & Hanney, 1999).

Second, although the systemic clinical approach is well recognised in the literature, there are numerous obstacles to its implementation in a clinical setting. Most obvious is the time consuming nature of retaining a broad perspective in terms of collecting, organising and integrating information from multiple levels of observation and discussion. Systemic thinking is strenuous, and requires that the therapist to simultaneously consider multiple interrelated variables and furthermore they appear to find it difficult to evaluate a large number of variables and their relationships - tending to work primarily from one or two perspectives (Doherty, 1989; Kerr & Bowen, 1988; Kozlowska & Hanney, 2003; Nurcombe & Fitzhenry-Coor, 1987). The need for sufficient space and time conflicted with institutional demands, which included: single session interventions, brief, time limited treatments, and the use of pre-set group programs. Limits imposed by fiscal stringency and the lack of remuneration for time spent in liaison with other agencies was also part of this challenge. Furthermore, some of the families were referred from remote areas of Australia that only provided funding for a one-week family admission. Creating an assessment exercise that elicited multi-layers of information in a time efficient manor was even more essential for these families (Kozlowska & Hanney, 2003).

Third, there was a clinical need to find a way to engage families’ best described as ‘avoidant’ or ‘dismissive’ - as classified using the Adult Attachment Interview (Main & Goldwyn, 1985-1993) - who had been unable to engage with other agencies. Parents of such families displayed a style of interaction characterized by a tendency to speak in generalizations, to dismiss affective information and feelings, to minimize the importance of relationships, and to find cognitive explanations for problems, e.g. referring to medical diagnoses as a sole explanation, such as Attention Deficit Hyperactivity Disorder. These families often portrayed themselves as having nothing amiss with their relationships and social adjustment. Information however, from referral agents, schools and other sources tended to describe them as significantly less well socially adjusted, as having less insight, more negative affect and as being stuck in negative relationship sequences. It became essential, therefore, to employ a technique that allowed for observation, exploration and identification of the families’ patterns of interaction and communication using a non-verbal as well as verbal approach, which was inclusive, particularly of the child’s thoughts and ideas, without the laborious task of doing so via verbal reconstruction. Furthermore it would hopefully avoid an adult-laden version of events (Kozlowska & Hanney, 1999, 2003).

Fourth, assessment techniques developed by attachment clinicians and used by other clinicians in the facility were useful for dyads, but needed to be modified when seeing families, where there could be up to eight people in a room. Thus, there was a need to find a vehicle to enable greater focus upon, and that would help, clarify patterns of interaction in chaotic or large families in a more tangible manner, a ‘here-and-now way’, which could be easily understood and made sense of by both families (that is, both adults and children) and therapists (Kozlowska & Hanney, 1999).

Fifth, in assessments, children were noted to often be sent to the corner of the room with various toys or drawing materials whilst the adults spoke about the particular child’s difficulties, which would seem to raise the child’s anxiety and result in further distress. The idea of involving the family in using an interactive assessment exercise was seen as a method to remove the spotlight from the identified child, be more child-inclusive and allow for a central and concrete focus of attention within families that often presented as chaotic, distressed and disorganized (Kozlowska & Hanney, 1999).
Finally, the children that had been referred to the child and adolescent psychiatric unit had apparently experienced some form of maltreatment and presented with a bewildering array of emotional, behavioral, developmental, attachment, family and academic difficulties. Child maltreatment occurs in the context of an interconnected web of individual, family and social factors (Belsky, 1980, 1993; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss & Marks, 1998). Maltreated children are not usually recipients of single-incident trauma, but develop in a context where exposure to varying patterns of household dysfunction and social contexts such as substance abuse, mental illness, family violence or criminality, poor parenting, negative parent-child interactions, marital difficulties, social isolation, low income, and failure to use community resources are commonplace (Belsky, 1993, Felitti et al., 1998). The array of presenting symptoms could include: post traumatic symptoms, impulsivity, distractibility, anxiety symptoms, self destructive behaviours, re-enactment, affect labiality, intractable depression, dissociation, cognitive and language difficulties, somatisation, interpersonal difficulties and pathological changes in identity (Egeland, Scoufe & Erickson, 1983; Scheeringa, Peebles, Cook & Zeanah, 2001; Terr, 1991; Thomas, 1995). As a result, these families present a confusing and difficult-to-treat clinical picture therefore to develop an assessment exercise that began to tease apart the complexities of these often chaotic and complex families was important.

The task

It became apparent that the assessment of maltreated children and their families presented a number of unique challenges. The family assessment and interactive art exercise needed to be cost effective, expeditious, produce multi-levels of information and be inclusive of all family members, regardless of developmental stage, as well as being able to address the unique presentation of abused, neglected and traumatised children and their families. It was obvious that when working with the children referred to the child and adolescent psychiatric hospital it was essential to first gain an understanding as to the unique clinical challenges and responses that were required to assess children and their families who have experienced trauma, neglect and abuse. The aim was therefore to develop an integrative approach that would offer a well-considered mixture of therapeutic approaches providing broader conceptual insights and multiple lenses to view the complexities of these children and their families (Lee & Everett, 2004). Having a reasonable appreciation of child development, the development of communication skills and how trauma affects the developing child and the family system seemed the critical first step (Kozlowska & Hanney, 1999).
CHAPTER TWO
Child development and attachment

When working with children, particularly in regard to understanding their behaviour, an understanding of child development is imperative. A formidable body of literature has identified specific milestones and accomplishments. It is however, beyond the scope of the thesis to review the extensive literature on the subject. Instead, key aspects have been explored, in particular the development of non-verbal and verbal communication and understanding, and other aspects that appear relevant in the context of working with the previously described client population.

It has been established that pre-school children and some school-aged children, due to their neurological immaturity, do not have the cognitive ability to express themselves fully through verbal communication (Hanney & Kozlowska, 2002; Kozlowska & Hanney, 1999, 2001; Price & Goodman, 1990). Prior to the ability to express through verbal communication, many authors have portrayed children’s non-verbal communications, such as art expression, as one of the pathways to understanding the child’s experiences as well as their internal world.

What clearly emerged in the majority of the literature was that children pass through distinct predictable levels of non-verbal communication. Lowenfeld and Lambert Brittain (1964) identified typical characteristics of art expression. They described the beginnings of self-expression as “The Scribbling Stage” (2 – 4 years), which they viewed as a vital stage in a child’s development. Kinesthetic experiences and explorations are evident in how children scribble - that is their ability to move body parts, explore objects and interact with their environment. Kellogg, (1970) in an attempt to understand the meanings behind scribbling, conducted an extensive historical appraisal of children’s non-verbal art expressions. The conclusion was that children had a tendency to reflect in their scribbling a similarity to how they approach and interact with their world. The characteristics of a lively and boisterous child could be seen in their ‘lively and boisterous’ scribbles. Children who lacked confidence displayed scribbling behaviour that was repetitive, which suggested a need to search for security. This repetitive behaviour would restrict further exploration and therefore impact on the child’s development.

According to Piaget (1951, 1962) between two to seven years of age, cognitive development is characterised by children’s emerging ability to use symbols, such as symbolic play and imitation, drawing or graphic imagery, mental images and language to represent their experiences and understandings of others. These developmental leaps correspond to the growth of the left-brain at about age three (Thatcher, Walker & Giudice, 1987).

The ability to talk about feelings, emotions and other internal states, called ‘internal state language’, evolves from the second year of life and increases dramatically during the following years (Beeghly & Cicchetti, 1994). Children start to develop narrative memory from the age of about three, when they begin to construct meaningful phrases (Terr, 1994). Prior to this age, narrative memories are absent, fragmentary or remembered visually (Terr, 1994).

In the three-year-old, scribbling has developed into more representational drawing, but the symbols in the drawings often represent multiple meanings (Owens, 1984). Representation of the self, that is, the ability to represent one-self using a picture of one-self or a doll that represents one-self, emerges between 3.5 - 4 years of age (Hewitt, 1998) and reflects a more complex use of
symbols. In agreement, the ‘Preschematic Stage’ (4-7) as described by Lowenfeld and Lambert Brittain, (1964) is when form develops out of the scribbles, as the child moves away from kinesthetic representation to expressions of the visual world. “A child in this ‘Preschematic Stage’ is involved in portraying his concepts or his own mental translations of what he has perceived in the past into some new formulation or symbol” (Lowenfeld & Lambert Brittain, 1964, p. 118).

Although the child’s scribbles seem to be informative regarding their physical development in that they permit observation of the child’s expression of kinesthetic experience it is not until they reach the ‘Preschematic’ stage (from about 4 years of age) where the use of drawings and art as an adjunct to therapy is useful (Hanney & Kozlowska, 2002). It was noted however, that a child who has experienced extreme levels of neglect in their early years, where the space between primary carer and child has been ‘dangerous’, would find it difficult to develop the capacity to symbolize (Winnicott, 1971). “The capacity to form images and to use these constructively by recombination into new patterns is – unlike dreams or fantasies – dependent on the individual’s ability to trust” (Plaut, F., 1966, as cited in Winnicott, 1971, p. 102).

A child’s understanding of time develops between 3.5 and 4 years and their temporal relations between 5 and 11 years (Sanders, 1985). Four-year-olds are able to tell simple stories of their own or other’s authorship and events are relayed in the order in which they occurred (Owens, 1984). Five years old children have a good temporal sense and understand words such as yesterday, today and tomorrow. Concepts of same and different are fully established by 5 years, with understanding of ‘different’ occurring between 2 and 3 years and ‘same’ between 3 and 4 years (Sanders, 1985).

According to Lowenfeld and Lambert Brittain (1964) children between the ages of seven to nine enter the ‘Schematic Stage’ of development, where they are able to symbolize individual concepts. For example, they develop an individual symbol for a human figure, which they continually return too, unlike the younger child’s array of symbols for the human figure. Visual expressions of children in the ‘Schematic Stage’ begin to relate their different symbolic representations to each other, that is, create the possibility for interactions between symbols. At the same time, the base line (ground) often emerges in their images.

The capacity to understand more than one dimension of a situation and see a phenomenon from multiple angles is a feature of ‘concrete operational thinking’, which, according to Piaget (1962, p. 169), emerges from around the age of seven. It is only with the onset of this ‘formal operational’ period, from about the age of 10-12 years, that children begin to think abstractly, think beyond here-and-now experience, and imagine alternatives possible in a situation (Piaget & Innhelder, 1969).

Lowenfeld and Lambert Brittain (1964) describe the ‘Dawning Realism’ as the phase of development, between the ages of nine to eleven years, where a child relates to being part of the group. Children of this age have a tendency to begin to question themselves, others and the world they live in, influencing them to attempt more creative ‘realism’ and become perhaps inhibited and critical about their non-verbal expressions. More aware of their environment, they no longer rely on schematic representations and may prefer not to show their work or “…substitute other means of expression to emphasis. We commonly see an accumulation of details on those parts that are emotionally significant” (Lowenfeld & Lambert Brittain, 1964, p. 188). They observed that children of this age, who were developmentally impaired, tended to be
less connected to their environment or notice detail, which could often be seen in their drawings, particularly in the lack of detail.

As children’s ability to utilize verbal communication develops, a discrepancy between non-verbal and verbal communication can emerge, where they may be more reliant on verbal communication. Many authors, including Di Leo (1970, 1983) argue “…drawings may express a subtlety of intellect and effect that is beyond the power or freedom of verbal expression” (1983, p. 5. For a similar argument, see: Malchiodi, 1998, Moore, 1994a and Ferrara, 1991).

Given that the need for the assessment exercise was focused primarily on younger children it did not seem necessary to further explore the development, communication skills and creative expression through the adolescent years. In summary, it seemed that studying child’s expressions and the potential for creativity could lead to a deeper knowledge of their internal world and stage of development.

The language emphasis of most schools of psychotherapy, and particularly family therapy, becomes more and more inappropriate the younger the child and the less developed the child’s verbal capacities. The risk is therefore, that this lack of maturity in younger children can make it difficult for them to understand the often-involved ideas and complex language used in assessment and treatment (Cederborg, 1997; Chasin, 1990; Combrinck-Graham, 1985, 1986, 1991). Involving pre-school children in multi-generational family sessions is a challenge, as their demands for attention can be so constant that the clinician may be unable to engage the family in an uninterrupted conversation. Limited verbal skills, an under-developed linear sense of past and future, of sequencing and causality, their concrete thought processes prevent them from participating in the conversation or being able to conceptualize family issues using language. As observed, this often has meant that the clinicians talk to the parents, whilst children play in the corner. Consequently, and understandably, children frequently interrupt or disrupt sessions. Observing how the parents manage the children during these times could be seen as important information but such data lacked the richness of information that could be gathered about the family if younger children were more able to fully participate in sessions (Hanney & Kozlowska, 2002; Kozlowska & Hanney, 1999). Thus, the frequent pattern in family assessment and systemic therapy, of avoiding or readily dismissing younger children, almost as if they were not full members of the family group, is problematic (Dowling & Jones, 1978).

The process of drawing, painting, or constructing is a complex one in which the child brings together diverse elements of his environment to make a new meaningful whole. In the process of selecting, interpreting and reforming these elements, he has given us more that a picture or a sculpture, he has given us a part of himself: how he thinks, how he feels, and how he sees.

(Lowenfeld & Lambert Brittain, 1964, p. 1)

That is, the child creates an art expression using their senses involving a process of ‘taking in and putting out’ the environment blended with their inner psychological and physical self.

Most children, before they have fully developed the ability to express themselves through verbal language use non-verbal strategies to express their thoughts and feelings. The child gains knowledge about the capacity to be able to be creative through doing. The use of creativity therefore seemingly becomes essential when working with younger children and attempting to develop a more child inclusive assessment exercise.
The central construct of creativity seems to be change, to create something different (Starko, 1995). Many authors have attempted to define creativity (Bateson, 1979; Ehrenzweig, 1967; Freud, 1933/1988; Jung, 1964; Klein, 1959; Thomson, 1997; Winnicott, 1971), however it is beyond the scope of this paper to do justice to the area, therefore only seemingly relevant aspects are explored. What was interestingly in the literature was the repeated notion that creativity was integral to psychotherapy - the central construct to both was change and the ability to symbolize was underlined.

Klein (1959) expressed the view that the impulse to create derives from a memory when the child’s internal world was in harmony, before it experienced destruction (separation from mother). The child strives to recreate this harmonious position, which it eventually overcomes (acceptance of independence). In ‘Freudian’ literature creativity was viewed as a form of sublimation, a displacement of emotions. In Jungian (1964) literature it was described as essential to human health and one of the five main impulses of ‘man’, which is similar to the Freudian view of sublimation. Winnicott (1971) declared that the capacity for creativity emerged from the use of objects between mother and child, such as the breast to thumb sucking. Creativity emerges from the ‘potential space’ between the mother and the child, where the child begins to experiment with feelings and where the mother begins to help the child to develop meaning. Alongside cognitive development the child is permitted to “...engage in a significant interchange with the world, a two-way process in which self-enrichment alternates with the discovery of meaning in the world of seen things” (Winnicott, 1967, as cited in Davis & Wallbridge, 1987, p. 64). It is from this interchange that communication and the ability to be creative and to symbolise emerges and thus again the ability to develop a self, separate from the mother. It is important to highlight that, in Winnicott’s view, when the “potential space” becomes fraught, for reasons such as maternal depression or deprivation, then the child’s ability to symbolize to be spontaneous and creative could become impaired.

Winnicott’s (1971) idea that creativity emerges from a space, initially between people and then perhaps later between artist and paper, where there is a process of externalisation, sitting back, reflecting and experimenting and then internalisation, has been supported and extended by other theorists (see for example: Ehrenzweig, 1967; Thomson, 1997; Bateson, 1972).

The literature continually placed an emphasis on the importance of key factors that can induce the ability to release creativity. Brittain (1956, as cited in Lowenfeld & Lambert Brittain) and Guilford (1957, as cited in Lowenfeld & Lambert Brittain, 1964) underlined eight important elements intrinsic to the development of the capacity for creative processes, which are outlined below.

1. ‘Sensitivity’ - the ability to be able to understand other people by the use of all the senses and to acknowledge the “experience of living”.
2. ‘Fluency’ – the skill to be able to think “rapidly and freely” non-verbally and verbally.
3. ‘Flexibility’ – the ability to respond and adapt to the unexpected.
4. ‘Originality’ – the ability to create something new.
5. ‘Redefine’ – the ability to change the use of objects and ideas.
6. ‘Abstract’ – defined by the ability to analyze the problem or identify relationships.
7. ‘Synthesis’ – the ability to merge various elements.
8. ‘Organise’ – the ability to put things together.

(pp. 7-9)
Lowenfeld and Lambert Brittian (1964) made various recommendations on how to explore children’s visual expressions, which emphasized the importance of sensitively assisting the child to verbalise and avoiding suggestions. That is, asking questions such as “tell me something about your picture”, rather than “what is this or that?” The observer was encouraged to ascertain whether a symbol has been drawn seemingly without investment or a particular meaning or if there is a hidden expression. Noting the discrepancy between the child’s verbal and symbolic expression can lead to further exploration. They believed an image could be an expression of a complete experience, as well as, an expression of the child’s relationship with their environment and their feelings and senses. Simply observing the child’s involvement and intensity in the creative process permits an understanding of where the child holds their investment (Lowenfeld & Lambert Brittian, 1964). They asserted that a child’s creative expressions are indicative of their emotional, intellectual, physical, perceptual, social, aesthetic and creative levels of development.

Thus, the child with a high and sensitive consciousness of body experience will not only show good co-ordination and control of lines and brush strokes in his work but will also project his ability for body control into his work.

(Lowenfeld & Lambert Brittian, 1964, p. 66)

Childrens’ physical growth, their fine and gross motor skills can be easily observed in how they use their bodies and the art materials. Children who are emotionally disturbed, subdued and restricted by their environment may have a creative tendency towards “escaping into pattern like representations” and creating stereotyped repetitions. Children who have been neglected, who have become detached from their feelings were noted to avoid personal symbols. Children who are perceptually well developed, have a tendency to show these experiences in their creative expressions, such as tactile and visual expressions as well as sensitivity to shapes, colours and their environment. Lowenfeld and Lambert Brittian (1964) noted that children who had lacked perceptual experiences had a tendency to “…show timidity in lines and brush strokes as an expression of lack of kinesthetic enjoyment; they show poor visual imagery, little or no ability to observe, and no inclusion of experiences relating to tactile or other sense experiences” (Countryman, 1955, as cited in Lowenfeld & Lambert Brittain, 1964, p. 67).

Creative expressions of children who are socially disadvantaged had a tendency to be “inconsistent, spatially uncorrelated items and the inability to identify themselves with others in subject matter as well as action” (Mattil, 1953, as cited in Lowenfeld & Lambert Brittain, 1964, p. 68). Children learn to be part of society by first making sense and taking responsibility for their own behaviour. Through the creative process the child begins to see itself and make sense of their human experiences and needs, which in turn allows the child to value the experiences and needs of others.

Lowenfeld and Lambert Brittain (1964) viewed the aesthetic as an innate characteristic of creativity, that is, children who are able to synthesis their sensual experiences, feelings, intelligence and judgment in relationship with their environment are described as integrated, which is seen as vital to psychological harmony. Children who lack aesthetic growth are deficient in the ability to express their feelings or thoughts in an organized manor. Finally, the child’s capacity for creativity is shown in their ability to be independent and unique, rather than inhibited where children often resort to “copying or tracing methods” (Lowenfeld & Brittian, 1964, p. 68).
Historically, there has been much written about the actual interpretation of symbolic representation (Di Leo, 1970, 1973, 1983; Jung, 1964; Kellogg, 1970; Moore, 1994a, 1994b; Wohl & Kaufman, 1985, 1992) even to the point of creating dictionaries of symbols (Cirlot, 1971), where specific symbols are given particular meanings. Jung (1964) was quick to emphasise the importance of being sensitive to the individual’s meaning applied to their symbols rather than assume that there is “stereotyped, intellectually formulated meaning” (Jung, 1964, p. 377). It is with this in mind that caution seems to be required in how children’s symbolic representations are observed and explored, particularly in the context of assessment with a pressure to find meaning.

It was noted that the majority of the authors reviewed placed an emphasis on “a safe place” as essential before any creative activity can occur and significance was placed on abandoning directives and rules, because ‘discipline eliminates creativity’ (Bateson, 1972; Lowenfeld & Lambert Brittian, 1964; Winnicott, 1971). These views were supported and eloquently captured in the following phrase; “…the need for spontaneity is essential – play to order is no longer play” (Huizinga, 1970, as cited in Dalley, Case, Schaverien, Weir, Halliday, Nowell Hall & Waller, 1987, p. 21).

In summary, Lowenfeld and Lambert Brittain, (1964) made links to a child’s general overall development and well being to that of their creative potential. They argue that a child’s mental and emotional growth can only be understood if the relationship between the two were equally valued. In understanding a child’s development and mental health, they also stressed the importance in making sense of the motivation and underlying influences of the child’s ‘creative act’.

Creativity therefore, seems to develop from a child’s ability to substitute objects that stand in for something else. Creativity emerges out of early relationships, where symbols are used as substitutes for comfort and to make sense of relationships. Creativity is both the ‘process’ and the ‘product’, it can be elicited or spontaneous and be both inherited, and learned. As children face new experiences, they explore their inner dialogues by utilizing a variety of external objects, such as toys and drawings. These explorations that occur in the external world were explored, reflected upon, and experimented with, which are then received back into the child’s internal dialogue, perhaps in a new form (Winnicott, 1971). The observer’s need to pay attention to the child’s process of decision making is underlined, as well as the inevitable content. Moreover, by not attending to the processes involved in the creative act, other levels of communication are lost.

It is essential to create a space that permits the observation of the creative process and the families’ interactions, as well as time for exploring the final art expression. Particularly highlighted in the literature were the importance of the mother and child relationship, and the pattern of interaction between them in potentially assisting healthy development and psychological growth. The need to have a more in depth understanding of how the mother-child relationship impacts on children’s development and creative potential was apparent. It was clear that childrens’ wellbeing and their potential for healthy relationships in adult life were determined by the quality of their early attachment relationships. With the integrative model in mind for working with traumatized children, which outlined the need to include social and family functioning, an exploration of attachment theory became essential.
Attachment theory

Understanding attachment relationships has, in recent years, become integral when working with children as it adds further knowledge in areas of child development, family interactions and human behaviour. Attachment theory stresses the importance of the early infant and primary carer’s relationship, its impact on the future well being of the child and how patterns of relating emerge. Attachment theory is basically a theory about the strategies that a child develops to protect themselves from danger and elicit their primary carer to protect and comfort them. It has become increasingly evident that a child’s capacity to develop emotionally and cognitively is closely linked to the quality of their early attachment relationships and that understanding these attachment patterns can be a predictor of later psychopathology (see for example Akister, 1998; Crittenden, 1999, 2002; Crittenden & Ainsworth, 1989).

In line with an integrative model, the importance of attachment in relationships was initially emphasised by Bowlby (1969, 1973, 1980) through the integration of a number of diverse disciplines: psychoanalysis; ethnology; and, social psychiatry. He was particularly interested in the effects of loss and separation on children during the war years. The focus of his work was upon understanding the patterns of interaction between young children and their primary carer.

Attachment theorists have argued a child’s neuro-biological development directly correlates to the infant-parent relationship. The ‘wiring’ of the child’s affective, cognitive and social development is set in place by this relationship (Perry, Pollard, Blackley, Baker, & Vigilante, 1995; Schore, 1996). Therefore, recognizing and understanding the patterns of attachment that children exhibit within their family system is crucial and can lead the therapist to a better understanding of the quality of family relationships and, potentially, aid in the development of treatment plans. A number of assessment techniques have been developed that involve detailed observation, which have attempted to categorize different attachment interactions of children at various stages of their development. Schore (1997) and other authors (Kandel, 1998; Rutter, 1995) have stressed the importance of social and family environments, in particular the attachment relationship in healthy psychological development of children and as a key to the emergence of psychiatric disorder later in life.

Assessments and attachment

Attachment theory has made an enormous contribution to the development of assessment procedures for infants, toddlers and preschoolers, and has strong theoretical roots embedded in the observation of mothers and their young children. Attachment theory is therefore, particularly valuable in recognizing relationship patterns and difficulties with young, often non-verbal children.

Ainsworth, Blehar, Waters and Wall (1978) noticed that certain groups of children seem to have similar strategies in the attachment relationships with their primary carer. In an attempt to classify the various attachment styles of 11 to 15 months old children, she developed an assessment known as the Ainsworth strange situation. This structured laboratory observational assessment involved the use of video analysis and an observer behind a ‘one-way screen’, watching various combinations of the mother, the child and a stranger in a room. Firstly, the mother is asked to play with the child, and after a short time, the stranger enters and sits down. Several minutes later the mother then leaves the room. After a short period the mother is asked to knock on the door and return to the room. The observer notes the child’s reaction to the mother
leaving and then returning and the child’s reaction to the stranger. The stranger leaves the mother and child playing and, after a short time, the mother leaves the child alone in the room before returning. Again the child’s reactions to the mother leaving and then returning were noted.

Three broad patterns of Attachment behaviour were observed and associated care giving styles (Types A, B, C) were observed by one year of age (Ainsworth et al., 1978). Main and Solomon (1986, 1990) were the first to expand the “Ainsworth’s Strange Situation” assessment by adding the “disorganized/disorientated” (D category) to account for dyads that did not fit the A, B, C system. Various others have extended the original measure to explore attachment relationships in the preschool and adult years. School-aged assessment measures are being developed (Main & Goldwyn, 1998; Priddis & Howieson 2009; Solomon & George, 1999). The Cassidy and Marvin (1992) system for pre-schoolers (1991/1992); the Main-Cassidy (1988) system for six year olds; and, the Main and Goldwyn Adult Attachment interview (1985-1993) include the A, B, C groupings as well as “disorganized” and “unclassified” categories.

The assumption underlying the “disorganized” concept is that fear, in terms of a frightened or frightening caregiver is central to disorganization (Main & Hesse, 1990). Crittenden, however, views the so-called “disorganized” group of relationships, as organized and has begun to describe subsets from this group in her “Dynamic Maturation Model” (Crittenden, 1997, 1999, 2000; Crittenden & Ainsworth, 1989; Crittenden & Di Lalla, 1988). Some of these differentiated categories build upon patterns of behaviour previously described by Bowlby (Kozlowska & Hanney, 2002). Disorganised attachment, or category “D” (Main & Solomon, 1990), refers to children who do not have a consistent strategy for organising responses and demonstrate an apparent lack of strategy or show behaviours adapted for protection from particular form of danger (Crittenden, 1998b). Examples of behaviours of category “D”, from the Ainsworth Strange Situation include: alternating; resistant; and, contradictory behaviours. For example, in relation to the latter, a child who sits on the parents lap but avoids the parents gaze, and/or a child who moves towards their parent on reunion but then freezes, and/or a child who smiles at the same time as exhibiting fear (Crittenden, 2002). Disorganised attachment is associated with high risk, or maltreating, families (Carlson, Cicchetti, Barnett & Braunwald, 1989; Crittenden, 1998; Lyons-Ruth, 1996; Lyons-Ruth, Alpern, & Repacholi 1993; Main & Solomon, 1986), and unresolved loss or trauma in the attachment figure (Main & Goldwyn, 1984; Van Ijzendoorn, 1995). Main and Hesse (1990) hypothesized that disorganisation of infant attachment strategies is related to parental unresolved fear, and is intergenerationally transmitted through behaviour that frightens or is frightening to the child. Wright (1986) discusses how the mother and child may be caught in an escalating cycle of fear. A child who is afraid, approaches the parent for comfort. The child’s fear and vulnerability, for example their cry, may trigger a fear response in the parent with unresolved trauma, leading to hyper-arousal and/or dissociation, which further frighten the child. Therefore, rather than being able to offer comfort and protection to the child, the traumatised parent may become frightened or frightening in their relationship with the child, thus becoming in themselves a source of stress and/or trauma. Schore (1997) similarly describes how a parent who is unable to regulate their own psycho-physiological state, will be unable to regulate the infants.

Crittenden (1995) has written extensively on the importance of understanding attachment and its later connection to psychopathology. In the “Dynamic-Maturation Model”, the focus is upon the child’s ability to seek protection from danger and to later find a healthy reproductive partner. Crittenden has focused on the interactions between genetic inheritance, maturation processes and individual life experiences that produce specific protective strategies of behaviour.
Crittenden (1979/2005) developed an assessment technique called the “CARE-Index”, which is a screening tool developed to make reliable and valid interpretations of mother child interaction for children from birth to 15 months of age. It is based on 3 minutes of videotaped play interaction occurring in under non-threatening conditions. The CARE-Index assesses the dyadic relationship, but primarily focuses upon the mother’s sensitivity to their child. That is, the ability of the mother to comfort the child and increase attentiveness at the same time as reducing distress and disengagement. The videotape is then coded using different coders with attention to seven aspects of child and mother behaviour, including affect, such as facial or vocal expression, position and physical contact etc. and cognition, i.e., pacing of turns, ability to perform the task, and an awareness of developmental levels (Crittenden, 1979/2005). The behaviours are evaluated separately and scored accordingly from 0-14, 0 being dangerously insensitive and 14 being outstandingly sensitive. The scores are then used to indicate treatment options i.e. a score of 5-6 suggests parental education etc. Crittenden (1979/2005) assessment was distinctive, in that it assesses risk to individuals and affective attunement. She however points out that the CARE-Index does not actually assess patterns of attachment, as this would require introducing a stressful situation to induce the child protective attachment strategies. It does however assess dyadic characteristics associated with attachment.

Main and Goldwyn (1998) developed an attachment assessment procedure for six years olds. The method has been standarised with some unstructured procedures. The assessor visits the child and careers in their home. One week later, the child and primary carer visit the laboratory where a Polaroid photograph is taken of the family arriving. The child and primary carer are then videotaped in a playroom followed by the carer leaving the child with the assessor for one hour. The assessor then interviews the primary carer individually. The assessment is analyzed on the discourse fluency between the primary carer and child and on the child’s response to the photograph.

When Cassidy and Marvin (1991/1992) developed their preschool assessment for children within the age range 2.5 - 4.5 years it was based on Ainsworth Strange Situation, but with some consideration to the child’s levels of comprehension, such as understanding instructions and being more self reliant, such as leaving the room to seek out the primary carer. The primary carer, on leaving the room, is told to tell the child that they are going to make a phone call so as to normalize the situation as much as possible. The assessment is videotaped and then coded according to five modalities; physical proximity and contact; body positioning; speech; gaze; and, affect. Not including the coding, which has to be completed by an authorized coder, the assessment process should take 20 minutes in total.

In summary, the attachment literature highlighted the importance of an early healthy relationship between the mother and child, where the mother’s sensitivity to the child moulds the child’s capacity to self regulate and develop healthy relationships to others. The effect of trauma on the development of a child’s brain was highlighted, which was shown by how poorly they scored on the attachment assessments. The importance of understanding and intervening in these negative patterns of interaction was underlined, if later psychopathology is to be avoided. Gaining more understanding of the effects of trauma on children, their attachment relationships and child development became imperative.

Whilst the attachment assessments reviewed were helpful in thinking about what and how to observe patterns of interaction the attachment assessments had remained focused on dyads, the mother and child relationship. The assessments were not in keeping with an integrative model and particularly failed to elicit wider systemic influences and the richness of the more non-verbal
internal worlds of the mother and child. To help guide the review through the literature on approaches that access this type of information it was important to establish a thorough understanding of how dysfunctional attachment relationships and trauma impact upon the actual biological structures of the child’s developing brain.
CHAPTER THREE

Impact of trauma on children’s development and attachment

The diagnosis of trauma

Traumatised children frequently present to health services with a wide range of symptoms and negative patterns of behaviour and interactions (Kendall-Tackett, Williams & Finkelhor, 1993). Symptoms of trauma may include arrest of developmental milestones together with a bewildering combination of emotional, behavioural and academic difficulties, including: physiological hyper arousal; nightmares; flashbacks; difficulties with affect regulation; anxiety symptoms; oppositional behaviors; aggression; and, difficulties with concentration. Post Traumatic Stress Disorder (TSD) in children is diagnosed using DSM-IV (1994) criteria, or in younger children using criteria in the Diagnostic Classification 0-3 (TSD) both require items from the following three categories: (1) re-experiencing the trauma; (2) evasive strategies employed to avoid stimuli affiliated with the trauma and (3) hyper-arousal. The 0-3 also includes interference with developmental momentum and new fears and aggressions. Re-experiencing symptoms include: nightmares; flashbacks; and, children may repetitively re-enact the trauma. Evasive strategies include: avoidance of triggers; social withdrawal; and, a restricted range of affect. Other possible symptoms include: fear of the future; thoughts and fantasies of death; emergence of new fears; emergence of aggression; and, regression in development (Adapted from ZERO to Three, National Centre for Clinical Infant Programs, 1994). Therefore, children who have been exposed to trauma exhibit a large range of symptoms and difficulties which may be misdiagnosed with other disorders, such as Attention Deficit Hyperactive Disorder, Oppositional Defiant Disorder, or other emotional disorders due to the wide array of their symptoms (Kozlowska & Hanney, 2001). The lack of recognition of trauma, and its effects on children, has been attributed to both social denial (Herman, 1992) and a low prevailing index of suspicion (Putman, 1993). Failure of recognition, however, is important as it impacts on treatment outcome (Brett & Ostroff, 1985; Kozlowska & Hanney, 2001, 2003).

Child development and trauma

Alongside the literature on attachment theory, many authors agreed that traumatic experiences, such as chronic severe inter-parental conflict, violence and hostility impact adversely on the emotional, behavioural, cognitive, social and physical development of children (Cherlin, Furstenberg, Chase-Lansdale, Kiernan, Robins, Morrison & Teitler, 1991; Cicchetti & Carlson 1989; Jenkins & Smith 1991; Perry, 1993a, 1993b; Perry & Pollard, 1998; Pynoos & Eth, 1984, 1985). An exposure to recurrent trauma impacts on a child’s developing brain (Damasio, 1994; Edelman, 1987; Hartman & Burgess, 1993; Kraemer, 1992; Levine, Tuber, Slade, & Ward, 1996; Perry, 1993a, 1993b; Pynoos, 1990; Rakic, 1995; Schore, 1997). Trauma in infancy and early childhood has a longstanding effect on both the structure and function of the developing nervous system and may sensitize the child to vulnerability to subsequent trauma (Damasio 1994; Edelman 1987; Kraemer 1992; Nelson & Bloom, 1997; Perry, 1993a, 1993b; Rakic 1995; Schore 1997). It has also been noted that children exposed to family conflict are between two and five times more likely to show difficulties in their behaviour than children from harmonious homes (Quinton, Rutter & Rowlands, 1976; Richman, Stevenson & Graham, 1982; Rutter, Yule, Quinton, Rowlands, 1975; Yule, 1991).
Traumatic experiences can be described as any event that is beyond ordinary human experience, which is threatening to the self, and in the case of children also threatening to their caregivers (Crittenden, 1999; Scheeringa & Zeanah, 1995). Traumatic experiences may involve exposure to verbal or physical violence between parent’s verbal or physical abuse towards the child, or overt attempts by one parent to alienate a child from the other parents – which is termed “alienation syndrome” (Gardner, 1985, 2006). There was an agreement that significant exposure to abuse and neglect or household dysfunction has cumulative lifelong effects on the development of children and on their psychological and physical health status as adults (Egeland, Sroufe, & Erickson, 1983; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss & Marks, 1988). The fiscal cost of maltreatment in terms of adult health, judicial and welfare budgets has to be enormous.

As described by Crittenden (1999), individual symptoms depend on a complex interaction between the child’s genetic potential, neurophysiological maturation and context (Crittenden, 1999; Jenson, Mrazek, Knapp, Steinberg, Pfeffer, Schowalter & Shapiro, 1997; Perry & Pollard, 1998; Sroufe, 1997). Trauma occurring early in life, and/or within the context of attachment relationships, is particularly disruptive to the developmental momentum of children (Egeland, Sroufe & Erickson, 1983; Herman 1992; Scheeringa & Zeanah, 1995). It has been noted that there are a wide range of impacts on brain development and such trauma may permanently modify an individual’s vulnerability to psychiatric disorder (Fox, Calkins & Bell, 1994; Herman, Perry & Van der Kolk, 1989; Perry & Pollard, 1998; Schore, 1997).

Although seemingly problematic, many of the presenting symptoms or behaviours of maltreated children can be viewed as adaptive strategies, which function to reduce the sorts of dangers these children have experienced (Crittenden, 1999; Jensen & Hoagwood, 1997). When the danger takes the form of a lack of parental response, adaptive strategies are likely to elicit parental attention, even if this involves aggressive or risk-taking behaviour (Crittenden, 1999). Hyper arousal symptoms, such as: hyperactivity, to external stimuli; hyper-vigilance; and, behavioural impulsivity, can be diagnosed as the disorder of Attention Deficit Hyperactive Disorder, or can be viewed as an adaptive trauma response for children exposed to violent and chaotic homes, where frequent scanning of the environment and quick responses to threat are advantageous (Jensen et al., 1997; Perry & Pollard, 1998; Thomas, 1995). The cost of immediate protective action, however, includes: suspension of more complete information processing; inability to recognise safe situations (Crittenden, 1999); lack of flexibility to adapt to challenging situations with new strategies (Sroufe, 1997); disruptions to developmental pathways (Egeland et al., 1983); and, disruption in the integration of experience and of the self. Therefore, although children may be primed to respond to danger, their learning and other developmental tasks are likely to be put on hold and result in significant cognitive and interpersonal deficits. If the child’s context remains unsafe, such adaptations will be resistant to therapeutic change (Kozlowska & Hanney, 2001, 2003).

Memories are intrinsic in post-traumatic stress disorder, so it seemed essential, when assessing children who have been exposed to traumatic experiences, to have some understanding of how memory works. Infants are born with a fully functional implicit memory system (non-declarative memory) made up of the imaged and procedural memory systems (Crittenden, 1997; Squire, 1992). For example, due to exposure to the acoustic properties of the mother’s voice in the uterus, the newborn can distinguish her voice from the voices of other mothers (De Casper & Fifer, 1980). The neonate’s capacity to remember reflects the non-declarative memory system, that is, memory which functions from birth and impacts on the infant’s behavior but is not accessible to conscious reflection.
Imaged memory consists of perceptual sensory images of the contexts associated with safety or danger, such as sounds, darkness, smells, visual images and bodily states. It remains unclear if infants encode early images in a form that can later be recalled and made conscious or verbal (Crittenden 1997). Imaged memory can, however, be accessed through drawings (Eth & Pynoos, 1985; Moore, 1994a, 1994b; Udwin, 1993).

Procedural memory refers to knowledge encoded as patterns of behaviour, habits, skills, gestures and postures (Crittenden, 1997; Moore, 1994b; Van der Kolk, 1987), which, once again, is not accessible to conscious articulation, but which is enacted through play and interactions with others. Procedural memory is accessible to the therapist through observation of interactions and behaviours, or through the collection of data through the technique of sequencing. The development of declarative/verbal memory (memory that can be verbalized), and the ability to sequence events, that is, to remember and articulate events as they happened, begins to develop from about 28 months of age. Events that occurred when a child was very young, with an immature declarative memory system, may never be accessible to verbal intervention, or may be retained as fragments or images (Terr, 1988, 1994).

Sensory information from the environment enters the central nervous system to be matched against previously stored patterns of information. If the input is threatening, or associated with previous threat, a fear response is initiated (Perry & Pollard, 1998). Children develop either a hyper-arousal or dissociate response secondary to trauma (Perry & Pollard, 1998). The hyper-arousal response involves hypersensitivity to external stimuli, hyper-vigilance, behavioural impulsivity or risk taking behaviours, cognitive distortions, physiological hyper-arousal and hyperactivity such as increased startle response and sleep disturbance. In Post Traumatic Stress Disorder these symptoms may become chronic. The response to dissociate involves disengagement from the here and now, which children do by: day dreaming; focusing on a specific object; pretending to be elsewhere; or, pretending to be someone else.

Traumatic memories are laid down at all levels of brain activity (Le Doux, 1993, 1994; Perry & Pollard, 1998; Schore, 1997). Procedural and imaged memory (implicit or non-declarative memory) are the two memory systems that are active from birth, Traumatised children may act out (procedural memory) their trauma in behaviour, gestures and play, but not be able to recollect it consciously (Squire, 1992) and may be able to express (imaged memory) the trauma through visual images - although they are not able to recollect it verbally (Crittenden, 1997). Therefore, given that declarative memory does not fully emerge until 3 years, in the event of traumatised children, the younger they are, they are less likely to be able to verbalise their traumatic experiences and are more likely to replay the impact and non declarative memory of the trauma through repetitive behaviours, gestures, art and play (Hanney & Kozlowska, 2001; Moore, 1994a, 1994b; Van der Kolk, McFarlane & Weisaeth, 1996).

In summary, it was clear from the literature that trauma impacts on a child’s emotional, behavioural, cognitive, social and physical development. How a child reacts to the trauma is linked to their genetic and neurophysiological maturation and their context. Children, however, develop a range of adaptive strategies to ensure their safety and survival in these dysfunctional environments and relationships. Memories of trauma are held in two memory systems, procedural and imaged. Children who have been traumatized hold the memory in two of the memory systems in the brain, procedural and imaged. Childrens’ traumatic memories are therefore, likely to be seen through ‘acting out’ (procedural memories) and through visual expression (imaged memories). These findings have huge implications for successfully assessing
and treating children, particularly those who have been traumatized before the age of three. The importance of understanding the child’s patterns of interaction, the attachment strategies they have developed in their family, as well as the quality of these key relationships, becomes more and more essential the younger the child. It seemed that treating traumatised children needed careful consideration and a greater understanding. Finding an assessment that permitted a child to act out as well as use visual expression was vital, which led to an exploration of how traumatized children had been assessed and treated in the literature.

**Treatment of traumatised children**

Although there seems, in the literature, to be a significant debate regarding key ingredients in the assessment and treatment of traumatised children, there appears to be consensus about a number of issues, of which four seem particularly important and are outlined.

First, the trauma must not be ongoing (Herman, 1992; Thomas, 1995), in other words the child must be in a safe situation and away from any further possibility of the trauma reoccurring.

Second, the availability of supportive attachment relationships is fundamental with a reasonable level of parental functioning (Benedek, 1985; Conte & Schuerman, 1987; Green, Korol, Grace, Vary, Leonard, Gleser, & Smitsion-Cohen, 1991; Lyons, 1987; McFarlane, 1988; Scheeringa, Peeples, Cook, & Zeanah, 2001; Thomas, 1995; Van der Kolk, Perry & Herman, 1991); and re-establishment of routines (Thomas, 1995).

The third point of consensus was that, “trauma-specific” therapy is important (Berliner & Wheeler, 1987; Finkelhor & Berliner, 1995; James, 1989), in other words there needs to be some focused work that particularly addresses the trauma. Putting both feelings and factual events about the trauma into a coherent narrative was the emphasis and that appeared to need to be the primary therapeutic focus (Main & Goldwin, 1984; Terr, 1994; Udwin, 1993). The common aspects of trauma-specific treatment include:

- encouraging expression of abuse-related feelings;
- clarification of erroneous beliefs that might lead to negative attributions about self or others;
- teaching abuse prevention skills, and
- diminishing the sense of stigma and isolation through reassurance or exposure to other victims.

(Adapted from Finkelhor & Berliner, 1995).

The last and fourth point of consensus in the literature is that it had been found that it is helpful to recovery to expose the individual to traumatic stimuli, that is, re-experiencing traumatic arousal within a context of safety in order to promote habituation of anxiety, to allow for development of strategies to cope with unpleasant affects and physiological sensations and to allow revision of maladaptive cognitive scheme (Deblinger, McLeer & Henry, 1990; Deblinger, Steer, & Lippmann, 1999; Foa & Kozak, 1986; Foa & Meadows 1997; Gaensbauer, 1994; Galante & Foa, 1986; Garmezy & Rutter, 1985; Lyons, 1987; March, Amaya-Jackson, Murray, & Schulte, 1998; Pfefferbaum, 1997).

Despite children’s developing abilities, as mentioned, preschool children have difficulties with many complex concepts and their newly developed skills tend to disappear when they are
anxious (Terr, 1994). Assessment of traumatised children’ and treatment intervention can be further complicated by the child’s sensitized response to stress (Kozlowska & Hanney, 2001). Fragmented imaged memories, which are repetitive, non-contextualised and not accessible to verbal recall and may be associated with distressing somatic states, can be difficult to comprehend (Lang, 1979; Van der Kolk, 1987; Van der Kolk & Fisle, 1995). Young children presenting in traumatic contexts are frequently unable to articulate or link together their thoughts and feelings and events that have happened to them. Attempts to discuss trauma related issues may result in a hyper-arousal stress response characterised by physiological arousal, overwhelming anxiety, hyperactivity, inattention and impulsivity; or an ‘emotional shutdown response’ where the child disengages from the here and now (Kozlowska & Hanney, 2001, Perry & Pollard 1998). Helpful discussion of issues in family assessment may simply not be possible, due to the child’s overwhelming distress. In other words, most traumatised children are likely to avoid thinking and talking about trauma related material, and so the therapist must find ways which contain their anxiety and physiological stress response sufficiently to allow exposure and habituation, and to allow traumatic feelings to be mastered and adaptively integrated into the child’s emotional life (Kozlowska & Hanney, 2001; March et al., 1998; Pynoos, 1990).

Exposure and de-sensitisation techniques significantly improve post trauma stress disorder symptoms in traumatised children (Deblinger, McLeer & Henry, 1990; Deblinger, Lippmann & Steer 1996; Deblinger, Steer & Lippmann, 1999; March, Amaya-Jackson, Murray & Schulte, 1998). Moreover, coexisting behavioural difficulties can be treated successfully, but require focused treatment, such as parent skill training (Deblinger et al., 1996; Friedrich, Luecke, Beilke, & Place, 1992; Stauffer & Deblinger, 1996). In view of the multiple natures of the abuse-related problems, Deblinger et al., (1990) assessed the extent to which each target symptom was a problem and assigned therapeutic modules accordingly. This approach permitted inclusion of children with varying symptomatology, and resulted in treatment where the dose of the targeted intervention was individually adjusted. Their data also indicates that a parent or parents when available must be included in treatment to maximize success (Cohen & Mannarino, 1996; Deblinger et al., 1996; Finkelhor & Berliner, 1995).

A language emphasis in the assessment and treatment of traumatized children to help them make sense of their experiences and feelings becomes more and more inappropriate, which is in keeping with the integrative model, and it underlines the importance of the inclusion of non-verbal approaches. The younger the child, the less developed the child’s verbal capacities and the more important that they are provided the opportunity to express themselves through non-verbal means, such as creating art, which led to the literature on trauma and art.

**Trauma and art**

The tendency for children to recollect traumatic experiences as visual images and for artistic expression to increase, following a traumatic experience, is well documented (Eth & Pynoos, 1985; Moore, 1994a 1994b; Newman, 1976; Udwin, 1993). As well as procedural memory, Johnson (1987) argues that traumatic memories are recorded in ‘photographic form’ that is, as imaged memories (non-declarative). This supports a treatment formula that incorporates the therapeutic use of art and that art can provide an important role in facilitating expression of traumatic memories - particularly when working with children (Howard, 1990). As previously mentioned, as well as “remembered” (declarative) traumatic memories children are able to express “unremembered” (non-declarative), through images or drawings (Eth & Pynoos, 1985;

Furthermore, procedural (non-declarative) memory is observable not only in play, skills and repetitive behaviours, but also through the physical process of creating art. The creation of art, a concrete visual expression depicting memories and experiences stored at both conscious (declarative) and unconscious (non-declarative) levels, offers an opportunity to exposure the trauma for conscious reflection and cortical processing.

In an extensive study of the art works created by children who had been traumatized, Moore (1994a) hypothesized that non-declarative memory associated with the trauma is expressed in “an accurate reproduction of the object or parts of the body involved - and placed physically on the body where the physical experience was experienced ‘procedurally’” (p. 225). Terr (1991) found that the images of traumatised children were often unelaborated and simplistic, frequently resembling stereotyped cartoons or doodles. Other researchers (Golub, 1985; Levinson, 1986; Malchiodi, 1990) have noted the recurrent use of metaphor and repetitive use of themes such as monsters in describing the experience of trauma. Moore (1994a, 1994b) has presented some interesting research findings about information embedded in children’s drawings. Particularly of interest was her idea that a child’s drawing, and the developmental level portrayed in the drawing, can act as an indicator of when developmentally the child was traumatized or when in fact their traumatic experiences began. It is her view that a child’s developmental processing and ability to express are arrested at that time. Recently she has begun to explore ideas that relate to the ability of children to express their attachment relationships through their art – a topic that has been explored by other authors (Fury, Carlson & Sroufe, 1997). Uhlin (1976) “hypothesised that through art, emotionally disturbed children become arrested at a certain level of development and may use repeated forms and symbols” (as cited in Rosal, 1996, p. 19). Whilst these were interesting ideas, in the context of assessment, with time limitations and a hesitancy to apply meaning other than the child’s own, they seemed an area that perhaps would require further in depth understanding in order to be helpful.

Children use art materials instinctively and spontaneously (Waller, 1993) and creating art is pleasurable and provides a contrary experience to that associated with the trauma. Facilitating desensitization and processing of traumatic memories (Kozlowska & Hanney, 2001) can potentially lead to feelings of competence and hope.

Children are more likely to cope better with adverse events, if they have an internal locus of control and a strong sense of self-efficacy (March, Amaya-Jackson, Murray & Schulte, 1998). Traumatic experiences can be expressed in a safe way, via artistic symbolism, and detour some of the anxiety often associated with exploring traumatic events, thus containing anxiety to a tolerable level to allow a child to understand, master and integrate the feelings and facts associated with the trauma (Levinson 1986; Malchodi 1990; Stonach-Buschel, 1990; Van der Kolk, McFarlane, Weisaeth 1996; Yule 1991). The less anxious a child feels, the higher the probability that one may be able to replace and re-route painful affective memories (Perry & Pollard, 1998) and engender positive expectations of the future. The actual art paper, or work of art, could act as a “transitional space” (Winnicott, 1971), where intolerable feelings or trauma related feelings, could be externalised in a concrete form allowing for exposure and habitation of the arousal response. The art could be manipulated, revisited and reworked enhancing feelings of mastery, competence, and hope (Kozlowska & Hanney, 2001; Johnson, 1987; Schaverian, 1992; Stonach-Buschel, 1990). A focus on visual images together with narrative takes advantage of children’s developmental capacities and provides a starting point for putting the children’s
experiences: their feelings, the sequential sequence of events, and the meaning of the trauma into a narrative.

Artworks can also be used as a stepping-stone to creating a coherent narrative or family story about a traumatic past (Kozlowska & Hanney, 2001). A coherent narrative involves the ability to sequence temporal events, articulate associated affect, and be able to give appropriate semantic meaning in relation to what had occurred (Main & Goldwyn, 1984). Failure to form a coherent narrative of traumatic events impacts on attachment relationships in the family and impedes resolution of trauma and makes the repetition of the abuse cycle more likely (Gillis, 1993; Main & Goldwyn 1984).

Children express themselves naturally through art (Kramer, 1958, 1971), which implies that the use of art in therapy can facilitate engagement, reduce anxiety, act as a common language with no developmental barriers, that is, all family members can equally contribute to the discussion (Kozlowska & Hanney, 1999). Art can act as the bridge between the realms of inner and outer reality (Winnicott, 1971). Unacceptable emotions can be expressed in a safe and constructive way and the concrete nature of art allows for manipulation, control and hence mastery over the expression of unthinkable and unspeakable emotions. Making art in family therapy with young children takes advantage of children’s spontaneous use of art to express themselves (Waller, 1993), and immediately includes them in the therapeutic process. In other words, art serves to make “the invisible visible” (Riley, 1985), creating visible and palpable illustrations of experiences.

In respect of the integrative model’s recommendation for working with traumatized children psychodynamic approaches, as well as a non-verbal approach is suggested. Therapists from different disciplines working with children have employed art and play to elicit children’s internal feelings and help them to make sense of their experiences. There is an underlying premise that creating safe environments for children to be able to access traumatic memories is essential (Rober, 1998). In considering the development of the family assessment and interactive art exercise it became important to review how therapists from various different modalities, including psychodynamic approaches had used art and play when working with traumatized children. In doing so a review of the child psychotherapy, followed by art therapy was done to help understand how psychodynamic and non-verbal approaches can contribute to providing an integrative approach to the family assessment and interactive art exercise.
CHAPTER FOUR
Therapeutic work with children

Child psychotherapy

Over the last century there have been a number of therapeutic models developed to engage, assess and treat younger children. Central to these models was the notion of play and art being an essential part of a child’s development and how they express their understanding of the world. Influenced by Freudian theory, both Anna Freud (1964) and Klein (1959) were among the first pioneers of play therapy - actively engaging children individually in clinical work involving play. They took the shared view that children express and make sense of their world through the externalization of their internal world (the unconscious) through play. Although sharing these core ideas they differed somewhat in their underlying theory of how children make sense of their worlds and process information, which in turn affected their approaches.

Freud (1964) introduced limited toys, drawings and paintings into the therapy room. She focused on the child’s unconscious motivations and their employment of ego defenses within their play and the meaning of resistance in treatment. She emphasized the emotional relationship between the child and therapist, refraining from direct interpretations, instead encouraging the child to verbalise their internal worlds and break through their defenses.

Klein (1959) also brought toys to the therapeutic space to help children vocalize their hidden feelings that surfaced in their relationship with the therapist. The children had the opportunity to externalize their internal world onto the toys and then engage in ‘dramatic’ interaction with these objects. The therapist would observe, refraining from actively engaging in the play. To help the children make sense of their communications; the therapist would provide meaning through “language”, in the form of interpretations; the child’s unconscious processes are made conscious with the help of the therapist’s interpretations.

Winnicott (1971) described the activity of play as the brain engaged in “creative activity” (p. 65), suggesting that the ability to play emerged in the “potential space” (p. 41), not within the child, and not separated from the child, within the interaction between the mother and child. In this place between the mother and child, children learn to create substitutes, “not the real thing”. Winnicott proposed that play allowed anxiety-provoking situations, or events to be faced in a symbolic way, to act as a bridge between the internal and external world and a place where children could make sense of their experience. He aimed to re-create this “potential space”, between mother and child in the therapeutic space by introducing interactive games. The ‘Squiggle’ game, for example was developed to engage and talk with children and observe what happens between the therapist and the child. The squiggle game involved the therapist making an impulsive line drawing, which the child was invited to comment on and turn it into something. In turn the child was then encouraged to produce his or her own line drawing, which the therapist then turns into something. The game would be continued over several turns introducing new line drawings. Winnicott believed that the way the child interacted with the game as well as the images they created, offered valuable information of their inner world, or what was hard to verbalise and their interactions with the world. Winnicott (1971) often worked with parents and children where he would interpret the play within the context of the parent-child relationship.
Out of these early developments in child psychotherapy various models of play therapy have emerged, such as Levy (1937) and Solomon's (1938) ‘Active’ play therapy. The ‘Active’ therapist would encourage the child to join them in using toys to re-enact their earlier traumatic experiences. In contrast ‘passive’ therapy also emerged at this time, where the child was allowed to play freely within the confines of the therapy room. The children heal themselves through their play and the passive acceptance of their expressions by the therapist. Similarly Otto Rank (as cited in Schaefer & Carey, 1994) created ‘Relationship’ therapy with the primary focus and healing occurring in the here and now relationship between the child and therapist. The child is provided with complete freedom to play with a range of toys, whilst the therapist observes, joining the child in play only when invited, and commenting only on the feelings in the room. This latter approach had a huge influence on what is now widely known as ‘Nondirective’ therapy (Schaefer & Carey, 1994). ‘Non-directive’ therapy has been mainly credited to Carl Rogers (1951) who also believed that individuals had the power to heal themselves from within. The role of the therapist was to provide the support and context to allow the child to find their own meanings and make sense of their experiences.

From this backdrop of psychoanalytic thinking and nondirective therapy, Axline published ‘Play therapy’ (1947), within which she described eight principles of play therapy. These principles are still largely accepted within the play therapy community (Lebo, 1955). Axline (1947) worked again from the idea that children have the capacity to heal themselves if provided with a safe place and a warm relationship to play where they are helped to apply meaning and understanding to their experiences. The child’s hidden feelings rise to the surface, so that they can face them, learn to control them or abandon them (Axline, 1969). The therapist is encouraged to take an “observing role” although at times if invited by the child would join in the play. Axline believed that children experienced her “non-directive” model of play therapy as cathartic, an opportunity for an expression of feelings. Rather than make interpretations, her approach involved the therapist verbally reflecting and wondering aloud.

Alongside Axline’s work, Moustakas (1959) enhanced the idea of focusing on the child-therapist relationship, at the same time he challenged the importance placed on the environment, proposing instead that the needs of the child should determine the setting and that children have the knowledge to know the most helpful situation. Goodman, Williams, Agell and Gantt, (1998), whilst working in medical settings, used what they call the “alphabet book” to help children deal with the emotional impact of severe medical illness. The pages of the life book are based on the letters of the child’s name and the content includes artwork about the child’s predicament e.g. a child’s experiences with cancer.

More recently, Cattanach (1997), influenced by narrative family therapists, White and Epston (1990), developed a model of play therapy by employing a social constructionist framework. Cattanach worked with the child’s ability to tell stories, where relationships between symbols and their meanings are explored with the possibility for new meanings surfacing. She underlined the importance of playfulness and the process of negotiating and re-negotiating meanings through story telling. In the ‘story telling’ space between the child and the therapist, reality can be re-created; new ideas can be played with, developed and defined. It is in these interacting stories, through language and social processes and not through objective observation, that she believes a ‘truth’ is established. According to Cattanach, when children play, they move freely between two distinct levels, that of “not play” and “play”, but she advises against attempts to pick apart reality from fantasy as it may leave the child bewildered. Cattanach encourages the use of clarifying questions to construct and negotiate meaning, so that children can be supported to express their point of view. She warns against the therapist applying their own meaning to the
children’s symbols. When a therapist does apply their own meaning an imbalance of power is created, that is the therapists’ meaning holds more power. Implicit in Cattanach’s work is that the story also has a particular meaning in the context of the therapeutic relationship.

Although most of the work described above focuses on the therapist and child working together without the parent involved, it seems that it was not alien for the therapists to at times also include the parent into the sessions. In particular, Moustakas (1959) seemed to value the importance of including parents in the play therapy and fostering the play relationship between parent and child. Also recognizing the importance of play in developing a bond between a child and their parent(s) Jernberg (1986), fashioned ‘Theraplay’, which involved the parent and child in a treatment strategy that reflects the early parent child relationship, where the therapist guides the child and parent with the use of play towards ‘attunement’ to each other.

The focus on creating attunement was also strongly emphasized in the work of attachment theorists, a number of whom developed a number of therapeutic play interventions, where parents were encouraged to partake in the therapy session. Muir’s (1992), ‘Watch, wait and wonder technique’, Lieberman and Pawl’s (1993), ‘Infant-Parent’ psychotherapy and McDonough’s (1993), ‘Interational guidance technique’ are inclusive of the parent and child. These interventions all require the therapist to remain in the room, without interacting with the child, whilst the parent and child play with a variety of toys. The interactions of parents with their children in a play setting seem best suited to the treatment of relationship difficulties of children and their parent(s) up to the age of about two. The therapist comments on the interactions between the dyad and makes links to the parent’s own history and their possible projections onto the child. Intervention in these forms of psychotherapy includes making overt what is happening in the interaction. This is done by the use of interpretive techniques, (intergenerational interpretations) to link the parent’s past experience with their behaviours and projections onto the infant (Muir, 1992; Lieberman & Pawl, 1993), or videotape feedback about parent-child interactions to look at positive care giving as well as behaviours that need to be modified (McDonough, 1993). The aim is to improve parent-child interactions and strengthen the attachment relationship. These therapeutic techniques seemed to often be used in demanding clinical settings, such as work with high-risk children of abusing parents. Parent child psychotherapy is usually done with a dyad, but may be combined with casework to manage families, and to involve fathers (Wright, 1986).

Influenced by these ideas McNeil, Eyberg, Eisenstadt, Newcombe and Funderburk (1991) developed a technique to assess and treat behaviourally disturbed 2 - 7 year olds, termed ‘Parent-Child interaction’ therapy. The focus is on the dyad rather than the family, where the therapist watches the parent and child play from behind a one-way screen, using a bug-in-the-ear microphone to comment to the parent about their play and relationship skills. This intervention aims to train parents in play skills, relationship skills and parenting techniques. Although both parents may sequentially take part in the program, this approach does not involve other children in the family nor does it address other issues such as marital conflict.

Thus, the observation of parents and their young, often non-verbal children seemed particularly valuable in recognizing relationship patterns and difficulties. Furthermore, it seemed that these more playful interventions influenced by play therapists and developed by attachment theorists, were more easily integrated into family work. Although this work was of interest, the emphasis seemed to remain on working with the child individually or within a dyad. This approach becomes theoretically problematic and clinically limiting, when treating children in the context of their families, and within the broader community and its cultures and institutions. Accessing
and observing a child’s context and the family system within which they live and have developed, seems integral to an integrative approach and the task of producing a systemic comprehensive family assessment that is child-inclusive.

**Therapeutic assessments of children**

Therapeutic assessment work with children seemed to play an important part in the process of defining whether a child is deemed suitable for further therapeutic intervention. Hence, there is an extensive literature on different types of play therapy assessment. In an attempt to confine the review, it seemed important to primarily focus on the literature that was similar in purpose and theoretically comparable to the proposed family interactive art assessment. Therefore, the focus remained on play therapy assessments that were more inclusive of all family members.

Orgun (1973, as cited in Landreth, 1982, p. 295) described a diagnostic family interview approach but argued that involving family members in play therapy assessment was not new. He describes early examples where mothers were invited into the therapy sessions (see for example Schwarz, 1950; Pappenheim & Sweeny, 1952, In G. Landreth, 1982). Landreth also talks about a three step family interview (Drechsler & Schapiro, 1961, as cited in Landreth, 1982, p. 295) that involved the use of two therapists each taking turns to observe the family and therapist through a one-way screen. Augenbraun & Tasem (1966, as cited in Landreth, 1982, p. 265) also proposed differential treatment techniques in family interviewing. Orgun’s assessment approach differs from the above assessment techniques in that the focus is primarily on the child’s communication through the processes and results of their play. Families are encouraged to find their own seating arrangement, which is seen as an indicator of relationship alliances etc and then the two therapists sit amongst the family. The therapists initially remain quiet so as not to discourage the children from communicating on their level. The therapists join in the child’s play if invited to do so by the child as well as verbally elicited the family’s emotional reactions to the child’s play at the same time as support the family to engage in the play. The session lasts for approximately fifty minutes, concluding with the therapists providing feedback to the family about the dynamics within the family unit and the function of the child’s presenting problem. The family assessment, however, is just part of an overall process where the parents are interviewed, the child is psychologically tested and where indicated the child receives an electroencephalography.

Describing the frustrations of finding appropriate assessments for families with young children, Ross (1994, as cited in Schaefer & Carey, p. 37) describes a diagnostic family puppet technique. Providing a range of family representational puppets, as well as a few fantasy figures, the families are encouraged to use the puppets to reenact a recent difficult family interaction. The family’s decision making processes and interactions are then observed and at times commented upon by the therapist, including suggestions to swap roles by exchanging puppets. The final part of the assessment, involves the family re-enacting the puppet sequence as they wished it had been. Irwin & Malloy (1994, as cited in Schaefer & Carey, p. 37) also utilize the use of puppets by encouraging the family to make up a story using the puppets. The therapist then leaves the room and observes the decision making process through a one-way screen returning once the family have decided upon a story. They describe the focus of their observations on which member functions as organizer, dominator, disciplinarian, scapegoat, victim, pacifier, and so forth” (p. 25). Once the therapist has returned to the room, the families are encouraged to perform their story. The therapist would only intervene in the performance if the family become stuck or were unable to resolve the story. After the story has concluded, the therapist works with
the family, still using the puppets, to persuade the puppets to talk to each other about problem aspects of the story. The puppets are then put away and the family has an opportunity to make associations, with the aim of developing insight to their own family dynamics and conflicts. They argue that the puppet interview can be used with a diverse population but believe it to be invaluable when working with families who particularly find it difficult to express themselves verbally and families who are of “the obsessive-compulsive, highly organized, intellectualized family” (p. 33). Other authors have utilize the use of puppets and story telling when working with young children and families (Botkin, 2000) yet they all seem to rely on the child being able to be verbally articulate and also for the family to be able to cope with playing with puppets which could create a great deal of performance anxiety in the child and the family.

The integrative model stressed the importance of non-verbal and psychodynamic approaches when working with traumatized children, which naturally led to a consideration of how art therapy had contributed to the literature on assessment. Art Therapy was an obvious choice of approach because of its roots in psychodynamic models and emphasis on non-verbal expression. Art therapy was also the other body of literature that described assessments involving all family members. Given the potential richness of this knowledge it seemed important to have a fuller knowledge of art therapy and art therapy assessments in their own right, especially with the integrative model’s emphasis and understanding of working with children’s non-verbal communication and that trauma - particularly, also, as early trauma is recorded in the imaged memory system.
CHAPTER FIVE

Art therapy

Art therapists have long been aware of the capacity of art to access and reach parts of our-selves unavailable through verbal communications.

Art therapy emerged in Britain, post World War II. It was largely informed by psychoanalysis, drawing on ideas related to the structure of sessions, the nature of the therapeutic relationship with notions of transference and counter-transference. Dalley (1987) attributes much of the current thinking in Britain in art therapy to the work of British psychoanalyst and paediatrician, D.W. Winnicott (1971) and ‘Object Relations’ theory. Now as a profession, in its own right the growth of art therapy can mostly be credited to Champleonwne, Adamson, Pickford, Laing and Halliday (as cited in Dalley, 1987). Britain, in contrast to America, seems to have continued to maintain it’s strong links with psychoanalytic ideas.

In America, art therapy also emerged from the psychoanalytic movement. Naumburg (1950) and Kramer (1958) were both trained in psychoanalysis (Rosal, 1996) and were noted pioneers of American art therapy. In 1950, Naumburg published An introduction to art therapy where she described the role of art in the treatment of mental illness, from its history of use in psychological testing, to the more “release through free expression” (p. 133), utilised by occupational therapists. Naumburg (1958) believed: “the process of art therapy is based on the recognition that man’s most fundamental thoughts and feelings, derived from the unconscious, reach expression in images rather than in words” (p. 152). On the other hand Kramer (1971) viewed the actual art making process as an acceptable mode of expression, a form of sublimation of aggressive and sexual drives. Nowadays art therapy in America, as reflected in the majority of the American art therapy literature, appears to have become short-term, theme centered and diagnostically focused in a climate of professional accountability and diagnostically based treatment funding Gilroy and Skaife (1997) report that: “American art therapists formulate their practice in terms of distinctive interventions, tools and techniques suitable for specific assessment procedures and treatment approaches” (p. 61). Art therapists in Britain seem to hold the view that art tools and requests to perform are inhibiting, as technique and pressure to please take over the creative process and the communication is lost (Dalley, Case, Schaverien, Weir, Halliday, Nowell Hall & Waller, 1987).

Art therapy in Australia has yet to find its theoretical position and remains an emerging field. With Australia’s health care system historically linked to Britain, but fast being influenced by America’s economic rationalist ideas Australian art therapy has yet to find a theoretical position. Consequently, the paucity of literature in Australia allowed the ideas that informed the development of the exercise to be drawn from both Britain and America contexts.

As the profession continues to grow around the world, the more recent literature (Robbins, 1994) reflects art therapists working from a variety of theoretical perspectives, often dependent on their own philosophical viewpoints, place of work, client population and current political climate.

The underlying premise of art therapy, however, is that art is a reflection of the unconscious, which gets expressed through the art therapist’s provision of space and art materials. Sensitivity to the creative process is seen as essential as the client attempts to express his or her internal world in an external form. Through the therapist’s ability to notice and explore using metaphor,
clients are encouraged to find their own meanings, for example see Sims and Whynot, 1997. Direct interpretations are avoided, although the therapist’s knowledge and experience remains significant. Some of the key aspects seem to be that art can offer a space where a client can explore feelings and events in a concrete form, which can act as a permanent record, be revisited, manipulated and reworked (Kozlowska & Hanney, 2001; Schaverien, 1992).

There is now a wide and international body of literature that describes the art of art therapy and the variety of approaches and client settings. In reviewing the literature, specific areas appear particularly relevant to developing the family interactive art assessment, including art therapy with children and assessment in art therapy. In addition, there was no doubt from the literature that at the heart of art therapy was a focus on the process of creativity and, that within that creative process, meaning could be found. Schaverien’s, (1987, 1992) idea of the “embodied” image appear significant as it highlighted the relationship between the artist and the image, the symbolic language and the meanings implied within. In viewing the image, Malchiodi (1998) use of a phenomenological approach suggests a way of looking at the image that encourages meaning to emerge from the artist, rather than the viewer/therapist.

**Art therapy and the creative process**

It seemed well established in the art therapy literature that the process of creativity, the making rather than the content, is intrinsically part of the overall non-verbal communication. Art therapist’s acutely observe, in detail, the creative process i.e.: how the art materials are approached, i.e. do they choose the first pencil available or search for a particular colour; and, how are mistakes managed - are they endlessly rubbed out or is the paper crumbled and tossed in a waste bin. Over time the art therapist, bringing the non-verbal communication to awareness, verbally raises these behaviours to awareness. The art therapist comes to gain understanding of the client through their curiosity about “what is implicit in style, materials, composition, rhythm, skill and so on” (Bateson, 1979, p. 103). This is a curiosity that hopefully eventually enhances client self-awareness.

On another level, it seems that art therapists’ hold the view that a child’s relationship with their creative expression is unique and requires time to develop. Once a child has become relaxed and is no longer tainted by constraints, symbolic language evolves, which allows an opportunity for a dialogue between the internal and external world (Dalley et al, 1987). This is a self-reflective dialogue, as well as a dialogue between the child, the art and the art therapist. This process can be likened to the basic pattern of creativity “the idea of consciously – rhythmically – alternating the process of giving out and taking in…” (Cane, 1983, p. 22).

These ideas were inspiring, as they seemed to move the art out of the realm of diagnosis or directed art tasks. In the art therapy arena, with direction and rules removed, it seemed that a space for creativity emerged that opened up the possibility for a child’s hitherto repressed inner dialogues to surface. This argument is in keeping with Bateson’s (1979) and other authors writing about creativity, who argue that new information pathways are opened up when constraints are removed.
The “embodied image”

Schaverien (1987) divides art into two arenas: the “diagrammatic picture” (the use of art as a pictorial description, such as face with the mouth turned down to describe an emotion) and the “embodied image”. She suggests that a diagrammatic picture is unlikely to evoke similar feelings in another person and that it has been made with minimal investment, that it “is an illustration of a feeling, rather than an embodiment of feeling” (p. 78). Consequently, she claims a diagrammatic picture is unlikely to be empowered, whereas an embodied image is a picture, which has emerged out of a child’s feelings and is empowered. This type of art surfaces in a therapeutic relationship that feels safe enough to allow the process of creativity to take over and where the picture becomes affective. The art is endowed with life, that of the child and that of the therapeutic relationship, in other words the picture becomes alive with feelings (Schaverien, 1987). An embodied image can be invested with magic, experienced as carrying power, hold the transference and be similar to a talisman or experienced as a scapegoat. Feelings that are seen as unacceptable are placed in the picture and can be disposed of, hidden, or left with the therapist. The possibility for enactment is created without causing harm to anyone.

In considering Schaverien’s ideas, there was a noticeable similarity with the idea of creating a space where rules and directives are removed and also where the art appears to embody the child’s inner dialogue on multiple levels. The emphasis on the different meanings that can be invested in art and the reminder of the respect and sensitivity that is required when responding to symbolic communication were helpful to consider. Bromfield puts it very eloquently when s/he says “…overzealous trampling over children’s drawings – as over their talking or playing – is the surest way to kill its displacing function, …” (1999, p. 155).

In an attempt to respect children’s communication in their own right, Malchiodi (1998) suggests a phenomenological approach. The therapist’s preconceived ideas are replaced by openness to multiple meanings, the context in which they exist and a preference for the child’s perspective. According to Smith, Osborn, and Jarman, (in press), although they recognize the approach is a dynamic process, they state: “it is concerned with an individual’s personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself” (p. 218).

Malchiodi depicted a therapeutic position of ‘not knowing’, recognising the link to social constructivist theories where the child is the ‘expert’ of the experience rather than the therapist. She comments on the structural elements that she sees within the art and, diverting from true phenomenological observation, also seeks associations.

Art therapy and children

There is an overall agreement amongst many authors (Kramer, 1971; Rosal, 1996; Case & Dalley, 1990) that young children are able to express themselves more freely though visual medium so that play therapy and art therapy have become the preferred option for treatment for young children. The development of child art therapy reflects the many different theoretical approaches that art therapists have employed, including psychoanalytic and developmental, which appeared to be the most appropriate to explore in more depth because art therapy’s roots lie in psychoanalysis and it informed and bridged the work of many art therapist involved with children. The developmental approach appeared relevant to the arena of assessment as it bridged
the work of Lowenfeld and Lambert Brittian (1964) with art therapy, as well as, adding to the understanding of the link between children’s art and their emotional and intellectual development.

In terms of a psychoanalytic approach, Naumburg (1950) and Kramer (1958) are best described as the pioneers of psychoanalytic child art therapy. Later art therapist such as Rubin (1984) and Landgarten (1981) contributed more explicit ways of working with different client populations. Similar to the majority of play therapists, Naumburg described her approach as “Dynamically Orientated”, where art acts as an opening for the “release of unconscious, repressed material, emotions, and conflicts” (Rosal, 1996, p. 2). The production of art appears as a safe vehicle for a child to release their control of ‘unsafe’ feelings and conflicts. She also saw the art as a place where transference between the therapist and the child could be articulated. To permit unconscious material to surface and support creativity, the therapist remains supportive and neutral to the child’s art expressions. Success was measured by the child’s ability to freely and spontaneously create and, similar to Lowenfeld and Lambert Brittian (1964), she saw stereotype art as reflective of a child’s disturbance. The therapist helps the child by working within the transference relationship, often spoken through the child’s art. Kramer (1971) challenged the idea of neutrality and advocated the role of the art therapist as actively supporting the child in their expressions. She believed that the process of making art, and the artwork, was a form of sublimation, offering an opportunity for the representation of a child’s aggressive and sexual drives. The art therapist was viewed as a model of ego functioning where, similar to Naumburg (1950), their role was to support the child “from chaotic discharge through stereotype to formed expression” (1971, p. 4), although Kramer saw the art therapist as more actively involved in the process by providing help and ideas.

The ability to create a safe environment to facilitate free expression seemed to be a strong theme throughout the child art therapy literature. Rubin (1984) also advocates that creating this space was the primary function of the art therapist. Once the child is provided with a safe place to freely express, she believed that the artwork held symbolic content of multiple levels of communication that included “…both positive wishes and their negative impulses” (Rosal, 1996, p. 5). She adopted a more active and directive approach, where the art therapist introduces themes or certain medium such as mask making or scribbling.

Landgarten (1981) took a similar position to Naumburg, viewing the art as an opportunity to create psychological distance between the child and their distressing unspoken and threatening feelings and conflicts. Akin however, to Kramer, she also saw the art therapist as an educator, helping children understand their problems and challenges they faced.

In summary, it seemed that psychoanalytic art therapy occurs in a relatively neutral and safe environment, with the aim of facilitating the child’s creative process and release of unconscious material with the hope of developing appropriate defenses and socially acceptable forms of expression. The symbolic quality of art creates psychological detachment and therefore is less threatening for the child than verbal communication.

At the same time as psychoanalytic art therapy emerged, the developmental approach to art therapy also surfaced. Inspired by Lowenfeld and Lambert Brittain’s studies of stages of art maturity, the development approach to art therapy was established. These ideas have previously been discussed, as well as Piaget’s ideas on play to encourage cognitive growth.
The expansion of developmental art therapy can be largely attributed to the work of art therapists working with children with disabilities and those placed in special schools. Uhlin (1976) worked with children with neurological and physical disabilities, and placed an emphasis upon the importance of the sensory qualities of art materials using the art of ‘normal’ children as a aspiration to help the disabled children to work towards developing a more healthy sense of self. He highlighted the need for the art therapist to be sensitive to the symbols and repetitive forms that are created, and to support the child in moving “beyond the stagnant schema through providing rich and varied art materials” (Rosal, 1996, p. 20). Working along the same premise, Williams and Wood (1977) identified four stages: an initial encouragement to engage with art materials; an increase in handling art materials; to working in groups; and, finally towards individual self-expression. The art therapist moves from a directive position in the early stages, towards reassurance, and finally offering guidance and constraining negative behaviour. What is noticeable in both Lowenfeld and Lambert Brittains and Williams and Woods approaches is the importance placed on group interaction as essential to emotional expansion. Another art therapist influenced by Lowenfeld and Lambert Brittain was Silver (1983, 2007) who used art to help children develop cognitive and creative skills. She primarily worked with children with communication difficulties and believed by providing children with the opportunity to express themselves through art, they could enhance their right brain development, which is essential for language and cognition and that they could more easily learn through art. Silver placed an emphasis on the art therapist’s challenging their own perception of disabled children and looking for and recognizing the positives in their work.

What seems apparent from the above approach is a consensus that creativity is paramount to emotional growth. Furthermore, a child’s ability to freely express and make use of symbols was also indicative of their emotional wellbeing. An art therapist primary function was to create the environment to support the emergence of the creative process. There also appeared to be a general agreement that art process and the artwork, apart from offering an opportunity to heal, may also be used as a diagnostic tool.

**Art therapy assessments**

There is clearly an agreement amongst art therapist that childrens’ drawing can be used to assess their emotional and cognitive developmental abilities (DiLeo, 1970, 1973; Hammer, 1967; Harris, 1963). Even before art therapy was established art was used to gain psychological understanding (Cummings, 1944, 1952; Goodenough, 1926; Hulse, 1951). The very in depth body of literature that evidences this was so extensive that only some of the predominate ideas and those that had some impact on the development of the assessment exercise were explored.

Various art therapists, predominately American, have developed assessment tools. The earliest reference however to art being used to gain psychological information was by Goodenough (1926) whose book *Drawings as measures of cognitive maturation* described the now widely used and accepted “Draw a person” test, where the client is asked to simply draw a person. Later, in search of more emotional information, psychologists continued to use drawings as projective techniques (Buck, 1948; Gillespie, 1994; Hammer, 1967, as cited in Oster & Gould, 1987; Kellogg & O’Dell, 1967; Machover, 1952; Robinson Russell, 1979). Kaiser, (1996) later described how a client’s degree of security in their attachment relationships can be indicated through a drawing task that involved drawing a bird’s nest alongside a written questionnaire about their relationship with their mother. Other authors (Fury, Carlson & Sroufe, 1997) also put forward the idea that attachment relationships can be represented in drawings.
Buck (1948), created the ‘House-Tree-Person’ test, and believed; the test aided the clinician in obtaining information concerning the sensitivity, maturity, flexibility, and degree of personality integration through analysis of the person. The house and tree provide additional information concerning the growth (tree) and the environmental feelings (house) of the patient. Many theorists have particularly focused upon the use of children’s drawings as aids in diagnosis and as developmental indicators (Burns & Kaufman, 1972; DiLeo, 1970; Harris, Roberts & Pinder, 1970; Kellogg, 1970; Koppitz, 1981; Machover, 1949). Anthony and Bene (1957) put the argument forward that an assessment was needed to assess the child’s feelings about various family members and their reciprocal feelings. The child was shown twenty cards depicting “people of various ages, shapes and sizes, sufficiently stereotyped to stand for members of the child’s family” (p. 542). The child is encouraged by the assessor to describe what feeling fits to the pictures.

As previously mentioned, Uhlin (1976) influenced by the work of Lowenfeld and Lambert Brittain (1964), “hypothesised that through art, emotionally disturbed children become arrested at a certain level of development and may use repeated forms and symbols” (as cited in Rosal, 1996, p. 19), which assists in understanding where the child is positioned developmentally. Burns and Kaufman (1970) have further expanded on the previous psychological tests that employ art by introducing, perhaps the most widely known and utilized clinical art tool, (Mills & Goodwin, 1991); “The kinetic family drawing”. Here a person is asked to draw their family doing something. Whilst this tool may help to provide useful information as to the individual’s beliefs about their family, it fails to elicit the family interactions, therefore missing the context of the individual’s beliefs. Also, if we are to believe that art reflects the context in which it is made, the art will mostly reflect the relationship between the therapist and client rather than their family. Kymissis and Khanna (1992) put the argument forward that when a family is in distress it is vital to assess each family member’s perceptions and in so doing suggested that each individual family member draws a picture of the family doing something together in the future. They believed that the idea of ‘Prospective’ kinetic family drawings were able to determine the intellectual ability of the drawer, their perception of their role within the family, the roles of other members of the family and the current family situation in the present and future.

Ulman and Dachinger, (1975), worked in the area of child psychiatry and used art as a diagnostic tool to understand child development. Although they reported an initial reluctance to work from a diagnostic approach, they went onto state:

It is right that we should make the distinction even artificially clear, for we must never pretend to be healing when primarily we are investigating. But in truth the experiences of the patient during the course of diagnosis may open up avenues of treatment for him.

(p. 384).

Ulman and Dachinger’s “Personality assessment procedure” involved asking the client to draw a series of four pictures on grey construction paper, 18 by 24 inches, using 12 coloured hard pastels with the paper set up on an easel. For the first paper, the assessor gives only the instruction to use the materials to make a picture, if necessary encouragement by the facilitator is permitted. For the second piece of paper, the assessor instructs the clients to use their whole body to make various movements and then record those movements on the paper. The clients are then asked to make a free scribble on the third sheet of paper with their eyes shut and when completed to look for images they can see in the scribbles. On the final piece of paper, the clients are given the choice as to whether they would like to proceed with more scribbles or to produce
another picture. Ulman and Dachinger concluded that the first picture portrays the clients more formal responses, while the scribble picture allows the clients to express more freely their unconscious feelings. The final picture permits the clients to return to their more comfortable stereotyped patterns of expression.

Kramer and Schehr (1983) developed the “Kramer assessment”. They described it as an evaluation session, which was not dissimilar to how they would conduct an ongoing art therapy session. That is, the child would be offered the opportunity to work with three different art materials; pencils, clay or paint. The assessor does not actively direct the child, but would be available for technical advice and encouragement. In the evaluation session, unlike an art therapy session, the assessor would encourage the child to make use of all three materials on offer. Kramer and Schehr dismiss the notion of directing the child towards a theme, such as draw your family, because they view this as an intrusion on children - particularly those from dysfunctional families. The evaluation session lasts for one hour. The children are provided with a pencil and rubber and asked to draw a picture of their choice on a piece of white 8 1/2 by 11 inch paper. Once completed, the children are then offered the choice of clay or paint. Due to the informality of the evaluation, Kramer and Schehr did not provide any formal assessment criteria but advised on the following headings as an aid.

1. The three mediums: The developmental stage the child is functioning compared to the chronological age. The other areas that they mentioned were as follows:
   a) Drawing: motor coordination, perceptual problems etc.
   b) Painting: affect, choice and response to colour, ability to mix paints etc
   c) Clay modeling: able to integrative work, type of regression then if able to move back to reintegration, response to material.

2. Character of the art works:
   a) No product – withdrawn/destructive etc.
   b) Product in the service of defense - stereotypes etc.
   c) Product in the service of primitive discharge – chaotic/aggressive etc.
   d) Attempt as formed expression – able to achieve or not etc.
   e) Comparison of the art works in three mediums – similar/dissimilar etc.
   f) Formal quality of the art work – empty/dull/ original/fragmented etc.
   g) Subject matter - message in work etc.

3. Child’s attitude during the session:
   a) Towards the assessor – cooperative/ withdrawn etc.
   b) Towards art work – invested etc.
   c) Towards the art materials – likes/ ability etc.
   d) Towards offers of assistance – accepting/ needy etc.

4. General observations etc.

(Adapted from Kramer & Schehr, 1983).

Overall they concluded that as well as offering an insight as to whether the child would benefit from art therapy the art evaluation was “most successful in spotting areas of ego strength” (Kramer & Schehr, 1983, p. 11).

Inspired by Winnicott (1971) and Gardner (1975, 1980), Gabel (1984) developed the ‘Draw a story game’ as a way to engage children in therapy by combining the techniques of drawing and children’s natural ability to tell stories. The child and therapist simultaneously draw pictures whilst telling stories. The idea was to establish rapport with children who are unable, or
unwilling, to participate in more direct verbal exchange. It was also a means of indirectly eliciting data about the child’s psychological functioning and current emotional issues.

Rubin (1984) termed her assessment procedure as “The Rubin assessment”, whilst arguing, “that any imposition of required media or topics seemed an unnecessary and distorting interference” (p. 52). She believed that when a child is given “free range” they are able to show their unique self. The assessment entails an unstructured interview that lasts for one hour. The child’s use of the space, time and art materials would provide the information for a diagnostic decision.

To fully comprehend the symbolic messages that are produced by the child, Rubin recommends that the assessor be familiar with knowing “how to look, what to look at, what to look for, and how to make sense of what has been observed” (p. 66). In other words, the assessor not only looks at what the child expresses, but also how the message is expressed. She suggests that there are multiple levels of meaning in the child’s expressions and behaviours, and attention should be made to verbal and non-verbal behaviour, interaction, response to the task and how the child approaches the materials provided. The actual process of the art making as well as the content, themes and form are also important elements of the assessment.

Silver (1983, 2007) has developed several art therapy assessment tests. She originally designed her “Draw-a-story” assessment as a means of assessing if clients were depressed. Clients are shown fifty cards with different images on them including people, animals, places and objects. The client is then asked to choose four of the images and think about what might be the linkages between them, which they then are expected to draw. They are then encouraged to title their work and make a three-sentence story about their image. The emotional content of the drawing is seen as offering information about the client’s emotional state and relationships. Silver later expanded the ‘Draw-a-story’ assessment to the ‘Silver drawing test of cognition and emotion’ (2007). This latter assessment test involves a sequence of three sub-tests: predictive drawings, drawings from observation; and, drawings from imagination. In the first subtest, the client is asked to add lines to drawings of objects to show how they can change in appearance. In the second part, the client is asked to draw their observations of a various sizes of cylinders and a small rock. The third sub-test is the ‘Draw-a-story’ assessment as described above. The sub-tests are scored from 0-5 and then compared to “normative data” provided in a manual.

In summary, a range of developmental, educational, and psychological theorists have used the use of art to gain access to non-verbal information. In particular, art has recently begun to be more directly linked with biological processes and seen as a pathway into various memory systems that are not accessible through verbal communication. Therefore, as previously underlined, an understanding of children’s developmental capacity to use symbols and express themselves through drawings is essential when working with families with young children.

Whilst it became essential to include childrens’ symbolic communication within the assessment, it also was apparent that many of these assessments lacked an understanding of the wider context and influences on the child’s symbolic communications. Most children live within a family system, which can have a profound influence on their development. Making sense of how the family system and the relationships within, had influenced a child’s development, was necessary if a comprehensive view was to be obtained. An understanding of systems theory seemed to be a helpful step in obtaining a wider knowledge that considered content, as well as context.

Understandably, clinicians can be overwhelmed when faced with treating traumatised children with such complex and challenging clinical presentations and at times unsafe family contexts.
Identifying and prioritizing key factors, and planning and implementing treatment, poses a significant challenge in most clinical settings. The integrative model values systems theory in the assessment and treatment of child trauma and other complex clinical problems.
CHAPTER SIX

Systemic family therapy

Systems theory

In understanding the theoretical underpinnings, main influences and ideas of systems theory, some of the history and concepts that influenced its development are explored. Family therapy initially grew out of the psychoanalytic theory, alongside the social science movement, and developed a variety of theoretical approaches under the umbrella of general systems theory. Von Bertalanffy (1968) has described it as a general theory of the organization of part of the whole (as cited in Donnelly, 1992, p. 126). Systems theory is an integrative theory, which helps clinicians organise information from multiple system levels into a well-defined treatment plan.

Systems thinking views the world as a network of connections, and understanding problems systemically refers to viewing them in a context and establishing the nature of their relationships, that is the process of those relationships (Von Bertalanffy, 1968 as cited in Donnelly, 1992; Bogdanov, 1912-1917). In other words, a problem cannot be understood by merely analyzing one of its parts or system levels (e.g. diagnostic category), but requires consideration of the broader system and of the relationships between its parts. For example, the child, family, school, work and community can be seen as interconnected system levels, which all impact on what happens to the child in the immediate context (Bronfenbrenner, 1979, Kozlowska & Hanney, 2003). Change on one part of the system may be sufficient to lead to changes at another level, or conversely, that may be insufficient, requiring intervention or multiple interventions at interacting levels leading to multiply levels of change. For example, in young children, dissociative symptoms frequently resolve subsequent to the re-establishment of children in safe and supportive environments without focused treatment being required. Conversely, exposure and desensitisation interventions target and significantly improve post-traumatic stress disorder symptoms, as well as having some impact on depression (Deblinger, McLeer, & Henry, 1990; Kozlowska & Hanney, 2003). Resolution of depression may require more focused treatment such as medication, or cognitive behavioural treatment, or may resolve when multiple other factors improve such as parental ability to provide care and containment, and/or marital conflict, and/or parental mental illness, and/or the child’s social relationships etc.

Systemic ideas were inspired by Bateson (1972, 1979), an anthropologist, who after studying various culture groups in New Guinea, formed the Palo Alto Group (USA) with the purpose of studying interactions and patterns of communication between various members of the family system, rather than the underlying material of an individual member. He began to view families as a system of interconnected parts that form subsystems, which impact on each other and other subsystems, such that “by observing systems one could formulate rules that could account for the functioning of interconnected parts” (Gurman & Kniskern, 1991, p. 42). Bateson identified two types of behaviour: symmetrical; and, complementary behaviours. The former behaviour refers to when a person equals the behaviour of another, and the later where one person reacts by taking the opposite position, in other words “each party reacts to the reaction of the other”. (Bateson, 1972, as cited in Gurman & Kniskern, 1991, p. 42). In summary the family system is a cybernetic system that is, a system that governs itself through feedback of information.

As a result of the ideas of feedback and circularity, systems theorists have been able to think about human behaviour beyond determinism, that is they interact recursively. In observing a
families interactions, family therapists can begin to distinguish those repeating patterns which are not describable merely as pragmatic responses to the current interaction, but are seen to be characterized by habit (Bateson, 1979) or redundancy; that is, they are laid down at levels of meaning which are habitual, may not be available immediately to awareness, and are repetitive. Thus, creating a situation where these patterns of interaction can be observed would be helpful in attempting to address less satisfactory habitual interactions. As systems theory developed, family therapists were encouraged to adopt the role of the observer, as the person who interrupts, makes choices, underlines aspects and sorts out the information pertaining to the patterns of interactions (Jones, 1987).

There were many different theoretical models that developed out of general systems theory. In considering the context, client population, training of the author and the requirement of the assessment the “Milan”, “Structural” and “Narrative” models were most appealing. In considering how these models could be influential in the development of the art exercise it is necessary to explore these models in more detail.

**Milan family therapy**

The key concepts that underpin the Milan model are described below - particularly those that appear to be relevant to the development of the assessment exercise. The ideas from the Milan model that were problematic are also identified and will lead to further exploration.

Inspired by Bateson’s theory of circular epistemology (Tomm, 1984a, 1984b), Boscolo and Checchin developed a conceptually and methodologically congruent model, which they termed the Milan model of family therapy (Boscolo, Checchin, Hoffman & Penn, 1987). The presenting problem is seen as a reflection of problematic relationships in the wider system, rather than within the individual. They saw the therapist working on two levels. “First-order cybernetics”, wherein the therapist works from a position of an observer studying and attempting to understand the interactions that maintain or change the system. “Second-order cybernetics”, where “the observer is seen as part of that which is being observed, and also as crucially implicated in constructing that which is being observed” (Jones, 1993, p. 21). They developed three principles of interviewing, which they termed: “circularity”, “hypothesizing” and “neutrality”.

**Circularity** – Palazzoli, Checchin, Boscolo and Prata (1980) have argued circularity is the ability of the therapist to conduct an interview based on the feedback from the family in response to the therapist questions about family relationships. The aim is to invite the family into different views about itself through introducing new information into the family system. The Milan model emphasized various types of questioning, termed “circular questions” in an attempt to draw out connections and differences between family members and the larger client system. Fleuridas, Nelson and Rosenthal, (1986) suggested a helpful and pragmatic classification of the various circular questions. The following is a brief example of some of the various types of circular questions typical to the approach:

<table>
<thead>
<tr>
<th>Problem definition questions:</th>
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<tbody>
<tr>
<td>A. Present:</td>
</tr>
<tr>
<td>• <strong>Difference:</strong> How is this changed over time? Has it always been this way? How would this change if your dad went back to work?</td>
</tr>
<tr>
<td>• <strong>Agreement/Disagreement:</strong> Who in the family agrees with you?</td>
</tr>
</tbody>
</table>
• *Explanation/Meaning*: How do you understand what he does?

B. Past:
• *Difference*: What was it like three years ago?
• *Agreement/Disagreement*: Who agreed with you three years ago?
• *Explanation/Meaning*: What do you think Joe did that helped make that decision?

C. Future/Hypothetical:
• *Difference*: What would be different from now?
• *Agreement/Disagreement*: Who would you like to share that view with you?
• *Explanation/Meaning*: What would happen if you did that?

Sequence of interaction questions:
A. Present:
• *Difference*: Have you always left the house when they fight?
• *Agreement/Disagreement*: Who in the family agrees that you should leave?
• *Explanation/Meaning*: Why do you think your mother leaves the house?

B. Past:
• *Difference*: Was there a time when you did not leave?
• *Agreement/Disagreement*: Who agreed in the past for you to leave?
• *Explanation/Meaning*: How do you explain that this has changed?

C. Future/Hypothetical:
• *Difference*: What would happen if mum stayed?
• *Agreement/Disagreement*: Do you think mum would agree with that?
• *Explanation/Meaning*: What would it mean for you dad if your mum stayed?

Comparison/Classification Questions:
A. Present:
• *Difference*: Is that the same as your friends?
• *Agreement/Disagreement*: Who agrees with this idea?
• *Explanation/Meaning*: How do you understand why they became so close?

B. Past:
• *Difference*: What happened before dad left home?
• *Agreement/Disagreement*: Would your sister agree that you were closest to dad?
• *Explanation/Meaning*: How do you explain that closeness?

C. Future/Hypothetical:
• *Difference*: What would happen if dad had stayed?
• *Agreement/Disagreement*: Do you think mum would agree with that?
• *Explanation/Meaning*: What would it mean for you dad if your mum stayed?

Interventive Questions:
A. Present:
• *Difference*: If you were to have the same as your friends what would change
• *Agreement/Disagreement*: If I suggested your mum stayed who would support me?


- **Explanation/Meaning:** What do you think your mum would think?

B. Past:

- **Difference:** How did they manage that in the past?
- **Agreement/Disagreement:** Who would agree/disagree with this view?
- **Explanation/Meaning:** Why do you thing that worked?

C. Future/Hypothetical:

- **Difference:** What would happen if dad had stayed?
- **Agreement/Disagreement:** Do you think mum would agree with that?
- **Explanation/Meaning:** What would it mean for you dad if your mum stayed?

(Adapted from Fleuridas, Nelson & Rosenthal, 1986).

In summary, circular questions attempt to draw out connections and differences between family members and the larger client system and effect the family therapist’s working hypotheses.

**Hypothesising** - the Milan model emphasizes the therapist developing a working hypothesis about the meaning of the problem in the family system. The initial hypothesis is created from the referral information and original contact with the family, previous experiences of the therapist and other prominent views. The intention of the hypothesis is to make connections between behaviour and meaning, it acts as a guide for the therapist’s questions. The aim is that by asking questions in this way the family would be able to begin to develop a systemic view of the problem, and allow for other meanings and problem definitions to enter the family system. The family therapist questions confirm or disaffirm the therapist’s/and teams hypothesis about the presenting problem. As information is obtained, the therapists’/teams’ working hypothesis is altered, affirmed and developed in response to the family answers, which then guides and orientates the family therapist further questions. The family therapist avoids providing answers and expressions of opinion and attempts to get every members’ perspective by attempting to hold a position of neutrality.

**Neutrality** - another key technique in the Milan model was the idea of the therapist maintaining a neutral position with the family. The family therapist’s ability to remain neutral to the system was seen as imperative. Neutrality is an attitude that the family therapist adopts that exudes a sense of respect and curiosity. The neutral therapist is removed from blaming any part of the system or from an investment in changing the system, seeking only to understand how the system functions. By adopting a neutral stance the therapist reflects the belief that there is no one world-view or ‘truth’, thus allowing all members of the system to feel respected and to express their own world-view.

**Framework**

The Milan family therapy team originally adopted a co-therapy model, with two therapists in the room. This was convenient for training purposes, but was also seen as mirroring the marital relationship. This was eventually discarded and replaced with a team approach. The family therapist remains with the family conducting the session, whilst another, or at best a team of therapists, sit behind a one-way screen. The team behind the screen were able to offer another or different perspective. Bateson (1978a) argued that by obtaining “more than one view of an event would enable us to achieve the cognitive and emotional equivalent of binocular vision, thus
gaining, in a metaphorical sense, perspective on our observations and experiences” (as cited in Jones, 1993, p. 31).

The Milan team, influenced by Bateson’s view about change, argued it is “the difference that makes the difference”. They recognized that the developing therapist/client relationship might prevent difference being introduced into the system. Therefore, the team behind the screen can hold different perspectives and allow the therapist to belong to two systems simultaneously, permitting the family therapist to be part of the therapist/client system but not fully part of it (Jones, 1993).

The Milan sessions would last for up to an hour and a half, with the family therapist taking time out to consult with the team behind the one-way screen. The family therapist, having consulted with the team would then return to the family and share the dominant hypothesis with the family by way of verbal feedback. The family therapist would then offer the team’s opinion as to the meaning of the behaviour with the family system.

Later, family therapists working within the Milan model developed the ‘reflecting team’ approach (Tomm, 1987), where a team of therapists, having viewed the interview through the one-way screen, would reflect whilst being observed by the family. The family, at times would be invited to swap positions and observe the team discussion from behind the one-way screen. The aim was an attempt to breakdown the expert/power issues that the ‘observation by team’ approach inevitably elicited.

The opportunity to view a family from this ‘meta’ position was exciting, particularly regarding the access to different levels of information that it offered; consequently it became a key consideration in the development of the assessment exercise.

In considering the Milan model there were several areas that were problematic when considering young children in family therapy. The Milan model, given the emphasis on questioning, required a degree of cognitive understanding and concentration that was not often available in the children referred. This appeared to limit the children’s ability to participate and, at times, seemed to escalate their behaviours. Many of the families referred to the hospital, where the assessment would take place, lacked a support network, and/or had lost their confidence in parenting and were at a loss on how to manage their children’s behaviours. The children’s behaviour was often ‘out of control’ and at times would become dangerous. The idea of neutrality was seen at times to be problematic, particularly given the issues of safety and the need for parental authority that often emerged (MacKinnon, 1998). With this in mind, a less neutral, and more directive model was also explored, which led to Structural family therapy. In Structural family therapy, the therapist seemingly takes more ‘control’ of the session, adopts a more ‘expert’ position and employs a directive approach offering structure, suggestions and support.

**Structural family therapy**

In reviewing the structural family therapy approach there were a number of key concepts worth exploring that seemed relevant to developing the assessment task; how to address childrens’ out of control behaviours; parental authority and the therapist’s position. Several key concepts that underpin the structural model are worthy of exploration. The ideas from the structural model that were problematic should also be identified.
Minuchin (1974) developed structural family therapy and, similar to the Milan therapist, his ideas were influenced by sociological and anthropological concepts, viewing the individual in their social context, environment or situation.

Families were seen as a hierarchical organizational structure, with subsystems, rules, boundaries, alliances and coalitions between members. Minuchin believed that for the family to be a functional system, a clear generation hierarchy needed to be established, where parents maintain the executive roles. Minuchin described the family structure in the following terms:

1. Subsystems were units within the family that are determined by common generation, sex, functions or interests, and any family member can belong to more than one subsystem.
2. Rules described how the family subsystems operate and correspond to the norms and expectations that regulate family life.
3. Boundaries were an emotional barrier that governs the distance and interaction between family members, that is, whom does what with whom, when and where.

(Adapted from Minuchin, 1974).

In contrast to the Milan approach, where the symptom was seen as being a reflection of a problem in the relationships between members of wider systems, in Structural family therapy, symptoms are seen as a result of a problem in the family’s structure where the boundaries around various subsystems had become ‘enmeshed’ or ‘disengaged’, and ‘hierarchies’ and ‘boundaries’ had become unclear.

Minuchin believed problems emerged in families when they were faced with a crisis, something different that impacted upon the family system, which required them the family to re-organise their system. If the family were unable to adapt to the crises, were inflexible, then a problem emerged, which was then maintained by the families’ interactions. “According to structural therapists, ‘dysfunctional’ families are characterized by boundaries which are either too diffuse or too rigid” (James & Mackinnon, 1986, p. 224).

The family session is viewed as an opportunity to change the family through a process where the therapist ‘joins’ with the family, assessing the families’ structures, and provides an opportunity for an “…enactment of dysfunctional and ultimately of functional transactions” (James & Mackinnon, 1986, p. 225). Structural family therapists focus on processes and use a more directive approach than the Milan therapists. Most specifically, structural family therapists attempt to change the system by realigning certain subsystems through questioning, challenging family’s rules or aligning themselves with one part of the system. The therapist would observe the family’s responses and “look for opportunities to create a ‘workable reality’, a new way of looking at the problem that allows for new solutions to emerge” (MacKinnon & James, 1986, p. 225). The structural family therapist’s adopts a range of questions, but is less likely to use the more complex reflective and interventional questioning style of the Milan model.

Although the structural model is helpful in considering how to manage childrens’ out of control behaviour and permits a simple framework for thinking about the family, there are, however, a number of shortfalls. Although Milan and Structural models come under the heading ‘systems theory’ they are remarkably different. Structural family therapists do not place any relevance on the function of behaviour, which is different to the Milan model where all behaviour has
meaning. Similarly, structural family therapy is in stark contrast to attachment theory, where the function of behaviour is vital.

The reliance on the therapist’s ability to solely observe and assess the family patterns of behaviour in the session, as opposed to more detailed observations and gaining verbal reports of a longer time frame, seems problematic. This could lead to a failure to understand the problem fully and any wider systems that could be impacting on the system.

Structural and Milan therapist’s view the presenting problem differently and intervene in the family system from very different positions. The Milan family therapists are non-directive and work from a position of second order cybernetics, by remaining curious and neutral to the family system. In contrast, structural family therapists work from more of a position of first order cybernetics, adopting a directive approach by joining with family members and actively using themselves and their beliefs to disrupt and re-align the family system. There is a huge emphasis on structural family therapist to be active, creative and challenging, which can be problematic as it relies on the therapist’s own personality.

Both models are useful on multiple levels in conceptualizing and developing the assessment exercise. The Milan notions of curiosity, questioning techniques, the notion of hypothesizing and at times adopting a neutral position appear to be significant ingredients to the success of this model to therapy. The idea of using a one-way screen to observe the family collectively and obtain a wider perspective is similarly useful in thinking about developing the assessment exercise.

The more directive approach of the structural model seems more relevant for children who may be out of control or disruptive. In other words at times the therapist would need to take a less neutral position and a more active role, particularly when faced with issues of safety.

It was interesting to note, that assessment in systemic family therapy was seen as part of the ongoing therapeutic work and not as a separate stage of treatment. Within the Milan framework the formulation of several working hypothesis about the families’ relational patterns is critical to the assessment process. However, they do not separate assessment from therapy, preferring to see the therapeutic process as a whole. Structural family therapists also tend to see assessment as part of the ongoing treatment rather than a separate entity, viewing it as part of a continual experiential exploration. Including the assessment as part of the ongoing work, gives another level of value to the role of the assessment process. The assessment could be seen as an opportunity for the family to begin the process of healing.

This way of working however, is problematic in the context of a tertiary child psychiatric facility where the emphasis is upon efficiency and multidisciplinary involvement. It is imperative to distinguish the assessment, because the primary function of the assessment is to develop an efficient treatment plan that could be communicated to a multi-disciplinary team. A defined assessment allows for the multidisciplinary team to have a common understanding and a beginning point, from where multi-disciplinary treatment goals can emerge. There is a risk of working with a multi-disciplinary team without a defined assessment, a treatment plan and shared goals because without a structure treatment can become confused and potentially unsupportive.
Systemic family therapy assessments

Worthy of mentioning as an early attempt in the field of family therapy to capture family interaction was Loveland, Wynne and Singer’s Family Rorschach.

It provides a relatively standardized task in which the impact of family members upon one another can be sampled; the task is sufficiently interesting and emotionally stimulating to a variety of families so that intervention of a tester or therapist is not required to elicit and sustain the interaction; the individual perceptual starting points from which family members begin communication are relatively accessible; and finally, the Family Rorschach procedure is an interpretative transaction in which meanings are attributed to the “reality” of the Rorschach cards.


Whilst this task was interesting it did miss the opportunity to see childrens’ non-verbal symbolic communication and relied on young childrens’ ability to verbally apply meaning to a shape on a card and communicate this meaning within the family. The idea of the family being left to their own patterns of communicating untainted by the therapist was appealing.

The value however of systems theory in the assessment of complex clinical problems is well recognized in the literature. Systems theory is an integrative theory, which helps clinicians identify and prioritize key areas of difficulty, and organise information from multiple system levels into a well-defined treatment plan. Treatment plans take into account not only patient, but also service factors, and, to be viable in clinical settings, must function within the limits of the organisation. Obstacles to applying systems theory in clinical practice include:

- the difficulty and time-consuming nature of collecting, organising and integrating information from multiple levels of observation;
- limits imposed by clinicians’ conceptual frameworks;
- absence of a clinical team or multiple perspectives within the team;
- lack of rigorous training;
- arduousness of trying to access and integrate service provision from multiple organizations, and
- pressures associated with service policy, fiscal stringency and demands for short-term outcomes.

(Adapted from Kozlowska & Hanney, 1999, 2003).

In contrast to the Milan and Structural approaches to assessment, Deacon and Piercy (2001) underline the importance of the assessment stage as providing a clear direction for family therapy and the key role of assessment is to reconcile both the subjective and objective views of the problem (see also Floyd, Weinand, & Cimmarusti, 1989, as cited in Deacon & Piercy, 2000).

Various theorists have made a number of suggestions as to what data is collected during family assessment (See, for example, Bernheimer & Keough, 1995; McPhatter, 1991; Thomas, 1990). The consensus of these suggestions is that at least the following data should be collected:

- the problem (history, definitions, intensity across time, past solutions, and clients’ motivations to solve the problem);
- family organization (membership, family history, power and hierarchy, socioeconomic status, cultural influences);
• family functioning (life cycle issues, roles, rules, communication, problem-resolution skills, goals);
• family strengths and resources, and
• goals for therapy and change.

(Adapted from McPhatter, 1991).

According to Deacon and Piercy (2001), historically family assessment methods are relatively new and that not until recently family therapists have come to rely on individual assessment measures such as: ‘behaviour check-lists’; rating scales; individual interviews; and, projective tests. In the past 20 years various family assessments, such as the “Paper and Pencil” test (Halversen, 1995) have emerged to measure individual family members’ perception of various family dynamics. Some of these assessments are described below:

• Family adaptability and cohesion evaluation scales (Olsen, Sprenkle & Russell, 1979).
• Family assessment device (Epstein, Baldwin, & Bishop, 1983).
• The measure of family health (Lewis, Beavers, Gossett & Philips, 1976).
• Eliciting whole-family interaction with a standardized clinical interview (Kinston & Loader, 1984).
• The family of origin scale (Hovestadt, Anderson, Piercy, Cochran & Fine, 2007).
• Home-based family assessment (Benotvim & Bingler Miller, 2002).

Thomas (1990) argues, however, that these methods are difficult to translate into clinical work, they do not lead to a precise treatment plan and do not facilitate engagement with the family. They also used seemed to be influenced by one theoretical model and therefore did not adopt an integrative approach recommended for the assessment of traumatised children. Floyd, Weinand, and Cimmerusti (1989, as cited in Deacon & Piercy, 2001) argue, “many quantitative instruments reduce holistic, contextually relevant data into linear constructs and ‘static statistics’ which do not adequately capture the culture of the family” (p. 357). Furthermore, Green and Vosler (1992, as cited in Deacon & Piercy, 2001) have concluded that quantitative assessment often failed to address the complexities of family context and that families may be reluctant to expose information about themselves on instruments that are being used to make decisions about their assessment and treatment. The field is increasingly being informed by constructionist thought, which may lead family therapists to be less willing to take the position of normative comparisons and seeking more ideographic methods (Deacon & Piercy, 2001).

Some family therapists have attempted to create more child inclusive assessment processes by utilizing tools such as the “Genogram” (Guerin & Pendagast, 1976). The genogram is a diagram that illustrates the family system, including the extended family, their names, gender, ages, dates of marriages, deaths, divorces, location, degree of contact and can include the quality of people’s relationships. It has been argued (Carter & McGoldrick, 1989) that the Genogram engages children in the assessment process and, by creating an opportunity for them to see they are part of a wider system, removes them from the ‘problem focus’ (Carter, & McGoldrick, 1989). Although this may be true, and even more so if the therapist is able to encourage the children to use their creativity in drawing out the Genogram, the amount of attention and verbal capacity required and the role of the family therapist in constructing the diagram makes this approach problematic. Whilst the information is important, it has failed to elicit other levels of information, such as family patterns of interaction and possible traumatic memories. The therapist is required to remain in the room, which prevents a more meta-observation of family
interaction, particularly as the therapist is seen as the expert of the Genogram - which, can be viewed as possibly undermining the role of the parent(s). This expert position means that the children and parents often look towards the therapist for instruction or management of any interactions that surface which in turn minimalizes the opportunity to witness the parents’ own abilities and modes of interaction. The diagram can become quite complex which means that the therapist needs to primarily be the one who was drawing. This prevents or limits any information that might be gained through the children’s images. In conclusion, although a useful exercise the data gained is somewhat limited.

A less verbally reliant and perhaps more creative family assessment exercise is that of the “Family sculpture”, which was inspired by psychodrama. Encouraged by the family therapist, the family use themselves to create a three dimensional representation of their relationships (Duhl, Kantor, Duhl, 1973). Although depending on the child’s age, it is perhaps more inclusive of children, but it also appears to rely heavily on verbal abilities and the ability to think conceptually. Again, this approach is limited in the information it can provide.

As previously mentioned, infants, toddlers, preschool and some young school-aged children may manifest traumatic sequelae, but may not have the cognitive maturity to undertake the verbal communication demanded in family assessment. Furthermore, at a young age, traumatic memories may not be accessible to verbal exploration. As evidenced by the literature, the assessment of traumatic sequelae requires the child to be an active participant in the assessment process. In clinical practice, however, assessing traumatised young children in family therapy poses a number of dilemmas. A number of studies have found that family therapists do not routinely include children in therapy sessions and relate this to a lack of training in working with children and poor knowledge of child development (Greenwood 1985; Johnson & Thomas, 1999; Korner & Brown 1990; Ruble, 1999; Setchel, 1998). Moreover, family therapy theory and practice has continued to emphasize the use of language as a primary therapeutic tool (Benson, 1991; Cederborg, 1997, Clarke, 1999; Dare & Lindsey 1979; Dowling & Jones, 1978; Kozlowska & Hanney 1999; Sanders 1985). This heavy emphasis on the verbal component of communication is reflected in the literature by terms such as “family discussion”, “family talk”, “therapeutic conversation”, “circular questioning”, “deconstruction of narrative”, and “externalizing conversation”. The idea of developing an assessment exercise that is more child-inclusive is underlined by this same body of family therapy literature (Chasin, 1990; Combrinck-Graham, 1986, 1991; Rober, 1998; Ruble, 1999). The primary aim, therefore, is to develop a family assessment process that facilitated engagement and maximizes children’s participation in the process.

Deacon and Piercy (2001) highlighted the need for experiential therapy methods such as art therapy in qualitative family assessment. They argue that not only are there benefits to engaging with families, but that it also offers a more creative collaborative opportunity. As well as the art therapy literature, it is also instructive to explore the family therapy literature that predominantly supports child-inclusive practice, which, amongst other things, has led to the work of Narrative family therapy. Narrative family therapy has endeavored to help raise children’s voices through the use of metaphor and creative processes.

**Narrative family therapy**

Narrative family therapy largely grew out of the ideas of White (2000) who described play as a place for children to bring together many different words and ideas, which are not in the wider
culture, usually placed together. The impact of this is that play can bring new information into a system and challenge certainty. The underlying premise suggests that children’s symbolic communication offers a unique voice that is less corrupted by social discourses and therefore closer to reality. This approach also seeks to facilitate the use of metaphor and a different level of language. Central to narrative therapy is the re-creating, or re-authoring, of children’s individual narratives, through the use of certificates, letters and documents, where the therapist takes an active role. The focus is primarily with individual narratives and on locating and solving the problem. Therapists working within a narrative framework have emphasized the importance of creating stories as a way to help individuals re-author their lives (see for example White & Epston, 1990). In other words, with the help of the therapist, and the use of story telling, people can change their views about themselves by reworking a personal story. This enables clients to alter their beliefs and hence release themselves from the ‘problem’. White’s ideas, whilst stimulating, the challenge remains to find a way to take and connect these individual narratives into the wider family context. It is this challenge that requires us to look further into the research literature to ascertain if others have found a way around this limitation.

Extending on White’s ideas, Freeman, Epston & Lobovits, (1997) and Lobovits, Epston & Freeman (2001) remark that being creative permits external self-reflection and that symbolic communication adds other levels, such as sensory and physical, to the generation of meaning. They emphasize that: “the map of verbal description does not fully represent the territory of lived experience, including the richness of visual symbolic processes, feelings, emotions, and sensations.” (Lobovits et al., 2001, p. 3). When the child is able to ‘see’ the problem outside of themselves, and a sense of detachment from the symbolic representation of the ‘problem’, they are invited to physically engage with the art, such as “moving, cutting or folding” (Lobovits et al., 2001).

Narrative therapy methods are highly cognitive and language-based and it has been argued that such techniques are exclusive rather than inclusive for young children (Chang, 1999; Coale, 1992; Hayes, 1995; Rober, 1998; Stacey, 1994). More recently, some narrative therapists have begun to explore ways to be more inclusive of children (see for example Berger & Gehart-Brooks, 2000; Chang, 1999; Freeman, Epston & Lobovits, 1997; Larner, 1996; Smith & Nylund, 1997; Stacey & Lopston, 1995). Stacey and Lopston (1995) present an argument for allowing children the opportunity to express themselves through literate practices. Other narrative therapists suggest the use of play, art and story telling in order to become authorities on their personal narratives and lives (see for example Larner, 1996; Smith & Nylund, 1997). Larner (1996) has attempted to link the child’s individual narratives to the family system by inviting the family to make interpretations about the art that a child has produced in individual therapy.

The overall emphasis in narrative therapy seems to be upon individuals in the context of their family, rather than the family co-creating a storybook aided by illustrations. Furthermore, the narrative approach emphasizes the re-writing of the client’s story to fit a more “heroic tale”. This is in contrast to the approach that will be put forward in this thesis, which aims to help the child and family to tell a family story. The underlying theoretical rational of narrative therapy is that the ability to remember events as they occurred, to consider associated feelings and to attach semantic meaning to what happened is healing and allows for resolution of past traumatic events (Main & Goldwyn, 1984). The sharing of images and experiences with family members “can be a dramatic revelation of commonality” (Wadeson, 1995, p. 146), and minimizes feelings of alienation. This is particularly important for young children who often feel alone with their problems and tend to blame themselves for what has happened.
A narrative approach seemed to require a high degree of active involvement between the child and the therapist as meanings are generated. Overall, art, in narrative terms, is still in the realm of a visual tool or directed task. Again, the primarily individual focus and the degree to which the therapist is involved in the system are problematic, such as the choice of symbolic material and how therapists participate in this process. Furthermore, of concern was the idea that art was the assumed container of the problem, which implies only one level of meaning. Bateson reflects the same concern when he describes artistic skill as “the combining of many levels of mind – unconscious, conscious, and external – to make a statement of their combination. It is not a matter of expressing a single level” (1972, p. 470).

Additionally, in considering the impact of the child’s art being individually created in the context of a therapeutic relationship rather than the family, brings to mind Bateson’s belief that art cannot be separated from the context in which it is made.

It is, I believe, of prime importance to have a conceptual system which will force us to see the ‘message’ (e.g., the art object) as both itself internally patterned and itself a part of a larger patterned universe – the culture or some part of it. The characteristics of objects of art are believed to be about, or to be partly derived from, or determined by, other characteristics of cultural and psychological systems”.

(1972, p. 105).

It is these sentiments that reveal the different levels of communication that can emerge in art when a directive style is employed and when the art is made in a separate therapeutic relationship rather than when children are given the space to engage in creative processes in the presence of their family. Finally, Larner’s (1996) argument that the child’s art be offered up for interpretation by their parents is concerning as it appears to indicate that the parents voice/story is again left to dominate.

A response to the dilemma of how to enable access to multiple levels of meaning/communication, leads to considering the work of Anderson and Levin (1997), who have developed a hermeneutic approach to family therapy in which they explore ways to work with liberating different dialogues in the context of the family.

**Hermeneutic approach**

Anderson (1992, 1995) stressed the importance of listening:

To listen intuitively means (…) to be open to the small “touches” which are almost invisible and almost inaudible, and vanish so quietly and so quickly that they are in most cases hard to detect. If we listened differently would we talk differently/is there something to be learned from art and artists?

(1992, p. 91).

The hermeneutic approach focuses on accessing and permitting as many levels of dialogue as possible. Anderson and Levin (1997) provide a non-directive, ‘tedious’ and slow-generative process, where the therapist intensely listens and produces questions related to the information given. It is in these conversations that meaning is created and, “each therapy conversation is a multiplicity of criss-crossing, overlapping, and sequential dialogues (internal and external)
within the conversation” (Anderson & Levin, p. 267). They describe a hermeneutic approach as a process of creating a safe enough environment to permit dialogues that have become restrained, so that they can become liberated by facilitating the expression of different internal and external voices into ‘a state of coexistence’. Anderson and Goolishan (1988) believe ‘meaning’ and understanding occur only when the therapists engages in a communication that emulates the system. Sims & Whynot (1997) suggest the therapist put aside any previous preconceptions and try to take a ‘not knowing’ position. Meanings are then co-constructed in a “dialogical space” between the therapist and the family, in other words “meaning is not a destination. It is a process” (p. 343).

In an attempt to privilege the family voice, by considering listening and speaking patterns, the focus becomes the process of the communication, rather than the content. Anderson (1995) refers to this as ‘reflecting processes’ where one moves between inner dialogues (listening) to outer dialogues (expressing). The pace of the session is slowed down so that the therapist is able to ‘truly’ listen and remain watchful of the other’s response before they respond.

The hermeneutic approach resonates with attempts to find a way of working with children. In particular, it supports having the space to notice processes. The emphasis on emulating the family’s communication system, particularly in relation to working with children is encouraging. This approach seeks to step back from adult-laden communication and supports understanding the many potential levels/types of communication that form a family’s story and therefore gives space to children’s communications.

The emphasis on external and internal dialogue, that also includes listening and being a ‘witness’, raises concerns about the time needed to talk with children, which can be at a different pace, and also helped in thinking about different levels of participation. Placing the emphasis on the process rather than the content is similar to art therapy, where the creative process, the act of making art, is recognized and valued as a form of communication. Consideration of these arguments leads one to consider if any family therapists had incorporated the creative process into their work. Art therapist and systemic family therapists are in a prime position to nurture creativity in that the therapy environment is conducive to safety and challenge. The intention would be to create a therapeutic space that allows clients to interact in new ways and to find creative solutions to their problems (Deacon & Thomas, 2000). In the wider perspective, however, Kiser and Piercy (2001) present an argument that as the field of systemic therapy becomes more restrictive in its accreditation requirements, it may become less conducive to creativity and the development of new ideas.

Deacon and Thomas (2000) and Kiser and Piercy (2001) have highlighted the benefits of the therapist’s ability to attend to creativity, with the underlying principle that being informed about processes of creativity would help develop further understanding of clients, as well as, encourage children and families to find creative solutions. These ideas were helpful in highlighting the importance of creating an environment of safety in an assessment. The need to have enough time to take note of the creative processes, as well as time to explore the final art expression is also supported. It has been important to review the family therapy literature that has focused on specifically working with children to gain an understanding has to how family therapists had tackled these dilemmas.
Systemic therapy and the creative process

Similar to “Art Therapy”, in “Systemic Therapy” the focus remains on the trial and error process of change in creating something unique (Openlander, 1991). Various family therapists have explored ways to integrate the creative process into their work (Deacon & Thomas, 2000; Gil, 1991; Greenberg & Johnson, 1988; Openlander, 1991; Papp, 1984; Watzlawick, 1966; White & Epston, 1990; Wiener, 1999) and even categorized systemic therapy approaches to the degree of creative processes involved (Kagin & Lusebrink, 1978; Openlander, 1991). It has been argued that systemic therapy has placed an emphasis on creativity, which is reflected in the language used, such as “unique outcomes” and “improvisational therapy” and many systemic therapist promote the use of creative thinking (Epston & White, 1992).

Papp (1984) argued, however, that the scientific language of systemic therapy avoids, what she described, as the more “human qualities” such as imagination and creativity. She draws from the idea that artists have made sense of human behaviour through “imagery, dreams, symbols and metaphors”, abandoning rules and “logical analysis” (1984, p. 22). She however, makes a link between artists and therapists in that they both make connections through the use of symbols and metaphors and both hope to create an opportunity for a different perspective. She posits that creativity emerges when one has consolidated all learning and techniques and rules are abandoned.

In agreement with these ideas, and alongside the other theorist mentioned, systemic therapists believe that creativity emerges when rules and reason are abandoned (Openlander, 1991). Openlander (1991) writes that creativity emerges from a distinct kind of thinking, intuitive and subconscious, that can be restricted by habit. She emphasised the ability to be flexible with regard to rules in therapy, which is echoed by other systemic therapists (Deacon & Thomas, 2000) who described the introduction of visual activities to challenge a family’s logical way of coping. Carson and Becker (2003) in exploring the use of creativity in systemic practice found that creative interventions were numerous and variable, but time constraints often acted as a barrier, which certainly was true in the child and adolescent hospital.

In summary, it appears that for a systemic therapist to enable second-order change (change that develops from within) the emphasis has to be on developing a therapeutic environment that is challenging, yet safe and supportive. Effective problem resolution can happen when a therapeutic space supports and encourages the creative process. Working with children who have experienced trauma serves to underline this challenge. Making the therapeutic space safe (Rober, 1998) and supportive for children becomes a key component in the development of the family assessment exercise.

Children and systems theory

Ackerman (1970), a renowned family therapist, once stated: “without engaging the children in a meaningful interchange across the generations, there can be no family therapy” (p. 41). The inclusion of young children seems to create a challenge to the family therapist who is primarily trained to work on a verbal level. Walrond-Skinner (1976) argue how easily younger child can disrupt a family session creating high levels of noise impacting on the therapist tolerance and leaving parents questioning what was achieved by including the children.
Furthermore, family therapists appear to struggle with communications across developmental proficiency or translating between the adult world of abstract thought and verbal communication and children’s non-verbal expressions and concrete imagery. From a psychoanalytic perspective, there is an idea that in the presence of children the therapist’s unconscious processes of envy and fear towards his own internalized child may be stirred or may give rise to feelings of longing (Walrond-Skinner, 1976; Zilbach, Bergel & Gass, 1972). Some family therapists argue that in the presence of children they are restricted in exploring some material. For example, Zilbach (1986) has concluded that within systemic family therapy, “young children were and often continue to be excluded with a theoretical justification for this therapeutic practice” (p. 31). Zilbach suggests six reasons why she believes child inclusive practice are important:

1. A child’s ability to make a hidden problem visible.
2. A child’s role in the presenting problem may be crucial.
3. Children often work as co-therapists and will offer information that may not emerge if left to the adults.
4. Early detection of other problems may otherwise go unnoticed.
5. The family dynamics are based on all members’ contributions.
6. To understand the family patterns of interaction all family members should be present.

(Adapted from Zilbach & Gordetsky, 1994).

It would appear therefore, the inclusion of young children is a vital and necessary part of family therapy assessment. Although the inclusion of children presents a challenge, exclusion can lead to a vital dynamic being missed, i.e. the relationship between siblings and how the family interacts.

Overall there seemed to be a desire to offer children the opportunity to voice their point of view, with a general acknowledgement that children express themselves’ through art and play. It was noted, however, that from clinical experience that if and when children produced art, it often remained unexplored. Holding sympathy with the need for space for adults’ verbal communication. At the same time knowing how children use these activities to communicate, led to a curiosity about how these symbolic communications could be more fully included. This dilemma was reflected in the literature, which described how the majority of family therapists, although appearing keen, could be more inclusive of children in their work (Chasin, 1990; Combrinck-Graham, 1986, 1991; Heins, 1988; Rober, 1998; Ruble, 1999).

Alongside these and other authors (Johnson & Thomas, 1999; Korner & Brown, 1990; Ruble, 1999), it is instructive to explore if further understanding of working with symbolic language would enhance this picture.

In view of the above difficulties of working with children, many clinicians have developed more concrete, non-verbal therapeutic techniques that function as an adjunct to “talk” in family therapy. Such techniques included puppet play, art, drawing, active metaphors, rituals, story telling, role playing, sculpting, unstructured play, and structured family art exercises (see for example, Busby & Lufkin 1992; Carlson, 1997; Chasin, 1989; Chasin & White, 1989; Donnelly 1992; Ford Sori, 1995; Gordetsky & Zilbach, 1989; Kozlowska & Hanney, 1999; Kwiatkowska, 1978; Landgarten, 1981, 1987; Lantz & Alford, 1995; Linesch, 1993; Nickerson, 1986; O’Brien & Loudon, 1985; Riley, 1985, 1993, Riley & Malchiodi, 1994; Rubin & Magnussen, 1974; Scharff, 1989; Schatz, 1998; Shearn & Russell, 1969; Sherr & Hicks, 1973; Villeneuve & La Roche, 1993; Wadeson, 1976, 1980; Zilversmit, 1990). Bing (1970) developed the conjoint
family drawing where the therapist “engaged the family in playing a series of games, involving building towers with oddly shaped blocks, as a family, as well as in competing sub-teams”. The other games included the parents discussing a proverb given by the therapist and lastly the family asked to do a family picture on one large piece of paper (p. 175). Each family member is given one crayon and told not to exchange with any other member. This was instigated so later analysis of the family picture can identify particular family members. The therapist remained with the family but is also observed by other therapist involved in the case. There were elements of this assessment such as the family picture and the emphasis on the observer role, which were inspiring. The length of the assessment, the therapist remaining in the room and limiting the use of colour was problematic as it could reduce a degree of expression were problematic. Other authors have attempted to engage children in family therapy by employing action techniques (Wolfe & Collins-Wolfe, 1983) such as doodle exercises, building with building blocks, clay sculptures of their world and sand pictures. The therapist gives vague directions to the family so as to maximize communication and patterns of interaction and then takes an observing position. Whilst these ideas were inspiring they needed to be modified as the building blocks and doodles were not specific enough so missed a level of symbolism and the clay and sand would not be suitable for an assessment that need to be efficient and with children who may become aggressive and agitated.

The literature tends to emphasis the uses of play and art through declarations of benefits and clinical examples, rather than an analysis of children’s distinctive communications. An attempt to address the latter issue has come from the family therapist, Wilson (1998) who has developed what he dubbed “a child focused approach”. This approach has been undertaken to fill this gap, which has suggested ways to weave symbolic communications into the verbal process.

**Child focused approach**

Wilson (1998) argues for the child to be central to the therapy process and encourages family therapists to consider various types of circular questioning that reflect children’s developmental abilities, the use of drawings, puppets and other toys and the use of metaphor. He comments that, “if adults can enter the playful or metaphorical depictions and descriptions in therapy, then the bridges between adult and child become easier to cross” (p. 66).

Metaphor permits a different level of conversation, which Wilson believes can be accessed through the toys or objects that children bring to therapy. The aim is to bring the child’s story into the open and then weave the story into the family’s description. These ideas are consistent with that of Bateson (1972) who held the view that metaphor can carry ideas across different levels of communication and can create understanding on multiple levels.

Working also with metaphor, Sims and Whynot (1997) suggest suspending making sense of the stories that families bring to therapy, and advocate for the importance of hearing family-generated metaphor. They place an emphasis on the therapist taking their time by slowing down the process of enquiry. The family’s associations to the metaphor are sought, which they believe connects different family experiences.

Wilson (1998) supports these ideas, as well as stressing that, when working with children, the importance of creating an environment that enables creative processes. He also valued the use of metaphors that arise out of children’s non-verbal communications and saw them as acting as a bridge between adult and children’s communication. Wilson’s primarily individual child focus
could be a problem for parents who may feel unheard, undermined or neglected. The tendency also to be directive in the use of art to elicit a story could miss the spontaneity of the child - the creative process.

All these approaches raise important contextual issues when developing any family assessment exercise. The emphasis on more child inclusive practice might be laudable, however, thus far the primary focus has been on the therapist/child relationship at the expense of overlooking the impact of the relationships within the child’s family context. Significantly, some family therapists have challenged the assumption that the mother-child relationship is primary. According to Bowen (1978, as cited in Kerr & Bowen, 1988) the father-mother-child (the triangle) is the most basic building block of the emotional unit, not the dyad. This idea is based on the theoretical assumption that any relationship between two individuals is inherently unstable and will involve others from the larger emotional unit, to stabilize it. Assessing children within all their immediate family relationships is essential for a truly systemic approach as recommended by the integrative model.

Overall, there was a clear indication that including the whole family in the assessment, at the same time as encouraging more child-inclusive practice was helpful. Systems theory views human behaviour in relation to process and content. Creating a family environment that felt safe for processes such as family interactions and creativity to occur, as well as content became evident. Family art therapy seemed to draw together all these elements and produce a more integrative model recommended for assessing traumatised children and their families.
CHAPTER SEVEN

Family art therapy

Family art therapists, and more recently some family therapists, have in conjunction with their usual theoretical orientation, used drawings to facilitate their work (see, for example, Chasin & White, 1989; Donnelly 1992; Ford Sori, 1995; Kwiatkowska, 1978; Landgarten, 1981, 1987; Lantz & Alford, 1995; Linesch, 1993; Hanney & Kozlowska, 2002; Kerr & Hoshino, 2008; Riley, 1985, 1993; Riley & Malchiodi, 1994; Rubin and Magnusson, 1974; Shearn & Russell, 1969; Sherr & Hicks, 1973; Wadeson, 1976, 1980). Integrating art therapy with family therapy, that is, having concrete visual images, it has been argued, could aid in the process of structural conceptualization, particularly for younger children (Ford Sori, 1995, Hoshino, 2008). Thus, a number of authors use art as a visual illustration to the story told in family therapy (Ford Sori, 1995; Hanney & Kozlowska, 2002; Hoshino & Cameron, 2008; Riley, 1993) or use art works produced in family sessions as a source of diagnostic information (Kozlowska & Hanney, 1999; Kwiatkowska, 1978; Landgarten, 1987).

Family art therapy emerged in America during the 1950s’ at the National Institute of Mental Health. According to the literature (Kwiatkowska, 1962, 1967, 1971, 1978; Levick & Herring, 1973; Muller, 1966; Sherr & Hicks, 1973), Kwiatkowska was the first art therapist to explore and use art therapy in the context of families. Kwiatkowska (1967), however, attributes the development of family art therapy, not only to the growing philosophy surrounding the role of the family in mental health and her work at the National Institute of Mental Health, but also to the work of various other authors (Kramer, 1958, 1971; Meares, 1958; Naumburg, 1950, 1973; Stern, 1953) and the development of group art therapy. Kwiatkowska (1975), however, did make the distinction that a family, unlike a group, is not linked with a common problem and, as a result of living together over a number of years, have formed their own distinct patterns of interacting. Kwiatkowska worked with the whole family but remained within a psychoanalytic tradition, where the problem was conceived as being located within a person rather than between them. The perspective was predominantly linear, rather than circular causality, with a focus on one member changing rather than all family members being viewed as part of the problem.

Kwiatkowska’s (1962) primary focus was on the research and development of family diagnostic and therapeutic techniques. The majority of her client population was families, where a member had been diagnosed with schizophrenia. Initially, Kwiatkowska (1962), worked using psychoanalytically orientated individual art therapy, alongside the primary therapist, who was often a psychiatrist or social worker. She later developed her role as a family art therapist after witnessing the benefits when family members joined an individual’s art therapy sessions. Kwiatkowska (1971) described her work as divided into three areas:

1. Family art therapy as an adjunctive to Family Therapy;
2. Family art therapy as the primary mode of treatment; and
3. Family art evaluation.

(Adapted from Kwiatkowska, 1971).

Family art therapy was seen as an opportunity to observe family patterns of interaction and make connections with an individual client’s psychiatric illness. She noted that the art works of family
members were similar in styles of thinking and perceiving, which were not evident in other assessments or observations. Kwiatkowska concluded that:

The family is less guarded than in the verbal situation, the groupings, the dependency on one member on another, become obvious in the choice of places, media and subjects. Anger and hostility are expressed without such an intense feeling of guilt: family members are often able to accept their real perception of themselves and perceive the other members of the family through their art projections as different from their habitual stereotyped images of one another.

(Kwiatkowska, 1975, as cited in Ulman & Dachinger, p. 120).

Later other art therapists, particularly in America (for, example, Kerr & Hoshino, 2008; Levick & Herring, 1973; Landgarten, 1981, 1987, 1991; Muller, 1966; Riley, 1985, 1990, 1993; Riley & Magnussen, 1994; Rosal, 1996; Rubin, 1987; Wadeson, 1973, 1976, 1980) and Brazil (Garcia, 1975), were inspired by Kwiatkowska’s work with families. The dominant approach seems to focus on the integration of psychoanalytic art therapy with systemic theory, where family art therapy was used as a diagnostic tool or parallel to family therapy. Overall the literature described directive approaches that involved observation of interactions with an aim to increase and permit equality in communication.

Muller (1966) conducted one-hour family art therapy sessions incorporating free and directed expression through art. The directed expression involved a variety of themes, with a focus on feelings. Muller believed that the use of art allowed the family to express more uncomfortable feelings in a less confrontational manner.

Levick and Herring (1973) described the use of family art therapy with extremely resistant and defensive families who had made slow progress using verbal interventions. Families were given specific tasks, such as being asked to do individual drawings of their family. The art-works were then used as a vehicle to address any concerns that emerged and were believed to be relevant to the family’s ongoing treatment. They reported that family art therapy allowed access to the “family’s physical and dynamic structure which had heretofore been undiscovered through the usual data collecting channels” (1973, p. 50).

Wadeson (1976) explored the idea of working with several families at one time, a technique which she termed “Multi-Family Art Therapy”. She argued that involving more than one family allowed the family to experience different beliefs, different views of the problem, and an opportunity to share how they have coped. Wadeson surmised that the use of art allows each member of the family to be equally seen and heard.

In “Family Art Psychotherapy”, Landgarten (1987) presents a family art psychotherapy/family systems approach, which she described as an integrative family art therapy model. She argues that the model was more responsive to the client’s needs. The model relied on the art acting as metaphor and as part of a diagnostic procedure. The use of art as metaphor was seen as helping when the family was avoiding more direct approach. Landgarten argued that family art therapy diagnostic tasks could be adapted to address a number of concerns including:

• Exploring the participants’ early experiences;
• Exploring the family of origin;
• Examining past and current histories;
• Surfacing preconscious material;
• Defense reduction;
• Gaining insight;
• Emotional experiencing;
• Understanding cause and effect;
• Observing transactional configurations;
• Pointing out dysfunctional behavioural patterns;
• Differentiation of family members;
• Uncovering conflict;
• Improving parenting, and,
• Problem solving skills.

(Adapted from Landgarten, 1987, p. 4).

Individual clients were viewed as part of a system and therefore how they operate within that system became the focus. Consequently, clients were seen in the context of their family and encouraged to undergo a standardized assessment, which involved three procedures:

1. Non-verbal team art task. The family was asked to divide into two teams; both teams are given a single piece of paper and asked to create a picture;
2. Non-verbal family art task, which involves a joint family picture; and,
3. Verbal family art task, which involves a joint family picture. Each person picks a colour crayon, which they must retain throughout the art tasks.

(Adapted from Landgarten, 1987).

Verbal and non-verbal communications between family members were not allowed during (1) and (2). Once the pictures were completed the team/family were encouraged too verbally decide on a title. The task elicited information in three areas,

• Process - diagnostic, family interaction, and practice tool;
• Content - expressions of unconscious and conscious material, and
• Product - concrete evidence of family dynamics.

(Adapted from Landgarten, 1987).

Whilst attempts to integrate psychoanalytic art therapy with systemic theory have continued (see, for example, Jenkins & Donnelly, 1983), other art therapists (see for example: Hoshino & Cameron, 2008; McCarley, 2008; Riley, 1993; Sobol, 1982; Sutherland, 2008) have aligned themselves with specific schools of family therapy, such as “Strategic” and “Structural”. The focus has been on art therapy and it’s ability to align or draw from particular schools of family therapy that had their origins in systems theory.

Evidenced in an article by Sobol’s (1982) where, although acknowledging other art therapist’s (Kwiatkowska, 1978; Landgarten, 1981; Levick, 1973; Rubin, 1978; Wadeson, 1980) the main theoretically underpinnings of the model drew from the work of strategic family therapist, Haley (1976). Sobol did compare and contrast the two approaches and concluded that art therapy is a way to communicate that leads to a better understanding, whereas the strategic framework destabilises and changes the families structure without regard for insight. Art in this context
becomes task orientated, that is, as a way to access a client’s inner world, to aid in the development of strategies and maybe employed to alter alliances within the family.

An effort has been made to establish a theoretical model of family art therapy. Arrington (1991) has developed a model that integrates historical, interactional and existential perspectives. The historical perspective was divided into two stages; the first stage attends to the symbolic content of the artwork and the second stage considers the developmental theorists and educators, such as Lowenfeld (1957). The interactional perspective, recognised the value of making art, the creative process and views art making as a motivation to aid healing. The other aspect the interactional perspective considered was the role art could play in exploring relational dynamics. The existential perspective focused on how the therapist, through the artwork views, the family and at the same time experiences their own reaction. The mainly directed task orientated model, however, stays within the paradigm of assessment and diagnosis, with an aim to elicit information about interactions and the unconscious.

Riley (1990, 1991) incorporated art therapy with the strategic family systems (Haley, 1976) model when working with individuals, couples and families although she has also explored other theoretical directions within family therapy (Social Constructivism, Structural Determinism and the Aesthetics of Therapy). The artwork creates observable and tangible images of the family story, which can then be ‘manipulated’ or reworked as part of the therapeutic process. Riley argues that the family art therapist, is able to be more effective since the information in the artwork allows her to wear a similar lens, enabling her to see the couple’s world and appreciate their viewpoint. With this unique lens, the art therapist can utilize many theories, many modes of interventions, and introduce a variety of art directives that reflect the couple’s story, giving new meaning to the ancient myths of the family.

(Riley, 1991, p. 5).

The use of art permits Riley to use ‘a similar lens’ to that of the family, which then allows her to work from a diverse range of systemic theories (1993). Riley and Malchiodi (1994), emphasize the creative process, the use of metaphor and the importance of the therapist refraining from making sense of the symbols, but rather to expand the family’s range of associations, from which meaning will surface.

Despite her use of art, Riley however, continues to stress the verbal aspect of family therapy, that is, the role of the therapist as a “master conversational artist” (Riley, 1993, p. 255). Riley has concluded that art therapy can be an added bonus, proposing that rather than move towards an integrated theory, art can be the “prime indicator” (p. 253) allowing the family to determine the more appropriate theory for them.

The predominant literature on family art therapy has been American, and it is not until recently that family art therapy emerged in the British literature. Jenkins and Donnelly (1983) attempted to draw similarities between art therapy and non-verbal family therapy techniques, such as “Sculpting” and “Genograms”, describing these techniques as being for the benefit of the family, rather than for the benefit of the therapist. They argue that by moving away from the focus on the mechanics of theme setting and delivery, and utilizing more ‘client centered techniques’ helps the family to elicit creativity and their own resources (Deco, 1990), empowering them towards change. In agreement with Deco (1990), the ability of a family, who are caught in
negative patterns of interaction, to elicit creativity creates a challenge and it is likely that the therapist would inevitably need to intervene. Donnelly (1992) later described using a “Solution Focused” approach to family art therapy, with a focus on how the family views itself he uses consecutive themes i.e. perceptions of the present and future, to allow the family to experience difference and possibilities for change.

Ford Sori (1995) and Deco (1990) adopt family art therapy using a structural perspective, where the art is utilized as an active interactional source of material. Deco (1990) described the need to focus on process rather than symbolic content. Attention was to be placed on not only the families interactions as they make the artwork, but also on positioning of family members, context of session, subtle non verbal communications such as facial expressions, expectations of therapist and family. Deco describes a team approach, where the therapist remains in the room with the family and the team and therapist develop working hypotheses. The artwork acts as a tool to facilitate enactments such as a mothers struggle to set boundaries with her young child. The mother and child are asked to share a piece of paper, with the mother encouraged to restrict the child to one half of the paper.

In an attempt to integrate art therapy with structural family therapy, Ford Sori (1995) proposed that art offers a concrete visual image of the family’s structure, boundaries sub-systems which are otherwise are difficult to conceptualise. When working within this framework, Ford Sori notes the actual position and size of family members, choice of colour, and strength of mark making as indicators of how the families system is operating. In particular she emphasised the benefits of integrating the two approaches during the assessment phase.

The therapist notes if one child is overly dependent on a parent to complete their portion of the drawing, or if one member appears distant and uninvolved in the project. Covert alliances may become evident as one dyad subtly excludes another family member from the family art drawing.

(Ford Sori, 1995, p. 19).

Overall, apart from Riley and Malchiodi, much of the literature described the art as something distinct, a parallel process to family therapy. There appeared to be no clearly established family art therapy theoretical framework. Instead, art therapists have continued to explore and argue for art therapy’s ability to align and integrate with particular systemic schools by adding another dimension. Kerr and Hoshino’s (2008) describe how various art therapy intervention techniques can be woven into family therapy practice to create a more integrative approach. What did become apparent was the emphasis throughout the family art therapy literature, of the multiple levels of information about families that can become accessible through the use of art, such as process data, family interactions and dynamics (Kerr & Hoshino, 2008). A number of family art therapists (Kwiatkowska, 1978; Landgarten, 1987; Riley, 1994; Rubin & Magnussen, 1974; Wadeson, 1980) have also recognized this and focused their work on developing family art therapy assessment techniques.

**Family art therapy assessments**

Kwiatkowska (1978) developed a structured “family art therapy assessment” that consisted of six-step process, which she termed the Family Art Evaluation. The six-step process involved,

1. A free picture;
2. Individual pictures of family;
3. Individual abstract pictures of family;
4. Individual pictures started with the help of a scribble;
5. Joint family picture developed from one of the individual scribbles chosen by family, jointly titled and signed; and,
6. A free picture.

(Adapted from Kwiatkowska, 1978).

Kwiatkowska (1962, 1967) advocated the use of an extra therapist in an observation role due to the complexity of family interactions. The family art evaluation offered insights into how the family expressed abstract themes and ideas, used their creativity, exposed their different family roles and worked together simultaneously as a family.

When the family works together with art materials, ... all members are engaged simultaneously in expressive activity. Without interrupting this activity they can comment spontaneously on each other’s creations; they can see how others perceive them, or expose their own perception of others. They move, change places, seek or give support, withdraw, lead or dominate the other family members.

(Kwiatkowska, 1962, p. 54.).

Overall, whilst these tasks are really informative they were too complex to span developmental abilities, not conducive to the short attention span of small or traumatised children and they were too time consuming.

Sherr and Hicks (1973) elaborated upon Kwiatkowska’s family art evaluation. Working as co-therapists, rather than one acting as an observer, they revamped the process, reduced the number of steps and, in an attempt to make the experience as comfortable for the family as possible, they played background music and offered light refreshments. Sherr and Hicks (1973) concluded that the technique highlighted previously hidden important family dynamics, allowed the family to view each other differently and offered a safe opportunity for the family to express confrontational issues. Further, they underlined the importance of the therapist being competent in the use of drawings.

Rubin and Magnussen (1974) also re-organised the family art evaluation to suit their client population and facility. They reduced the number of steps and asked the family to jointly execute a mural. The referrer would observe through a one-way screen whilst the family art therapist remained with the family. Following the completion of each step, the family was invited into discussion. Rubin and Magnussen concluded,

In the course of the three tasks and discussions, we observe a great deal of behaviour - verbal and non-verbal, independent and interactional - on the part of each individual family member. We collect much symbolic data from the products produced - from their form, content, process and style of execution - and from the associations to them from each individual, in terms of his own works and those of others.


They found a strong correlation between the observed family behaviour to the symbolic content of the images.
Evidently, also inspired by the “family art evaluation”, Landgarten (1987) developed an art exercise, which was also an opportunity to look at family functioning: as a diagnostic, inter-relational and rehearsal tool. The family would be asked,

1. To divide into two teams who work on a single piece of paper in silence;
2. Joint family picture in silence; and,
3. Individual free picture.

(Adapted from Landgarten, 1987)

These tasks focused mostly on non-verbal communication, and fail to elicit family gossip, and family interactions as a whole.

Wadeson (1973), whilst working with couples, described a five-step assessment procedure that involved the following requests:

1. The couple to work together in silence to produce an artwork. The aim was to assess non-verbal communication and conflict resolution;
2. The couple to produce an individual self-portrait, that each gives to the other to edit and complete in order to understand each persons perceptions of self and other;
3. An individual abstract of the relationship to understand partners’ view of the relationship;
4. A family portrait to assess family of origin influences and relationships; and,
5. A scribble to assess pertinent underlying intra-personal issues.

(Adapted from Wadeson, 1973).

Wadeson (1980) also describes family art therapy assessments where she similarly requests individual family members to draw a picture of the family. Wadeson viewed the art as being a ‘tangible object’, which she saw as easier for the client to refer to, rather than speak about them self. She argued that a ‘tangible object’ could be returned to and therefore avoided memory distortions. In contrast to verbal communication, art allows for spatial expression, which means the image can show all the families relationships occurring simultaneously as opposed to linear verbal descriptions. Wadeson’s focus is on the emotional content of the artwork rather than the patterns of interaction that occur in the process of the art making (Donnelly, 1992).

Riley and Malchiodi (1994) also use both individual and family shared tasks, such as ‘a group family drawing’, to give the therapist opportunity “to observe interaction, form a hypothesis about the family system and create interventions to alter dysfunctional sequences of behavior” (p. 197). A creative diagnostic tool developed by Yerushalmi and Yedidya (1997) asks clients to make a family album using collage attempts to access the inner world “as well as to understand the interpersonal theatre” (p. 261). Their assessment involved observations and questionnaires completed by the clients. The approach by using a questionnaire limits the involvement of younger children and again places the focus on the individual.

Riley (2003) eloquently argued that art was vital in helping families see the child’s problem from each other’s perspective, challenging the myth that everyone shared the same view of the problem. “Art expression can address multiple perspectives, helping the family to see how each other defines the problem and it’s solution. Multiple images of the same problem can be expressed and all can be witnessed by the family and the therapist” (p. 89).
Whilst all the family art therapy assessments were influential and were helpful in guiding the development of the family assessment and interactive art exercise collectively however, the family art assessments described posed a number of difficulties. For example:

- Too much attention to the individual members of the family rather than the family as a whole, which does not maximize data about family interactions;
- did not address circular causality;
- too great an emphasis on the interpretation of the artwork;
- too time consuming and complex for the children experiencing psychological trauma; and,
- due to the amount of instructions and steps to the assessments required the therapist/s to be in the room.

Furthermore, the family art therapy assessments described did not to elicit the array of multiple levels of information required. There was too much focus on the individual and the instructions and expectations were too complicated to be understood by the varying developmental stages of the child and family members hence there is an increased risk that children become less involved and more disruptive.

Although there were a number of inadequacies in the family art therapy approaches described to meet the exact requirements of this study the benefits of using art with families was clearly helpful and adapting these ideas to meet the needs of the study seemed to be the way forward. Manicom and Boronska (2003) describe the benefits of bringing art therapy and family therapy together which “can amplify the child’s voice within the family, using art as a means of extending the family story” (p. 217). They underline the importance of seeing a child in the context of their family and that using art had reduced family tensions at times of potentially high conflict. Hoshino (2008) also argues the absolute value of developing a collaborative and integrative approach between art therapy and family therapy. “The marriage of the two provides a framework that is infinitely useful for diverse clients in various settings, who may not respond as prolifically to verbal therapy alone” (Hoshino, 2008, p.61).

**Literature review in summary**

In summary, the overall journey through the literature was guided by the overriding premise that an integrative approach to the assessment of children who have experienced trauma was the most effective approach. In adopting an integrative approach provided an opportunity to draw from a variety of theoretical perspectives in response to the client’s needs rather than the therapist’s orientation. An integrative approach was reflective of the need for a multidisciplinary approach due to the complexities of these children and by drawing together the ideas from different theoretical approaches a coherent methodology was created.

There were also some core concepts or ideas that also had a hand in shaping the review of the literature. One of these ideas was the importance of considering the requirements of the ‘context’ - the need to provide a family assessment that could be conducted in a short time frame but was able to access multiply layers of information and expose entrenched family patterns of relating. Another major challenge was the recognition of the complex needs of the specific client population and how to engage these families that could be often described as
avoidant/dismissive. A further major foundational and guiding notion was the desire to provide a more child inclusive assessment.

What was evident from the majority of the literature, was that assessments of children that relied wholly on verbal information were problematic, mostly because they failed to elicit essential information - more specifically, the child’s experience and their procedural and imaged memories related to their trauma. The literature highlighted the profound effects of trauma on child development and subsequent behaviour and the need for an integrative, comprehensive multi-professional assessment, so misdiagnosis was avoided and treatment plans were appropriate. Consideration needed to be given to how traumatic memories were stored in non-declarative memory (imaged memory), which again stressed the importance of child and family assessments not solely relying on verbal recall. As trauma seems to be retained in imaged memory, a strong argument was made for the inclusion of art in child and family assessments (Kozlowska & Hanney, 1999).

The research literature reveals that children use symbolic communication to make sense of their experiences. Not only does art act as a vehicle for traumatic memories, it is also a natural, familiar and pleasurable form of expression for children. Art reduces anxiety and has the possibility of realigning the children’s level of contribution on equal terms with the adults. Art was also seen as rich source of metaphor, which can access and carry ideas across different levels of communication. Art is clearly a different level of communication that needs to be equally respected for the many levels of meaning it can contain. Communication is not seen as being merely embedded in the content of the art, but also in the making. The art was also viewed as ultimately reflective of the context in which it was created. Maintaining curiosity, really listening and observing the family’s responses was underlined as integral to working with internal and external dialogues.

There was some agreement that in order to provide a more child inclusive practice, assessments needed to be respective to the girth of ability and developmental stages, encompassing all family members. The research literature was in agreement in relation to the significance of facilitating a ‘safe’ environment for the child to express their thoughts and feelings through creative processes and in turn increase their contribution in the assessment. In order to accomplish a ‘safe’ place, the research literature pointed towards providing both a degree of freedom as well as a boundary, a semi structured arena, where therapists could be sensitive to a child’s creativity, but at the same time providing a sense of security with direction and boundaries.

With the aim of observing family interactions, the research literature suggests that removing the therapist out of the family system prevented the possibility that the therapist tainted the family’s interactions, as well as, providing an opportunity for a meta-perspective, which were all vital in the quest for obtaining a clear pattern of family interaction.

Various assessments within the play therapy and art therapy research literature were noted in our review, but demonstrably failed to meet the requirements of our context and were inappropriate for the specific client group. The assessments in general were either too long, where financial considerations came into effect, or too short - where the degree of information that could be obtained was not sufficient. Many of the assessments focused on dyad relationships and where not easily transferable to the family system, or focused on the family but failed to maximize the observation of family interactions (Kozlowska & Hanney, 1999).
The family therapy literature was able to articulate the difficulty in engaging children in assessments, but there is clearly a paucity of information on ways to address this concern. The literature was laden with interventions that can be noted as primarily language based, although the Milan ideas on circular questions, hypothesizing, and neutrality in thinking about ways to bring new information into the family and the structural ideas on family dynamics can be noted as being helpful. The use and benefits of the one-way screen were valuable, particularly the suggestions on the collection of data. The importance of working with the family to re-construct their story was clear as was, when working with children the use of metaphor, which can be drawn from their non-verbal communications and woven into the adult conversation. Taking a position of ‘not knowing’, of listening and having time to sit back and consider were emphasized and further supported the use of video.

The research literature showed how several family art therapists had attempted to draw systems and art therapy concepts together and facilitate child and family assessments that were also attentive to developmental differences. With few exceptions, it can be noted attempts at integrating the approaches have been unsuccessful, in that often the art became an appendage rather than integral to the process. The varied assessments offered by the literature that were more integrative, were again either too short, and therefore lacking in information, or too long for the client’s to sustain their attention and are potential too costly. Many focused mostly upon individual members within the family and involved the therapist remaining in the room, which failed to provide a clear picture of the family’s interaction.
CHAPTER EIGHT

Methodology: Structuring the family assessment and interactive art exercise

Introduction

This chapter will describe how the structure of the family assessment and interactive art exercise using an integrative approach was actually formulated out of the literature. In doing this, recognition is first given to the previous different theoretical approaches to assessments that were described in the literature review. Attention is given as to why these approaches did not fully meet the assessment criteria required. The ideas that were drawn from these different therapeutic approaches are then illustrated. How the various approaches influenced and shaped the methodology of the family assessment and interactive art exercise is then explained. The actual structure and methodology is then clarified in more detail.

As was noted from the outset, the purpose of this study is to create an efficient and comprehensive assessment that could provide first-rate treatment plans for children between the ages of two to eleven with complex psychiatric difficulties and those exposed to significant abuse, trauma, neglect and with family relationship problems. The challenge was to create a family assessment that engaged the child in the assessment process, as well as obtaining a broader systemic understanding of the child’s behaviour. The context of the child and adolescent psychiatric hospital dictated that the assessment needed to gain multiple levels of information in the shortest amount of time in order to develop an effective first-rate treatment plan.

Preceding this study a number of challenges had arisen in the assessment of traumatised children referred to the child and adolescent psychiatric hospital. The primary challenge was a significant lack of child inclusion in family assessments. This lack seemed to be due to a number of features including: the primarily language emphasis of the assessments; the developmental differences amongst family members including speech and language; the time consuming nature of collecting multiple levels of information; avoidant and dismissive families; and, medical diagnosis being given by the family as the reason for the child’s problem.

Presented with these challenges, and inspired by the recommendation from the literature that an integrative model would be the most appropriate approach when assessing traumatised children, led to an over arching literature review across various theoretical approaches. After reviewing the literature, it became apparent that although there were numerous assessments across a variety of theoretical models that have been used over a number of years to assess these children, there was not an assessment conducive to address the challenges described.

The attachment literature focused on the mother child relationship, yet it was recognized however, that trauma impacts on all family relationships. Attachment theory also highlighted the importance of having supportive attachment figures and a safe environment when assessing traumatized children. Being therefore able to observe a family’s pattern of relating can be helpful in understanding the impact of the trauma. Involving the whole family in the assessment process seems imperative, as long as the family is not the ongoing cause of the trauma. It also seems important to understand the quality of attachment relationship patterns between all members of the family rather than focusing on the dyad, mother/child. This focus solely on the mother child relationship was also noted in the literature on psychotherapy and play therapy assessments. Focusing on dyads (mother/child) fails to elicit wider systemic influences for example conflict
between parents and also misses the richness of wider family interaction and non-verbal symbolic expressions. Whilst attachment theorists particularly focused on the dyadic relationship between mother and child, there did not seem any reason why their methods could not be extended to include all family members. The other difficulty with many of the assessments presented in the attachment literature was the high levels of analysis required, which was not conducive to providing an efficient and expeditious service.

The importance and quality of family relationships on a child’s development and ability to cope with traumatic experiences was also outlined in the literature. Systems theory views the world, and the family, as a network of interconnecting systems. To make sense of one part of the system, i.e. that of the child, requires an understanding of the system the child exists within. Understanding a child’s problems therefore requires an assessment that observes the child in their family context. In observing the child in their family context the therapist has the opportunity to observe and highlight family interactions that may have become negative or habitual. In obtaining a comprehensive assessment of a child exposed to trauma therefore required an assessment that was inclusive of the family as well as the child. The need to find a tangible vehicle to focus, for what are at times quite chaotic families, also became increasingly apparent.

At the same time as needing to involve the whole family in the assessment process so as to understand the child and families patterns of interaction and communication, the challenge was to avoid adult laden descriptions of the child’s problems and create a more child inclusive practice. The family play therapy and family therapy assessments that were described in the literature as play, seemed to rely too heavily on the child’s verbal ability to verbally re-tell a story, for example the family puppet story. Whilst these assessments could increase children’s engagement in the assessment process, they risked falling into adult language and missing the more subtle symbolic imagery and non-verbal communications associated with making art. The puppet play may support the expression of a child’s procedural memory, but misses the opportunity for an expression of imaged memory. Playing with puppets would be a relatively new experience for some children and families, which could possibly create performance anxiety. According to the literature, children who have experienced trauma are helped when they can express their memories in a way that does not raise anxiety. It is observed that they can return to, rework and experience mastery over the trauma. Limiting family assessment to only using play techniques such as in play therapy, family therapy and psychotherapy approaches, misses the child’s opportunities to return and rework their traumatic memories in a concrete form.

The family assessment needed to increase the involvement of children, as well as hopefully reduce their anxiety. A child’s capacity to understand the complexities of language, impacts on their ability to fully participate in the adult language increasingly used in systemic questioning, including concepts such as time, distance, sameness and difference. It was evident from the developmental literature, that children develop the capacity to language their experiences over time and that language based assessments become less and less helpful the younger the child.

In creating the family assessment and interactive art exercise, it became clear that it was imperative to include a non-verbal form of expression something that was tangible and did not raise the anxiety of the child and could include all family members. Working with traumatised children can trigger a hyper arousal stress response characterised by physiological arousal, overwhelming anxiety, hyperactivity, inattention and impulsivity or an emotional shut down. Children naturally, and comfortably, use art as their symbolic language and as an expression of
their inner world, which should reduce the child’s anxiety and increase their involvement in the assessment process. The pleasurable aspect of art can allow trauma to be re-experienced in a safe way, hopefully detouring some of the child’s anxiety, and allowing them to express, master and integrate their traumatic memories. Art also has the capacity to express traumatic memories that are encoded in the brain in two areas, imaged memory (visual expression) and procedural memory (acting out). Art, with its wonderful ability to cross all developmental boundaries, made it the obvious choice when working with families at varying developmental stages. As described in the psychological literature, art has an extensive history of being employed to assess, in varying degrees, the non-verbal communications of both children and adults although there seems to have been a primary focus on the individual. In seeking to understand the behavior of an individual family art therapist, Kwiatkowska’s (1978) seemed to understand the need to include the individual’s family members in the assessment. She also saw the importance of using art as an aid to understanding the symbolic expressions and patterns of interaction that occurs in families.

Family art therapists have produced a number of methodologies for child and family assessments that use art. Whilst these assessments were inspiring and aided in developing the family assessment and interactive art exercise, they required a degree of adaptation. Overall, they were too time consuming, involved complicated instructions, often involved more than one assessment session, included multiple families, required a degree of knowledge or confidence in using art materials and required the therapist to remain in the room with the family restricting opportunities for close observation. Although Landgarten’s (1987) family assessment task was too complicated and involved too many steps and instructions her description of dividing the assessment into three areas: process (diagnostic, family interaction), content (expression of unconscious and conscious) and, product (concrete evidence of family dynamics). (Adapted from Landgarten, 1987), was helpful in considering how to structure the family assessment and interactive art exercise.

The key point throughout the literature on art therapy and family therapy was the emphasis on employing an approach that created a safe enough environment that permitted the creative process to emerge. The therapist needed to stand back and observe the families creative potential, whilst limiting the rules and directives. Creating an opportunity for the therapist to observe the family’s creative process, which was also underlined in the art therapy literature, as well as allowing time for an exploration of the artwork, seemed equally valuable. The opportunity to observe a child’s procedural memories (acting out) was also seen as helpful by attachment theorists in understanding the impact of trauma on family relationships. Inspired by Landgarten’s (1987) three stages, the family assessment and interactive art exercise also developed into three stages. The first stage required the therapist to introduce the art exercise; stage two required the therapist to leave the room and observe the families creative process; and, the third stage involved the therapist returning to the room and exploring the process and symbolic content of the artwork.

The idea from the attachment and family therapy literature of the therapist leaving the room, so as not to taint the family’s creative processes and interactions and also increase the therapist’s capacity for observation, was helpful. Kinston and Loader (1984) make a strong argument that questionnaires or interviews do not provide valid or reliable data on family interaction and that some form of observation is essential. Some of the family art and play therapy assessments, described in the literature, also suggest the helpfulness of using a one-way screen. For example, two therapists take turns to play with the child and family while the other observes behind a one-way screen. The concerns with this approach were not with the use of the screen, but with the
reliance on the child’s ability to play, which may cause a degree of performance anxiety and, the focus remaining on the child and the interactions between family members compromised as the focus is on the therapist and child. Furthermore, if art, as described in the literature is understood to be a reflection of the context that it is created within, then it seems even more important when assessing children and their families that art is created within the context of their family rather than with a therapist.

The hermeneutic approach of ‘actively’ listening and taking time to notice processes, also supported the idea of the therapist leaving the room so as to provide an opportunity for the therapist to have quiet observation without interruption or disruption. Systems theory encourages the therapist to adopt the role of the observer so that they can search and underline the family’s patterns of interaction. Allowing the therapist the chance to be positioned behind a one-way screen optimizes the therapist’s ability to observe. The richness of information that can be obtained by observing the family’s creative processes and interactions appeared an essential component.

The systemic idea of also having a multidisciplinary team behind the one-way screen was helpful as it allows multi-perspectives to contribute to the observations and hypothesis. The multidisciplinary team can also hold on to different perspectives. Although a family art therapist, Kwiatkowska (1978) did not work with a multidisciplinary team she did acknowledge the need for an extra therapist due to the complexity of family interactions. The other advantage of having a multidisciplinary team behind the one-way screen is that they are likely to be responsible for implementing the treatment plan. Involving them means they have the opportunity to become known to the family and they are also able to contribute to the assessment process. Influenced by the Milan family therapy literature on using hypothesizing, the time spent behind the screen would be valuable for the team to create working hypothesis. The Milan method of creating working hypothesis helps the team to focus and think about the meaning of the problem within the family system, making the connection between meaning and behaviour. It can also act as a guide for the therapist’s questions.

The dilemma that then arose, was how the therapist would be able to leave the family and take an observing position without the family feeling overwhelmed and anxious. The therapist needed to leave the family with a set of instructions that were supportive of the creative process without being too descriptive so as not to restrict the family’s creativity. At the same time, the hope was that by giving simple instructions this would help focus a chaotic family with a challenging child, who may otherwise struggle without boundaries or rules. A simple art exercise was required that involved few instructions that would maximize family’s interaction and communication, and with limited instruction to permit the therapist to stand back and observe. Generally the instructions in the family art therapy assessments, that are presented in the literature, are too complex and too time consuming for children suffering psychological trauma. Sherr and Hicks (1973), recognized this, have attempted to reduce the number of the tasks that Kwiatkowska (1971) had suggested, but took away the role of the observer. The richness provided by the observer position was too much of an integral role to lose. They added music and offered light refreshment, which seemed too distracting. Also they required the therapist to be confident in the use of art materials, which was an impractical consideration in developing the art exercise within the parameters of a multidisciplinary team. Rubin and Magnussen (1974) also reduced the number of art tasks, but included the request for the family to create a joint family mural. They kept the therapist in the room with the family and placed the professional who referred the child behind the one-way screen again an impractical suggestion, which loses the observer position. These methods, whilst inspiring, clearly needed some degree of adaptation to
suit working with children suffering psychological trauma and complex psychiatric difficulties. They also did not meet the needs of the child and adolescent psychiatric hospital.

Recognizing the need for a simple set of instructions and the clarity in which structural family therapist view the family system, was inspirational. The structural family therapist views the family as consisting of different sub-systems within a wider family system. Problems appear in families when the boundaries between these subsystems become enmeshed, distant or blurred. Encouraged by these ideas it seemed helpful to first ask individual members to focus on defining themselves using the art. Once they have created a representation of themselves symbolically, then the idea would be to ask them to negotiate their position within the wider family system by collectively making a family picture using the individual pictures. The idea was that the family’s process of how they negotiated and positioned each individual picture would offer valuable information into family relationships, structures, and boundaries. Their interactions and creative processes are meaningful information. It is important to note, that the making of art also allows a valuable window into a child’s developmental abilities such as fine and gross motor skills and their level of dependency on their family to achieve the task and to their inner dialogues.

Once the family had completed the art process the therapist would then need to return to the room to explore the symbolic content of the completed family portrait and the process that occurred whilst the family undertook the family assessment and interactive art exercise. Inspired by the Milan non-directive style of circular questioning, where the therapist adopts a position of curiosity and attempts to draw out differences and connections between family members, is seen as most helpful in exploring the individual and family pictures. The idea behind this style of questioning is so the family can be alerted to different views within the system. Whilst the language of circle questioning alone can be challenging for a child the younger they are, with the support of the art images and the use of metaphorical language arising from the process and symbolic content they can be easily adapted to communicate with younger children. Also, the Milan style therapist adopts a neutral position, which permits the exploration of multiple truths, in the quest that each family member is able to express their own truth and experiences in a safe environment. These ideas assisted the thinking as to the kind of questioning that could be adopted in exploring the process and symbolic content - particularly when dealing with traumatic imagery.

As outlined repeatedly in the literature, traumatic memories can be difficult to speak about. However, art can act as a vehicle for traumatic memories to be expressed in a less frightening manor. The Narrative family therapy approach emphasizes the importance of being able to externalize the problem, where the child is permitted to see the problem or trauma as outside of themselves. Art naturally lends itself also to the process of externalization and once expressed the trauma can be cut, moved or folded etc.

The decision to videotape the family assessment and interactive art exercise was influenced by the attachment theorists who used videotape review and transcripts of their assessments in order to gain a more in depth understanding. The idea was that once the assessment was completed and recorded on videotape, it could be subjected to analysis and that complex family interactions could be reviewed. Also the videotapes could be shared with the family at a later date as part of a treatment intervention.
**Ethical Approval**

Ethical approval was sought and obtained from the Royal North Shore Hospital, Sydney, Australia Research Ethics Committee and the University of Western Sydney, Nepean Research Office, Human Ethics Review Committee.

As part of the Royal North Shore Hospital Human Research Ethics committee a lengthy application was submitted. In conjunction with the ethics committee, an information sheet (see Appendix 1) which was given to the participants and a consent form (see Appendix 2) to participate in the research were created.

The primary criteria for being involved in the research were to have a child referred to the child and adolescent psychiatric hospital for an assessment. Participation was on a voluntary basis and there were no selection criteria apart from having been referred for an assessment. There was no exclusion criteria either, as the intention was that the family assessment and interactive art exercise would be employed with all families referred to the hospital.

As part of the referral process, and before the assessment began, all the children and their families who had been referred to the child and adolescent psychiatric hospital were invited to attend an introductory session where they would be shown around the hospital and have the opportunity to meet the multidisciplinary team. It was arranged that the family would be informed about the study at the end of these introductory sessions.

The families were asked if they would be willing to participate in the study. They were also told that their agreement would not in anyway influence their assessment or treatment whilst in the hospital. The families were given a written information sheet (see Appendix 1) for participants, which had jointly been created with the Royal North Shore Hospital Human Ethics committee. The information sheet gives an explanation of the study and methodology and intention of the research. The families were then left with this information so that they could consider, in private, if they would agree to participate. Initially eight families were approached.

When the child and family returned to the child and adolescent psychiatric hospital for their assessment, they were asked if they had considered the request to participate in the research. Two of the families approached declined to partake in the research and did not provide a reason. Six families agreed to partake in the research. The families who elected to participate were then given a consent form (see Appendix 2) to sign that agreed to their participation in the research project.

Only four videotape transcripts of families have actually been used to illustrate the methodology due to the poor quality of the videotaping in two of the families that made them impossible to transcribe adequately. An opportunity was also made available for the families who agreed to participate to discuss any concerns that they may have about the research and to withdraw without any explanation at any point.

All the families that undertook the family assessment and interactive art exercise were asked if they would also consent to be videotaped as part of the assessment process. Those videotapes were used to analysis and review more complex family interactions and at times were used as part of the treatment by reviewing certain aspects of the videotapes with the families.
The aim of the family assessment and interactive art exercise was to provide an opportunity for therapists to consider and analysis information gained from the way a family completes the assessment, as well as the completed image. The form of the symbolic images produced, their relationship to each other, and the way they are created and arranged, were the focus of the evaluation. The intention was to consider the data obtained in relation to: attachment patterns, sequences of interaction (both verbal and non-verbal); relationship patterns (marital, sibling, parent, child); parenting skills; motor skills; cognitive and developmental abilities; and, unconscious material. The emphasis of the research is of a qualitative nature and was not intended to establish validation against another assessment tool.

By investigating the use of the family assessment and interactive art exercise in a more formalized way, it is hoped that this will provide information about what the assessment offers and how it does this. It is anticipated that this may provide an alternative and more efficient method of assessment.

**Structuring the family assessment and interactive art exercise**

Given the clinical time restraints in the child and adolescent psychiatric hospital, young childrens’ short attention span and the need for an effective assessment, and so that treatment could get underway as soon as possible, it was felt that the structured art exercise should take no longer than an one-hour to one and a half hours.

Structurally the family assessment and interactive art exercise involved three main steps:

1. The therapist and team to begin the process of creating hypothesis about the child’s presenting problem. The therapist then introduces the family to the interactive art exercise. (Opportunity for the therapist and team to begin to create hypotheses and meet the family).

2. The therapist leaves the family and joins the multidisciplinary team behind the one-way screen to observe the family doing the art exercise. (Time for the therapist and multidisciplinary team to gather information from observations of family interaction, expression of unconscious and conscious material and to further develop or dismiss hypotheses).

3. The therapist re-joins the family after the family completes the art exercise and explores, through circular and narrative type questioning, the process of doing the art exercise and the symbolic content of the art product. (The therapist and multidisciplinary team gather further information from the therapist’s discussion with the family. The artwork provides concrete evidence of family dynamics, traumatic memories, opportunities for the family to gain new information about themselves, and a time for intervention. The strengths in the family are emphasized, for example, noting positive interactions and reframing negative interactions allowing the family the opportunity to re-construct their story or think about things in a different way).
In practice, the family assessment and interactive art exercise followed several phases.

1. **Preparing the room.**

   The ideal room setting would consist of a low table in the centre of the room surrounded by chairs, reflecting the number of family members and one for the therapist. It is imperative that all the technical equipment is tested and checked that it is in working order so as not to delay the assessment or cause the child and family or even the therapist any unnecessary anxiety or time wasting.

   Prior to the session the art materials should be laid out in the room. The art materials should be chosen for their qualities of strength, efficiency and developmental suitability. It was found that one set of eight to ten oil pastels or wax crayons provided the best option due their size, robust nature, depth and range of colours and developmental suitability. The family was provided with a large size glue stick and two pairs of scissors, one for the use of adults with a sharp blade and the other safety scissors were suitable for children. The art materials were limited so that the family had to negotiate sharing them and also the scissors in particular required some degree of adult supervision.

2. **Preparing the multidisciplinary team.**

   Prior to the assessment the multidisciplinary team should meet, for approximately thirty minutes, to go through the referral and highlight any areas of concern and areas that need more careful observation, such as fine motor skills etc. that might have arisen from the referral. The multidisciplinary team should then spend time creating various hypotheses about the presenting problem. These hypotheses would then be supported or disregarded through the multidisciplinary team’s observations and discussions with the family. The hypotheses should also guide the therapist’s questions to the family about their experiences and interactions whilst doing the structured art exercise.

3. **Setting up the family assessment and interactive art exercise**

   The family is invited into the room with the therapist and introductions are made and the process of the session is explained. The rest of the multidisciplinary team is seated behind the one-way screen. The video equipment would not be turned on until the family consents.

   The therapist’s first task is to explain the process of the family assessment and interactive art exercise. The room set up, including the use of cameras, videotape and the multidisciplinary are explained. It should be explained that the structured art exercise helps the multidisciplinary team understand how they operate together as a family and through these observations the therapist and multidisciplinary team are able to perhaps better understand some of the worries in the family. How the multidisciplinary team contribute to the assessment is described: that ‘more heads are better than one’; the helpfulness of multiple perspectives, and the importance of the team remaining behind the one-way screen as this limits their impact on the family’s interactions. The family should be invited to meet the multidisciplinary team if they wish. The helpfulness of using a video is explained, at which point, written consent is sought from the family. If they agree to the assessment being videoed the multidisciplinary team are then able to switch the video recorder on.
The family is then informed of the process of the family assessment and interactive art exercise.

a. The therapist gives the family verbal directions for completing the structured art exercise.

Each member of the family is given an A4 piece of white paper and asked to draw a self-portrait. They are asked to then cut out their self-portraits and with their self-portraits make a ‘family picture’ using one larger piece of white A1 size paper. No further instruction is offered.

b. The art materials are given to the family:

One pack of 8/10 wax/oil crayons with a range of colours
A4 white paper (one for each family member);
one A1 piece of white paper;
one pair of safety scissors and one pair of adult scissors,
and one stick of glue.

c. The therapist then leaves the room and joins the multidisciplinary team behind the one-way screen (Observation).

d. The therapist and the multidisciplinary team, from behind the one-way screen, observe and take notes whilst the family completes the structured art exercise, which should take approximately thirty minutes (Collection of data).

e. When the family is finished the therapist re-joins the family. The therapist shares with the family some of the therapist and the multidisciplinary team’s observations, particularly focusing on family strengths that the therapist and the multidisciplinary team have observed.

f. The therapist asks questions of the family about the experience of working as a family doing the structured art exercise, as well as exploring the artwork, seeking contributions from each family member. The therapist also seeks clarification from the family about any concerns that the therapist and multidisciplinary team may have had during their observations (Exploration and Feedback).

4. **Observation**

The use of the one-way screen has a number of functions. With very young children it is difficult for therapists to remain in the room without the children attempting to engage them, which can have a significant impact on how the family system interacts. On many levels, negatively or positively, once a therapist joins a family, the family system and how it operates changes. To minimize the influence of others into the family system a one-way screen is advised, although even that has a degree of impact, which the therapist and the multidisciplinary team need to bear in mind. The therapist’s absence from the room also clearly underlines that it is the parent’s role to supervise the children, and allows for no ambiguity. The one-way screen permits the therapist and the multidisciplinary team a meta-perspective of the family.

The opportunity to work with a multidisciplinary team behind the one-way screen allows for a richer source of information. Different perspectives, such as cultural, gender and professional
views and ideas become available. It also adds to the possibility of more behaviours and interchanges being observed and noted that might have been missed by a lone therapist.

The use of video provides further opportunity to review the assessment and can also add to the possibility that the family can review the session as part of the treatment plan, learning about themselves and exploring different ways of responding and interacting as a family.

5. **Collection of data on multiple levels is sought:**

**A. Family system structural data:** parenting skills, roles, hierarchies, boundaries, alliances and coalitions are observed. Such data emerges from the following observations:

- how the family negotiate, or not, to start the exercise;
- who in the family makes the decisions;
- who helps whom;
- who works with whom;
- whose suggestions are used or ignored;
- whether the family works as a team;
- whether particular members are included or excluded in regards to verbal and non-verbal communication;
- the space each person uses;
- the atmosphere in the room; and,
- how the parent(s) manage the children’s behaviour and conflicts about sharing the art materials etc.

**B. The children’s developmental level of skill attainment:** gross and fine motor skills, language and speech development, regulation of affect, regulation of attention, and cognitive/symbolic development. This data is evident from:

- watching how the child approaches the art exercise and uses the art materials;
- listening to how the child follows the instructions;
- listening to how the child speaks;
- observing how the child uses the space in the room;
- observing the child’s interactions with other family members as well as the therapist;
- observing and listening how the child negotiates his or her space on the family artwork;
- observing how the child deals with frustration; and,
- noting the developmental level in their artwork.

**C. Family interactions and individual style of interaction (Attachment patterns).** These include observation of displayed affect and verbal and non-verbal interactions. What strategies do the children use to relate with their parents, to elicit nurturance, to ensure parental attention, and any other attachment behaviours, such as facial expressions.

**Other data:** expressed either in the artwork itself or in the interactions around the artwork such as perceptions of self or others in the family or indications of trauma. Possible examples would be a child refusing to place herself in the family picture, scribbling over another person, or
insisting that a person is not included or they are next to the mother at the detriment of her younger sibling.

6. Exploration and feedback

The therapist returns to the room and feeds back to the family the therapist and multidisciplinary team’s observations of family strengths. A discussion about the process of making the art and the artwork with the family begins. The therapist should take a curious position using open-ended explorative questions (link to question types) that explore the family’s meanings. This type of open-ended question is useful for exploring children’s ability to use language. Later questions using the artwork and the metaphors that arise from the symbolic content can become more concrete, e.g. ‘How come you placed yourself on the other side of the paper from the rest of the family?’ ‘If you could change your position in the picture where would you put yourself?’ and ‘Why have you glued yourself over your daddy’s head on the paper?’

The therapist may ask about the interactions of different family members as represented in the artwork, e.g. ‘What do you think your sister is saying to your dad?’ or ‘How come you are holding your brother’s hand?’ Asking such questions is a way of seeking to bring new information into the family system.

The family or therapist may notice a particular theme or something markedly distinct about the artwork, which can be explored further. The artwork maybe seen as representing a coherent story, or be un-integrated. Who is placed next to whom, who is isolated, who overlaps with whom, who is not included, are all sources of potentially useful information. Interpretation of the artwork is usually avoided, as interpretations maybe premature or inaccurate.

Difficult behaviour can occur at any point during the art exercise but they are more likely to arise at this stage, as the parent(s) attention is not wholly focused on the children and it involves turn taking. The therapist may ask the parents how they would like to handle the disruption. The therapist may support the parents or model, setting appropriate limits on the children, to ensure that everyone gets a turn at talking and listening.

7. Integrating the data

The therapist then inquires about the similarities and differences between the family doing the structured art exercise and how the family conducts itself at home. This may mean eliciting the meaning of behaviour at home and of the artwork, or exploring specific sequences of behaviour and at times linking this to the family of origin sequences. These inter-generational links can be made by asking questions such as, ‘Do you remember how you gained your mother’s attention when you were your brother or sisters age?’ ‘Did you ever as a child feel that way?’ and ‘If your parents were in the picture where would they have been?’

The therapist and team’s observations maybe shared with the family and questions can be asked e.g. ‘How similar was his behaviour to when he is at home?’ or ‘Was how you managed the task as a family, similar to how your family is at home?’

8. Developing goals

As the information arises, the therapist works alongside the family to formalise the information into treatment goals. The family may be given a homework task, e.g. noting how often a
particular child interrupts when his sibling tries to talk to their father or remembering to praise a child or gain good eye contact with a child before giving an instruction. These goals are reviewed and worked on in subsequent meetings with the family. The videotape, the process and the artwork can be brought into subsequent sessions as a reminder of the assessment.

**Summary**

To summarize, one of key requirements for the child and adolescent psychiatric hospital, and the aim of this study, was to develop an assessment tool for traumatised children and their families that would be efficient, more child inclusive, less anxiety provoking and effective - at the same time as providing a first rate treatment plan. How the family assessment and interactive art exercise was then developed has been outlined - describing the influences from the literature as well as noting the inadequacies of previous assessments. In an attempt to maintain simplicity, and efficiency, the family assessment and interactive art exercise was divided into three distinct areas: instruction; observation; and, exploration. Within these three areas there are eight phases, which have been outlined in detail and collectively constitute the methodology of the family assessment and interactive art exercise.

Once the family assessment and interactive art exercise had been developed, it became necessary to explore if, when used with the children and families referred to the child and adolescent psychiatric hospital, it would achieve its aims and objectives. A selection of families was asked to partake in the study and in the next chapter the results of the application of the family assessment and interactive art exercise to a small number of these families is described.
CHAPTER NINE

Results

The aim of this study was to address a number of challenges that had arisen in attempts to helpfully assess traumatised children with complex psychiatric difficulties along with their families who had been referred to a child and adolescent psychiatric hospital. A review of the literature did not provide an assessment that would meet the needs of these children and their families or the requirements of the child and adolescent psychiatric hospital. Drawing from the literature and the past methodologies and approaches, the family assessment and interactive art exercise was developed from a synthesis of these assessment tools and theoretical approaches. Once the family assessment and interactive art exercise was developed it became an integral part of the assessment process and applied to all the children and families referred to the child and adolescent psychiatric hospital. The results of applying the family assessment and interactive art exercise are described in this chapter employing the use of vignettes taken from four of the families who agreed to participate in this study.

The intention in this chapter is to illustrate how the family assessment and interactive art exercise achieved its aims and objectives. That is, a family assessment that is more child-inclusive and encompasses ideas related to working with trauma. Multiple levels of information also need to be accessible so that first-rate treatment plans can be developed. Alongside the vignettes, the therapist and multidisciplinary team’s discussions and ideas are interwoven to demonstrate their thinking and the ideas generated from observing the child and family partake in the family assessment and interactive art exercise.

The eventual formulation, diagnosis and treatment plan are also included to illustrate the multi-layers of information that can be obtained by applying the family assessment and interactive art exercise.

Six families, who had been referred to the child and adolescent psychiatric hospital, agreed to participate in the study and agreed to allow the videotape of their assessment to be transcribed. As was previously noted, eventually the number of families who were involved with the study was reduced to four because of the unfortunate quality of two of the family’s videotapes making them impossible to transcribe.

The video tapings of the four remaining families was reviewed by the therapist and then transcribed. Alongside the video tapings, the therapist and multidisciplinary team’s observations and discussions, from behind the one-way screen, were also noted and interwoven into the transcripts. Several poignant moments from each of the four video recordings and transcripts, including the therapist and multidisciplinary team’s contributions, have been extracted. These vignettes have been used to illustrate significant family interactions that occurred whilst the family undertook the assessment and interactive art exercise and were key elements for the development of the treatment plan. The therapist and multidisciplinary team’s thoughts, from behind the one-way screen, have been interwoven into these key moments. The intention being that an understanding develops of how information from the assessment was considered and hypothesis were created that contributed to forming the treatment plan. The subsequent formulations, diagnosis and treatment plans were also all recorded and have been included at the end of each of the four family vignettes.
All of the family names have been changed and any identifying information has been removed to maintain the confidentiality of the families. Again, it needs to be noted that documented consent was obtained from every family prior to commencing the assessment.

The names assigned to the families were: Antler; Breeze; Cettle; and, Delta. The child, who had been referred to the child and adolescent psychiatric unit, with the presenting problem, was identified using the family initial and 1, such that, the referred child in the case of the Antler family, being known as A1. Likewise in the Breeze family, the referred child being known as B1. The other children in the families were identified as A11, B11 and A111, B111 etc.

**Family 1 – Antler**

The Antler family included a mother and her two children - the referred boy (A1), a six-year-old and his sister (A11) who was eight-years-old. The children had had minimal contact with their father since leaving his full time care three years ago. They had been returned to the care of their mother after she had stopped her involvement with drugs and her mental health had stabilised. The family was now living with the maternal grandparents, who were first generation Italian migrants. A1, the referred child, and his sister, A11 had both been exposed to the following:

- recurrent traumatic events from birth perpetrated by one of their attachment figures;
- experience of sudden unexpected separations from at least one of their parents;
- experienced of a family breakdown;
- mother had been diagnosed in the past with a mental illness;
- exposure to their mother’s recurrent suicidal ideation, involving repeated hospital admissions;
- mother had suffered with Post Natal depression;
- exposed to parental drug and alcohol abuse; and,
- child protection agencies had been involved with the family.

At the time of the referral, A1 had been expelled from pre-school because of his violent behaviour and because he could not be contained in the classroom; spending the time roaming around the school.
Clinical vignettes of the family assessment and interactive art exercise

Genogram

A1 and his sister, A11, along with their mother had recently moved in with the maternal grandparents. A1’s parents had separated just after his birth. He had spent the next three years of his life with his father and paternal grandparents but was returned to the sole care of his mother when he was about three. He no longer had any regular contact with his father.

Referral

A community paediatrician had referred A1 to the child and adolescent psychiatric unit. The referral was due to his difficult behaviour since the age of three and concerns that he was still soiling. The behaviours described in the referral included:

- clingy, regressive behaviour, demanding to stay close to his mother for protracted periods, sucking his hand until sore and refusing to sleep in his own bed;
- faecal soiling;
- aggression at school and at home, including spitting at his mother and sister and hitting himself, placing his hands over his ears when asked to do something;
- hitting his peers;
- anxiety symptoms, and
- swearing at adults.

The community paediatrician had not reported any developmental concerns but described A1 as very anxious.
The family assessment and interactive family art exercise.

Present

Mother, A1 and his older sister, A11, as well as the maternal grandmother, who spoke limited English, attended the assessment. Although invited, unfortunately the maternal grandfather had refused to attend.

Process

When the family entered the therapy room A1 initially presented as quite regressed; hiding behind his mother’s legs, using a baby tone in his speech, and trying to sit on her lap. A11 on the other hand, seemed to be left to get on with the task at hand. The maternal grandmother took a back seat position, perhaps as a result of her limited understanding of the English language.

**Mother:** *(Towards A1 and indicating to chair next to her)*, Sit here!

**A1:** *(Said in very baby tone)*: I want to sit on your lap.

**Mother:** You want to sit on my lap, you sit here next to mummy.

**A1:** *(With his finger in his mouth, whining)*. No, don’t want to.

**Mother:** Look we are going to draw a picture of A1.

**A1:** No.

**Mother:** And mummy’s going to draw a picture of mummy.

**A1:** Wanna sit on your lap.

The communication continued in this way for quite a while, with the mother becoming increasingly frustrated in her tone. She does however eventually persuade A1 to sit next to her, rather than on her lap. What is immediately apparent to the therapist and the team is how compliant A11 was when she was left to her own devices. A11 completed her own picture without any requests for help of offers of support or encouragement from her mother or maternal grandmother.

The therapist and team noted that the mother tended towards a more persuasive style of parenting, increasingly becoming frustrated when the desired result was not achieved. A1 would benefit from a more assertive approach, giving him a strong message that his mother was in control. When A1 did eventually emerge from behind his mother’s legs he became enthusiastically involved in the art exercise.

The family appeared to enjoy their time together, intermittently laughing and interacting as they completed the art exercise. A1’s self-portrait was developmentally simplistic (equivalent to approximately a four-year-olds). The image was in contrast to his pre-occupation with the detail on his mother’s self-portrait, insisting she draw her rings, necklace and ‘boobies’. The therapist and team’s hypothesis was that his preoccupation with the detail of his mother’s drawing was reflecting his relationship with her, an enmeshed, hyper-vigilant and anxious attachment.

**A1:** *(Referring to his mother’s drawing)*, you need a necklace and a locket.

**Mother:** Oh! Very true.

**A1:** And rings, remember.

**Mother:** And my rings. *(Draws)*. One goes here. One on my thumb.

**A1:** One on the last finger.
Mother: (Draws in the rings, as A1 watches). And necklace.
A1: Mum?
Mother: There you go. I think that’s all.
A1: (Turning Mum’s picture towards him). Then, cut it out.
Mother: Cut it out?
A11: Right you are.
Child A1: Mummy’s is the best one. Colour that in. (Indicates to something on Mummy’s self-portrait).

The team noted that the mother responded and parented very differently with the children. Once A1 was engaged in the art exercise she continually praised and encouraged him, using a soft and gently tone, whilst on the other hand using a sharp tone in response to her daughter who she was also at times quite dismissive towards, offering no praise or encouragement.

Mother: (To A1, referring to his attempts to include his grandfather in the picture). Where you going to stick….? You better leave some room for us, okay? Just put him in the corner, right?
A11: Here! No, down here. You can’t put him up…you can’t put yourself there. (A1 sticks his picture of his grandfather in the top corner, not the bottom where his sister had indicated).
Mother: Oh good boy. (Rewarding A1, whilst conflicting with A11’s attempts to organise A1).
A11: I’ve finished mine.
Mother: Mmm.
A1: You’re too big, Mum.
Mother: I’m too big? No, I fit there.
A1: A11 is too big.
Mother: A11 is a big one. (Agreeing with A1 and making a derogatory remark about her daughter).

The therapist and team were very curious regarding the family’s interaction around the position of the maternal grandfather, given the family were currently living with the maternal grandparents. A1 insisted on including his grandfather and wanted to include his grandfather at the top of the family picture; his mother wanted him placed in the corner leaving room for others and A11 wanted to place him at the bottom. The therapist and team’s hypothesis was that the Italian grandfather was playing a key role in the family dynamics. Grandfather’s refusal to attend the assessment, his role and relationships in the family would need to be explored further. He clearly seemed important to A1, suggesting a close relationship, which was perhaps not shared with the rest of the family, in fact they all seemed to have a different view. Although it was acknowledged in the team the possibility that we were drawing from a stereotype, it was hypothesised that the dominant role of men in Italian families and the difficulties that can arise in first and second-generation migrant families could be impacting on relationships within the family and how the children are parented.

The family was unable to acknowledge their mixed feelings towards the grandfather and his refusal to attend. A1 had attempted to include him by placing him at the top of the picture but then had discarded the idea and drawn him on a very small piece of paper. He then had given the picture to his mother, who had then placed the picture under A1’s feet on the family picture.
A1 insisted his self-portrait was placed next to his mother’s on the family picture, mirroring his actual behaviour in the assessment.

Mum: *(Finished gluing drawing)*. Where are we going to put mummy? Here? *(She puts her drawing at the far end from where A1 has placed himself)*.  
A1: No *(He takes his Mother’s picture and moves it so it is next to his drawing)*.  
Mother: Next to A1.

Throughout the art exercise mother was observed to treat A1 like a toddler. She failed to impose or implement any limits on him, leading A1 to impose an inordinate amount of sway over his family. That is, A1 used regressive behaviour to elicit nurturance and to organize the family behaviour around him.

A11’s self-portrait was large and dominating, the same size as her mothers and included identical adornments of jewelry. The therapist and team’s hypothesis was that the image was reflecting her elevated role in the family and certainly was representative of her overly mature presentation. The positioning and largeness of A11’s image also seemed to underline the lack of any effective hierarchy in the family. The therapist and team’s hypothesis was the that mother had lost her confidence as a parent and was in a disempowered position. This hypothesis was reinforced throughout the assessment in her attempts to manage A1’s behaviour and was reflected in the content and process of making the family picture. The children were observed giving mother praise, whilst the mother sought assurance from her children.

A1: That looks good, mum.  
A11: It’s better than mine.  
Mother: Oh, no. Do you think so?  
A1: You need arms.  
Mother: I need arms? Do I?

The family described the family picture as ‘a happy family’ and found it difficult to discuss any worries they might have or sadness. A1 became noticeably agitated and attempted to distract his mother away from the topic.

The team noted that there seemed to be an overriding theme of being able to fit or not fit together or if there was enough room for all the family to fit.

Mother: *(Indicating towards a picture A1 has added on the other side of his Mother than where he has placed himself)*. No. A11 will go here. Actually we’re not going to fit everyone in. Just draw a little one of (...) to put there. Yeah?

And later….

Mother: Are we going to fit them all in?  
A11: *(Reassuring her mother)*, Nana’s small, that’s right. We’ll be able to fit them in.

And later….

Mother: I don’t know if they’ll all fit.  
A11: Please.  
A1: I drew her small.
Mother: Let’s just see how much room I’ve got, first. Okay?
A11: I can draw her small.

Once the family had finished the interactive art exercise the therapist returned to the room. The task now was to explore various themes in more depth that had arisen from the therapist and multi-disciplinary team’s observations and discussions behind the one-way screen.

One of the therapist and team’s hypotheses was that different members of the family wanted the family to change in different ways, and perhaps the family felt like they were being pulled in many directions. The therapist used the completed family portrait to explore this hypothesis of how different members of the family would like to change their family picture.

Therapist: (Towards A1). Anything else you’d like to say about the picture, A1? (He nods).
A1: Rainbow.
Therapist: You would like to put a rainbow in it. What is it… What happens when there’s a rainbow?
A1: It’s in a blue sky.
Therapist: In the Sky? And what’s the feeling when there’s a rainbow?
A1: Happy.
Therapist: (Turns to A11). So what about you? If you could change the picture…change in any way you like, how would you change it?
A11: (Looking at the picture). I’d probably take my brother over here (Indicates from one side of the picture to the other) and….my mum there (next to A1). I’d go there (Points to where her mother was positioned) …and grandfather there. (A11 moves grandfather from where A1 had eventually placed him, below him in the bottom left of the picture, to the top right above her mother and A1).
Therapist: You’d like to put grandpa up above where Mum is?
A11: ….and Grandma.

The team wondered if this could suggest a desire to have her mother closer to the grandfather, as well as bringing the grandmother closer, possibly with the recognition that her mother needed support. The team’s hypothesis was that perhaps her grandparents had provided the family some stability and safety. The team also wondered if she was able to get her needs met through her grandparents rather than her mother who was tied up with A1’s demands for attention.

At times A11 became very confused as to who each person was and where she wanted them to be placed. The team’s hypotheses suggested that she had a difficulty knowing who was who and who was boss in the family.

Therapist: But mummy was over there… with A1?
A11: Oh, yeah …. Mixed up.
Therapist: Do you think it is a good idea to put grandpa over here with grandma?
A11: yes.
Therapist: Right (Turning to look at grandma). Would grandma agree with that? Would grandma like grandpa to be over here? Yes …(to A11). Is that right? (A11 nods in agreement). And what about … um … would mummy be pleased having granddad closer to her?
A11: (Looks towards mother). Yes.
The therapist and team had hypothesised that A1’s behaviour reflected the families’ difficulties in talking about their worries and that the mother’s emotional breakdown meant that the worries had become hidden in fear of upsetting their mother. A11 had become the ‘happy’ child who presented as having no needs and A1 clung helplessly fueled by his anxiety of his mother’s mental health.

**Therapist:** *(Towards mother).* Do you agree with the kids that it’s a happy family? *(Pause).*
**Mother:** Yes and no.
**Therapist:** Mmm. Is it … do you think the picture is sad?
**A1:** No.
**Therapist:** A1 does not think so.
**A11:** No.
**Therapist:** Would you agree with that, or not?
**Mother:** The picture’s only crappy.
**Therapist:** *(Towards grandmother).* Why do you think it’s difficult for (mother) to think about at home who is sad?
**Grandmother:** Mmmm.
**Therapist:** It’s hard to explain it? *(A1 looks up at his mother and she bends and kisses him).*
**Grandmother:** Yes. The time when her husband had gone, she not happy no more…I never see my daughter happy no more.

Later,

**Grandmother:** Not because of him … I just no see my daughter happy no more.
**Therapist:** (To mother). What would you say to that?
**Mother:** I’d say I agree.
**Therapist:** Who would you say is the unhappiest? *(Indicating to picture).*
**Mother:** I’d say its A1.
**Therapist:** And then who is next?
**Mother:** Me.
**Therapist:** *(To A11)*, Would you agree with mum or do you agree with Nana?
**A11:** Mum.
**Therapist:** Right. And when you say Mum, who do you think is the saddest in the family? *(Silence for a while).*
**A11:** I think both.
**Therapist:** And which do you think … do they have the same sadness or is one sadder than the other?
**A11:** I don’t know.
**Therapist:** So you drew a happy family … is that something that you’d like?
**A11:** *(Nods in agreement).*
**Therapist:** It sounds like there’s some feelings underneath … that aren’t so happy. What do you think they’d have to say about it?
**A11:** I don’t know.
**Therapist:** Just have a guess. Would it be about school, or about home or …?
**A11:** About home.
**Therapist:** And what kind of things would be making them sad at home?
**A11:** I don’t know.
**Mother:** Um … not having a male figure.

The therapist and team’s hypothesis that A1’s behaviour, particularly the anxiety and ‘clingy’ behaviour directly correlated to his worries about his mother was important for the therapist to explore. Challenging the family story that A1 was the problem and allowing the family to see A1’s behaviour as sad rather than bad or mad would allow the family to begin to make changes around him, rather than expect him to change.

**Therapist:** Mmmmm. How much do … how much do you think he worries about you?
**Mother:** Um … I speak to him. I let him know what’s going on with me …
**Therapist:** Mmmmm.
**Mother:** ..and when I have been ill I’ve always said, you know, spoken to him about it … um … you know, he’s very close to me and when I’m not there I know … it’s … (A1 hands mother a drawing he has been working on as she talks).
**Therapist:** Is anyone else in the family worried about you?
**Mother:** My parents.
**A11:** (Quietly), And me.
**Therapist:** (To A11). Are there any other ways that you kinda let your mum know that you are worried about her? Other than asking her, do you think?
**A11:** No
**Therapist:** How do you think A1 lets her know?
**A11:** Ask?
**Therapist:** He might ask, too, do you think? (To mother). Does he ask you about that?
**Mother:** No.
**Therapist:** No. How do you think he shows you he is worried about you?
**Mother:** Cuddles me…
**Therapist:** Have there ever been times when he hasn’t had to be so close to you? Like cuddling you, being near you. Are there times when you notice he’s not doing that so much?
**Mother:** Only when I have said no, for some reason, then he just walks … doesn’t come near me.

Later,

**Therapist:** What do you think he worries about?
**Mother:** That I won’t come back.

**Family picture.**

The family were very keen to take the family picture home and in view of the grandfather not attending the session it was felt that by taking the picture home it was a way the family could include him in the family assessment. The family was asked to return the family picture but unfortunately that never happened. Nevertheless the family did return and had used the family picture to share their experiences with the grandfather.
Family strengths

At the end of the assessment some of the family strengths that had been noted by the therapist and the multi-disciplinary team, were fed back to the family. The family was acknowledged for having been through a lot together and evidently was very worried about each other. It was explained that the children had showed this by their different and many attempts to take care of their mother in the assessment. The family was told that they clearly have a strong sense of family, which was demonstrated by grandmother attending the assessment and the family being offered a home, at a time of crisis, in the grandparent’s home. The therapist acknowledged that this could create unique challenges for everyone but they seemed keen to face them.

Data collected from the family assessment and interactive art exercise

The following data was collected by the team and utilized in creating a formulation and treatment plan.

- Relationships with maternal grandfather and his role in the family
- A1 appeared to display an anxious attachment with his mother
- Different parenting styles for each child, perhaps reflecting the quality of each relationship
- A11 has developed pseudo parental position
- Lots of sadness at home that is not spoken aloud
- Children extremely worried about their mother
- Loss of father and paternal grandparents
- Confusion around adult roles and responsibilities
- Families tendency to play down concern of mother’s mental health
- Mother’s loss of confidence as a parent

Formulation

Overall the mother’s mental health and past drug and alcohol abuse was having a profound and worrying effect on the family. A1 was presenting with a Type C attachment, whilst his sister, presented a Type A attachment pattern, both bringing unique problems in developing future healthy relationships. A1’s care eliciting behaviours such as: whining; sulking; crying, and clinging so as to monopolize his mother’s attention and affection and create for him self a feeling of safety. A1’s behaviour was having a detrimental impact on A11 who had developed a pseudo mature style, with ‘no needs’ and a mask of ‘happiness’, when she clearly was deeply worried and anxious and was at risk of losing her relationship with her mother.

The family underplayed the children’s experiences of significant losses, perhaps in a futile attempt to emotionally hold the family together. In particular, uncomfortable feelings were avoided, perhaps to prevent the mother from having any further emotional breakdowns.

The children seemed confused as to who was ‘boss’ in the family. The mother’s seemed to lack confidence as a parent, which seem perpetuated in the context of living with her own parents. Cultural differences and the experience of migration needed to be considered and how the family and extended family organize themselves within this challenging context.
Diagnosis

The child and adolescent psychiatrist completed the diagnosis below although the family assessment and interactive art exercise contributed to the information available in making the diagnosis it was not solely responsible.

D.S.M. IV

Axis I
- 313.89 Reactive Attachment disorder
- V61.20 Parent child relational problem
- 313.81 Oppositional defiant disorder
- 311.0 Depression Disorder N.O.S.
- 307.70 Encopresis
- V61.1 Partner relational problems
- V61.8 Sibling relational problem

Axis II
- Nil

Axis III
- Nil

Axis IV
- Educational problems; academic problems.

Axis V
- GAF (over last 12 months): 60

Family Goals and Treatment Plan

- Home visits by psychiatric nursing staff to support mother in establishing consistent care giving by placing the mother back as ‘boss’ of her family and to be supported by grandparents to re take this position.
- A1 to sleep in his own bed.
- Establish family rules for safe behaviours, such as, A1 not being allowed to hit self or others. It also emerged that he had been licking himself, his mother and sister.
- A1 to be rewarded when he acts more like a six-year-old and his ‘four-year-old’ behaviour to be ignored.
- Weekly family art therapy to allow the opportunity to explore the following issues:
  - the relationship between mother and grandparents;
  - establish family house rules whilst living in grandparent’s home;
  - A1 and A11 to express their worries openly;
  - A11 to work towards expressing her needs for nurturance instead of looking after her mother’s needs, and,
  - family to work at expressing their feelings, and tensions more easily.
- Individual psychiatric assessment and treatment for mother to be put in place.
Family 2 – Breeze

The Breeze family consisted of mother, father and the referred boy (B1), a five-year-old and his sister, (B11) who was four-years-old. The family was living in their own home. B1 and his younger sister B11 had experienced the following:

- the father had been diagnosed with a slowly degenerative terminal illness;
- the father had had to give up his work;
- financial problems, and
- the mother had returned to full time work after being the main carer.

At the time of referral, B1 had already been diagnosed with receptive language difficulties, Semantic Pragmatic disorder and with Asperger syndrome, a mild form of Autism.

Clinical vignettes of the family assessment and interactive art exercise

Genogram

B1 lived with his mother, father and his younger sister, B11, (four-years-old). When B1 was nine-months-old his father had been forced to give up work after he was diagnosed with a terminal degenerative nerve disorder. B1’s mother, who had been his main carer had returned to full time work.

Referral

A community Paediatrician had referred B1 to the child and adolescent psychiatric unit due to B1’s difficult behaviours, both at home and at school. These behaviours included:

- aggressive behaviours, including hitting, kicking and throwing objects when limits set;
- impulsive behaviours with no regard for danger;
- manipulative behaviours where B1 uses emotional cues for his own gain;
self-harm behaviours: pulling out his hair; hitting himself and biting himself, and,
obsessive behaviours: fixated on construction toys.

Previous to the referral, the Paediatrician had diagnosed B1 with a Semantic Pragmatic disorder, Receptive language disorder, a low average IQ and described B1 as having Autistic traits within the Asperger’s range.

The family assessment and interactive art exercise

Present

Mother, father, B1, and his younger sister, B11, all attended the assessment.

Process

At the beginning of the assessment the father and mother’s initial approach was quite striking. The father immediately leaned back in his chair with his arms folded behind his head, whilst the mother sat back with her arms folded. The two children, B1 and B11 both sat around the table with drink bottles in their hands waving them about, as if waiting for instruction from their parents, which was not initially forthcoming. There was a sense that both parents were overwhelmed and had adopted a position of being resigned and helpless in being able to change their situation.

Mother: I’d better tell you we are not good drawers. Hope that’s all right. *(Laughs).* *(B1 holds up his drink bottle and starts to wave it around. Parents do not intervene).*
Therapist: So, B1, I need good listening, please.
B1: Yeah.
Therapist: O.K. So what I want you to do is… um I want you to each take a piece of paper, O.K.?
*(B1 picks up the large sheet of paper, the parents do not intervene).*
Therapist: The little one… hold on! I need you to listen. A little one each, O.k.? … and I want you to draw a picture of yourself…
Mother: Oh, great!
*(Mother puts down her cardigan and sunglasses on the floor and father lean forward, Mother laughs and reaches for a piece of paper. As they do so B1 drags a chair to the table and joins them although he is still waving his drink around and neither parent intervenes),
Therapist: … on the piece of paper, O.K? *(Non-verbally indicating to B11 to join her parents). B1? *(Shows them the paper they are to use)*. I want you to draw a picture of yourself. Then I want you to cut yourselves out and on the big piece of paper I want you to make a family picture together.
Father: Oh, O.K.
*(The therapist leaves the room and joins the team behind the one-way screen).*

This extract showed the interactive art exercise was able to draw together and focus a family, where the parent’s non-verbal communications indicated a possible reluctance to engage, and the children’s behaviour was at risk of becoming challenging. It seemed the task was helpful in engaging and focusing the parents and, in so doing brought the children’s attention to the table.
(B1 looking down towards his drink and making noises).

Mother: (To B1). Can you tell us what we’ve got to do?
B1: No.
Mother: You see, you were to busy playing with the cup.
Father: Give me the cup. Remember…
Mother: B11, did you hear what we’ve got to do?
Father: (Leaning forwards towards B1). So what we were going to do is … you said we were going to try, do you remember the deal? We’re going to try (Emphasis on word ‘try’). O.K? So are you ready now, do you want me to tell you what we’re going to do. Are you listening very good?
(B1 is sitting staring, raises his arms over his head, then puts them back at his side, mirroring his father’s early stance).
Mother: (To B11). Listen to daddy as well.
(Mother opens the box of crayons and puts them on the table, as B11 picks up a sheet of paper).

Mother: B11, can you put that down a minute (Takes largest piece of paper from the table and puts it on the floor.) Put this on the floor for now…
Father: (Voice is slightly raised and very deliberate, and he is half on his knees leaning across the table). What we are going to do is, everyone gets a piece of paper (He puts a sheet of paper in front of B1, as mother holds the paper, and all the family look towards B1). No, no playing around. Here’s yours, here’s my piece, B11 and mum…
Mother: (To B11). Can you sit on that one.
B11: Me? (The father gets up and takes his seat and sits next to B1)
Father: ….and you get a crayon, and you have to draw…yourself. So …B1’s going to draw B1. (Voice of father goes quieter). B11 is going to draw B11, Mummy’s going to draw mummy and daddy’s going to draw?
B11: Daddy!
(B1 yawns, and puts his hands behind his head).
B1: I don’t want to draw myself…
Mother: …then when we have finished we have to cut them out (Mother holds up scissors, then puts them down on the floor) then we take the stick glue, and …(The mother picks up a large piece of paper). …paste them on this big bit of paper. So, I wonder who’s going to finish their drawing first?…
B1: Me! (B1 leans forward).
Mother: …and gets to cut it out with the scissors, first.
Father: What colour, what colour are you going to do? What colour top are you going to do? (B1 picks up a crayon).

The eventual enthusiasm and persistent encouragement from the parents finally manages to get B1 engaged in the task. The extract showed a good example of the mother and father working together; ignoring B1’s attempts at oppositional behaviour and knowing that he would respond to introducing an element of competition. The therapist and team’s hypotheses was that B1’s apathy and confusion, that took an enormous effort on the part of his parents, was perhaps reflecting the family’s response in the face of father’s terminal illness. B1’s display of apathy and confusion was helpful in that it had the result of getting both parents working hard together to move on with creating a family picture.

The therapist and team also noted that the B1 continually resorted to copying his father’s initial stance of leaning back with his arms behind his head. They wondered how the father was
adjusting to his illness and the significant changes in his role as a male provider, father and husband.

Later,

**Father:** (To B1). You’ve got to draw B1.

**B1:** I’m going to draw B1 in a… in a… in this rocket.

*(Mother draws as father and B11 watch B1)*

**Mother:** No.

**Father:** No.

**Mother:** You’ve just got to draw a person. You’ve got to draw yourself.

**B11:** … going to, too.

**B1:** I’ve got grass.

**Mother:** … I’ve got brown hair. No, you are not drawing grass, B1, you’re drawing people, you’ve got to draw yourself.

**Father:** You’ve got to draw people, mate. Draw yourself. So … that might be my head.

**B11:** Then I’m drawing Daddy and mum, and me…

**Mother:** No, no. The lady said just draw yourself, because then we’ve got to paste it on to … the other piece of paper.

**B11:** Mummy?

**Mother:** Yes?

**B11:** Um, I love you.

**Mother:** And I love you too, B11.

The therapist and the team noted how both the mother and father both seemed to struggle to respond with a degree of flexibility to B1 or to accept his choices about how he wanted to express himself through his portrait. The therapist and the team were curious about B1 wanting to represent himself as inside a rocket. One of the hypotheses that emerged was that perhaps B1 saw himself as cut off emotionally from his family.

The reflections of the therapist and team also raised the question as to whether the parents were simplifying and repeating the instructions because they were themselves anxious about the art exercise or they genuinely did not believe that B1 and B11 had understood.

Later,

**Mother:** Let me know if you need some help cutting out, B11.

**B11:** No, I don’t.

**B1:** I need some help cutting out.

**Mother:** Do you? Could you come around here, and I’ll help you do it. *(B1 gets up and moves around next to mother)*.

**B11:** I’ll be careful that I don’t (…).

**Mother:** (To B1). You hold it, and I’ll hold this so you can cut around it. *(The mother gives B1 the scissors and holds the paper for him)*.

The therapist and team were interested in how B1 jumped in asking for help when B11 was offered help by his mother. The therapist and team hypothesis was that B1 was missing the attention of his mother and his negative behaviour was a way of expressing his need to be close to her and receive her support. The mother did however respond to B1’s request and she was impressive in how she supported B1 in using the scissors rather than take over.
And later,

Mother: …There! Perfect. Great. (Mother and B1 have finished there cutting out).
B11: I’m cutting out mine very well aren’t I, Mum?
Mother: Show me. (Looks at B11’s artwork). Yes, you are cutting it out very well.
B1: You’ve got a big one.
Mother: Yes, how come I’m bigger than you? Is it because I’m the adult…
B11: Yes
Mother: …and you’re the child? (Mother laughs, and B1 puts his arm partway round her neck). That’s right, isn’t it? What’s Daddy doing? You have got stripes on your….
Father: Yes. (Father stops his cutting out and shows them his artwork).
B1: Daddy’s bigger.
Father: Yeah how is that?
B1: (Comparing the three art works) You’re bigger.
Mother/Father: Yeah.

This interchange from a structural point of view is a rich demonstration of negotiation around family hierarchy. With father’s illness in mind the therapist and team hypotheses that the interaction reflects the families changing structure. The children seemed to be asserting or assuring themselves that their father is in the ‘bigger’ position in the family. The father seems to be questioning his ‘bigger’ position. B1 responds to his father’s doubt by asserting his father as the ‘bigger’ person. Children’s anxiety, when their parent’s authority and status is challenged can have quite a marked effect on their behaviour. The therapist and team were increasingly becoming curious to the degree that the father and mother’s reaction to the diagnosis of a terminal illness was having on B1’s behaviour.

Later,

Mother: Actually, lean, lean it on here… (Mother gives B1 a piece of scrap paper). …then we won’t get glue all over the table.
B11: Done it! Done it.
Father: What happened to your foot? (Laughs). You’ve amputated your foot. (B11 puts her hands behind her back).
B11: Its dumb.
Mother: Can I help you? (To B1).
B1: Its done.
Father: Maybe we can just put a foot on it’s own, for you.
Mother: (To B1). You going to stick that on the big piece of paper, and we’ll give B11 the glue.
Father: I am just going to give B11 a new foot...
Mother: Hang on then, I’ll do the glue on mine.
Father: We have to give her an operation (Pause). What d’you reckon? That’ll fix it up all right?
B11: (Nod yes). Just stick it on there. Can we please have the glue?
Mother: Certainly.
Father: (Putting paper in front of B11 so she can glue). There you go.
B11: There you go.
B1: Can I please stick this?
**Mother:** Hang on. Just let me clear this spot. Move all this out of the way. (*Mother clears the table to create space. B1 sticks his artwork on with a loud slap.*)

**Father:** (*To B11.*). Stick that on first then, we’ll glue you on the paper in a second.

**Mother:** (*To B1*). Can you put me on? Thanks B1. (*B1 sticks his mother’s artwork on the paper.*). While we are waiting for B11 do you want to put your name on with a crayon …underneath you, so everyone knows who you are? Or above it.

**Father:** What about that bit?

**Mother:** (*To B1*). It is hard to draw with crayon, isn’t it? (*B1 writes on the paper as his mother watches.*). Oh, well done B1.

The interactions here seem to represent a family working well together, the parents supporting each other and managing the separate needs of the children. In the context of illness in the family, and the introduction of hospitals, the therapist and the team noted the interaction between B11 and her father, where B11’s foot was “amputated” and together he helps her to “fix it”.

Later,

**Mother:** …B11 where are you going to put you?

B11: Don’t know.

**Father:** No. Where are we going to stick you, B11?

B11: On this bit… on that piece of paper.

**Father:** No! We’ve got to stick you on this piece of paper. Now whereabouts do you want to be?

B11: (*B11 pointing*). Right there.

**Father:** You gonna move beside B1? Yeah? (*B11 nods*).

B1: No! She ... (*B1 covers the space indicated by B11 with his folded arms*). (*B11 points to another spot*).

B11: Beside mummy.

**Mother:** O.K.

**Father:** O.K. you put yourself where you want to be.

The therapist and team noted that actually, although father had said that B11 had been able to put herself where she wanted in the family, her choice of position had been stopped by B1, who had placed his body over the position and neither parent had intervened. A hypothesis emerged that the parents had a tendency to placate B1, which was possibly a response to feeling overwhelmed by their situation and their unsuccessful attempts to control his behaviour in the past. Placating B1 would be to the detriment of B1 and certainly have negative impact on his sibling. If the parents were not challenging his behaviour because of a fear that he would escalate the behaviour it would mean that B1 was controlling the family. This position was a very scary place for a five-year-old and could certainly be a cause for an increase in negative behaviours; as B1 searched for boundaries to feel safe. The therapist and team’s hypotheses was that trying to keep the peace, not feeling strong enough to stand up to B1, feeling out of control and having ‘given up’ could all be ways that the father’s illness had impacted on the family and their parenting role.

Later,

**Mother:** That’s all right, keep going... (*B1 slapping the paper hard to fix B11’s artwork to the paper. The father then moves his hand away so B1 can glue the foot in place, it gets stuck to B1.*).
**Father:** Aw, gees, it’s stuck on his hand. There! There you are. You can kick mummy now.

**Mother:** Yeah. Watch that foot.

**Father:** All right. I’ll put the glue on. Who wants to stick me down?

**B1:** Me, me.

**Father:** B1, you want to stick it, do you?

**B1:** Yeah.

**Father:** O.K. *(The father gives his drawing to B1, who sticks it in place).*

**Mother:** *(To B11).* Do you want to put your name on top of you, could you just write your name for me. *(B11 takes glue from his father).* No, with a crayon. *(B11 uses the glue stick to glue some scrap paper. Mother turns back to B1, who has stuck father’s artwork so that some of the picture is off the piece of paper).* Do you want to just peel it off and try… no, no, don’t put his head in half. *(…as B1 tries to do it, his mother peels it off for him).* Ouch! Try that.

The therapist and team noted the process where B1 pastes his father’s portrait half in and half out of the family picture. The mother was quick to notice this and bring the father’s portrait fully back into the picture. The process certainly seemed to reflect the family’s underlying dilemma, that is, whether the father was still in the family or not and perhaps feelings of ambivalence on behalf of the father and the family’s future.

Once the family had finished the interactive art exercise, the therapist entered the room and rejoined the family. The rest of the team remained behind the one-way screen. The therapist explored various themes in more depth that had arisen from the therapist and multi-disciplinary team’s observations and discussions behind the one-way screen.

In order to keep the referred child engaged, because of the risk of escalating the child’s behaviour, the therapist invited B1 to begin talking about the family picture. B1 initially refused, so the therapist turned to B11 and asked her about the family picture, rather than placing any more attention on B1.

**Therapist:** *(To B11).* So what do you think you are doing in the picture?

**B11:** I’m going with mummy to pre-school.

**Therapist:** And what do you do at pre-school, is that a good thing or you don’t like to be there?

**B11:** I like to go.

**Therapist:** You like to go? So what kind of thing is that smile saying? Is that a smile? Or is it something else?

**B11:** She’s smiling.

**Therapist:** *(Therapist pointing to B11’s artwork which has been stuck on top of her mothers).* …and what do you think it is like for mummy for you to be on top of her like that? *(Mother laughs).*

**B1:** She goes…..

**Therapist:** Uh, uh! Hold on. You didn’t want to actually speak a moment ago, B1, so now you need to wait *(To B11).* So what do you think it’s like for mummy?

**B11:** Funny.

**Therapist:** It’s funny. Is that right mummy?

**Mother:** No, your hair is tickling my face.

**Therapist:** So, do you have, does your hair tickle Mum’s face a lot?

**B11:** Yes.
Therapist: Yeah, and is mummy happy about that?
B11: No.

Later,

Therapist: So B11 you’re up on one um one… No B1’s up on one foot hopping. Is that right?
B11: Daddy is …daddy…
B1: No. Daddy…
Therapist: (Referring to B1). Hold on I will come back to you in a minute.
B11: Daddy’s hopping.
Father: I’m hopping!
Therapist: Dad’s hopping? Where is he hopping to?
B11: In the house.
Therapist: He’s hopping in the house? Does dad often hop in the house?
B11: Yes.
Therapist: Why’s that?
B11: Because…..
Therapist: Because?
B11: I don’t know. (As B11 says this she slides of the edge of the chair onto the floor).

The team hypotheses was that given the father was at home more, after recently losing his job because of a terminal illness that was causing a significant reduction in his agility, the conversation above seemed to suggest that the children, and in particular B11 were trying to make sense of the change. The father’s terminal diagnosis was clearly a very delicate topic and needed to be treated with sensitivity. The therapist felt that the themes that had arisen though the assessment of being disabled, losing agility and movement and the children’s desire for it to be ‘fixed’ in a hospital could all be explored at a later date using the artwork as a springboard.

The discussion of father “hopping’, led to B1 escalating his behaviour to such an extent that the focus of the session moved away from exploring the drawing any further and helping the family make the link between uncomfortable or even joyful feelings and behaviour. The therapist and team had been curious about how each member of the family deals with uncomfortable feelings. When the therapist explored this, the father admitted struggling to make sense of his own feelings since witnessing a traumatic experience; when he was standing next to a colleague as he severed his arm in an accident. Working with the family to understand the link between feelings and behaviour, particularly as the family seemed to understandably, be struggling to come to terms with the feelings about the father’s diagnosis. With an attachment model in mind, the ability of the parents to make sense of their feelings would help B1 and B11 make sense and cope with there own feelings, rather than act them out in negative behaviours. As the therapist spoke she was able to use the artwork and the process of the art exercise to remind the family of how B1’s pictures turn from lovely to being covered in black.

Therapist: (Pointing to B1’s self portrait). …he’s really shown us there’s a lot of black.
Mother: A lot of his drawings do that, he can draw a lovely picture you know of a person or animal, and then…he just covers them.

Throughout the assessment, the father was observed by the therapist and team to have a tendency towards dismissing or avoiding the impact of his health on the family and seemed unable to acknowledge any uncomfortable affect, smiling when difficult issues were raised. Both parent’s
seemed sensitive to exploring family issues, preferring to view B1’s difficulties in terms of “his brain does not understand”.

**Family picture**

![Family Picture]

**Family strengths**

The team observed the parents as very dedicated and at times sensitive towards their childrens’ practical needs. Mother, was particularly sensitive to B1 and was noted to support him in developing skills, continually affirming him and at the same time as checking out his understanding. The family at times was noted to be very playful and relaxed together. Overall the parents were able to positively and fairly interact with both children.

**Data collected from family assessment and interactive art exercise**

The following data was collected by the therapist and team and utilized in creating a formulation and treatment plan.

- The impact of a diagnosis of terminal illness on the family
- Uncomfortable feelings do not seem to be spoken aloud.
- Mother and children extremely worried about their father.
- Father dismissive of his diagnosis.
- Mother overwhelmed with trying to keep the family going.
- Father’s change of status and role.
- Changes in parent roles.
- Financial worries.
- Parents feeling overwhelmed, affecting their ability to stand firm when children push boundaries.
- Inconsistent parenting styles leaving the children confused as to the rules of the family.
- Limits and consequences on behaviour not followed through with.
- B1 placed in a position of authority and decision making way above his age capacity.
- B1 displayed a Type C attachment style, displaying aggression, coyness and helplessness in order to gain his parent’s responses.
- Markedly different views between parents about B1’s behaviour difficulties and diagnosis.
- B11 was noted to repetitively stir B1 by punching, kicking him or taking toys from him, which was not addressed by the parents.
- Observed by the team, and surprisingly not addressed by the parents, was B11 sitting with her legs splayed and in the air displaying her underwear with her dress around her waist.

Formulation

B1 is a five-year-old boy whose early childhood was marked by his father’s deteriorating health and subsequent job loss, his parent’s difficulties in expressing or resolving emotional issues related to the father’s diagnosis of a deliberating terminal illness and his parent differing parenting styles, lacking in consistency, predictability and follow through on limits. Parental child relationship had clearly been complicated by the father’s illness and differences in affect expression, in particular expression of intense positive affect, for example sadness or joy. As a consequence B1 has developed various behavioural strategies to elicit care giving behaviour, to emotionally engage his parents, especially his father, to ensure proximity and the maintenance of a close relationship.

Diagnosis

The child and adolescent psychiatrist completed the diagnosis below although the family assessment and interactive art exercise contributed to the information available in making the diagnosis it was not solely responsible.

D.S.M. 1V

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<td>Axis 1V</td>
<td>-</td>
<td>Problems with primary support group – health problems in the family. Inadequate discipline. Economic problems.</td>
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Family goals and treatment plan

- Family art therapy, weekly to help the family deal with the impact of a deliberating terminal illness on the family
- Home visits by psychiatric nursing staff to continue to address behaviour management.
- B1 to be attend site school for four days a week and one day at home school - integration to home school to increase as B1 is helped to respond positively to limits.
- Psycho-education programme regarding living with Aspergers

Family 3 – Cettle

The Cettle family comprised of mother and the referred girl (C1), a eight-year-old, her young brother, (C11), five-years-old and a younger sister (C111), eighteen-months-old. The children’s father was living overseas and would be arrested and charged with physical abuse of C1 I if he should return. The children had not had any recent contact with their father although it appeared that their mother was in telephone contact. The family was living in a women’s refuge. The referred child, C1 and her siblings, C11 and C111 had all been exposed to the following:

- exposure to recurrent traumatic events from birth perpetrated by one of their attachment figures;
- experienced sudden unexpected separations from at least one of their parents;
- experienced a family breakdown;
- a mother who had been diagnosed in the past with a mental illness;
- exposure to their mother's recurrent suicidal ideation;
- exposure to parental alcohol abuse;
- exposure to chronic domestic violence, which had at times involved the Police, and
- child protection agencies had been involved with the family.

The referred child, C1 had also been the victim of physical abuse by her father and a family friend had sexually abused her. She had been expelled from primary school because of her violent behaviour.
Clinical vignettes of the family assessment and interactive art exercise

Genogram

C1 had witnessed chronic domestic violence and alcohol abuse by her father, which had resulted in her experiencing over sixty departures and returns to the family home. Her father had received seven apprehended violence orders.

Although not supported by social services, C1’s mother had some telephone contact with the children’s father and he apparently was waiting for them to move overseas to be with him. The mother was denying that she intended to join the father and fortunately was unable to do so for at least three years because she was being held under bankruptcy law. The department of social services believed that the mother currently had every intention of joining the father once this time had passed.

Referral

A community Psychologist had referred C1 to the child and adolescent psychiatric unit due to C1’s difficult behaviours, both at home and at school. These behaviours included:

- history of sexual abuse;
- history of physical abuse by father;
- oppositional behaviours at home;
- disruptive behaviours at school;
- difficulties with social skills: peer problems including isolating herself, and,
- appears withdrawn.

The department of social services had been informed of the sexual and physical abuse, however, at the time of the referral they had minimal involvement with the family apart from monitoring them and providing financial support.
The community Psychologist also raised concerns about C1’s younger brother, C11 that included:

- continual repetitive rocking;
- dribbling, and,
- exhibiting frozen postures for significant periods of time.

**Present**

The mother, C1, and her younger brother, C11, and her younger sister, C111, all attended the family assessment.

**Process**

On entering the room the whole family immediately positioned themselves around the table on their knees, C1 placed herself, on one side, next to her mother and the other two children went to the other side of the table. The therapist explained the family assessment and then left the room to join the team behind the one-way screen.

_C11:_ …these crayons.

_Mother:_ Yeah, come on.

_(C11 is looking at crayons in container. C111 is reaching for container that has been emptied of its crayons. Mother and C1 are watching)._  

_C11:_ I am going to draw me first.

_C1:_ No, they will come back and tell you when to do it.

_Mother:_ No, they’re only going to watch. They’ll be listening to us you’d better watch what you say.

_(They all pick up crayons to start, C11 is already scribbling with a crayon)._  

_C11:_ C1, C1, will just have to do a scribble, because C1 doesn’t know how to do it. (_C11 standing, with container in hand, looking down at C111. Mother and C1 started drawing)._  

_C1:_ …can do it properly, but C111 can only scribble (giggles) …told you to help it. (_C1 giggles again at C111’s scribbles. C11 is leaning towards C111 pointing to her drawing)._  

_C1:_ Oh, C111 (laughing).

_C11:_ Oh, C111 (laughing).

_Mother:_ Come on, Draw or you’ll run out of time. And draw yourself, C11.

_C11:_ I am. (_C11 picks up crayon and begins to draw. C111 begins to make loud noises._

_I’m doing a little … or a bear._

_C1:_ Not a big face. (_C1 looks at mother’s drawing, C111’s noises become increasingly louder)._  

_Mother:_ Shhhh!  

_(Quiet for a moment as all draw).  

_C111:_ Eeeeee! Hoot, hoot!

_C1:_ Where’s brown?

_C11:_ I need brown, too.

_Mother:_ I am drawing, too, C11.
From the interactions above the therapist and team noted how the mother seemed to become absorbed in her artwork, rather than engage or manage the children. The therapist and team hypothesis was that mother’s own childhood needs had not been met and, in some ways, she remained a child rather than the adult in the family. The mother’s focus on her own drawing was particularly poignant, given the age of the youngest child, who clearly needed some level of support to join in the task. It was interesting that both C1 and C11 attempted to include C111 in the task, although their attempts were mostly through teasing and derogatory remarks. Through the first ten minutes of the task the only vocal interactions the mother made were to tell the children to be quiet, to draw and to remind them that she was drawing too. As the children’s behaviour escalates between them, the mother continued to be pre-occupied with her drawing:

C1: …brown, too. Red, red. Is anyone using the red?
C11: (Sulkily and stands up, arms folded). Aww. I’m never gonna get brown.
C1: C11, they are watching you.
C11 (immediately sits back down, still with arms folded).
C1: Where’s my brown.
C1: Just wait!
C11: Actually everyone.
C1 turns and looks up at the camera.
C1: Look I can see the TV.
C11: Cor! (He gets up and walks around the table towards the camera, looking up at it). I can ...
C1: C11, get back!
C11: This is really weird.
C1: … we don’t have much time.

The therapist and team, behind the screen became very concerned about C111 carrying a pair of scissors around. There was much debate about whether to go in and intervene. It was also noticeable how C1 had adopted the parenting role with C11, using the “watching” team behind the screen as back up.

(C11 attempts to draw with crayon, mother stops her own drawing and moves some paper towards C111).

Mother: … draw, too?
(Mother takes C111’s paper and begins to draw on it).
C111: Ahhh, Ahhh! (C111 points at C1 and throws her crayon).
C1: … different colours?
C111: Oh, oh. (C111 bends down and picks up crayon and then leans across table to draw on the paper the mother was drawing on, but then moves away still holding the scissors).
C11: Mummy, do we … today?
Mother: No. (Mother continues to draw).
The mother’s interaction and interest in her three children was notably lacking and, at times extremely concerning, as the eighteen-month-old continued to roam about the room with a pair of scissors in her hand. The therapist and team hypotheses was that C1 was presenting with challenging behaviours in an attempt to draw her mother out of her depression and take control of the family. At the same time C1, aware of her mother’s lack of attention and care for the younger siblings, had also stepped in to take care of them, which evidently created tensions in her relationship with her mother and siblings leaving her feeling rejected and isolated.

C11: (Reaching over for a crayon when he thinks C1 has finished with it). Thank-you. (Then when he still does not get the crayon he wants). Aw! (Impatient). I don’t know when you… (Leans his elbow on table and head on elbow as if fed up).
C1: …Let’s just draw our bodies. (Then to mother) We’re sticking on our bits of paper.
Mother: Sorry! (Mother moves paper away from C1).
C1: Well didn’t you know that? (Mother takes her picture, glances at C11, and then turns and begins to cut out her own picture).
C11: I see, stupid picture, isn’t it? (Turning to C1).
C1: …Its beautiful.
C1: You didn’t say please.
C11: I did so.
Mother: Hey… he said ta.
C1: Not very polite, is it?
C11: Is it Mummy?

This interaction strongly supported the therapist and teams last hypothesis, in that C11 has learnt to seek guidance and reassurance from C1, rather than his mother. On the one hand, it seems that mother has left C1 to take over the parenting role but on the other hand chastises and undermines her when she attempts to parent. As C1 steps into the parent role perhaps her mother is reminded of her of own difficulty in rising to the challenge of being a parent. The therapist and team hypothesis was also that C11 was left confused as to who should be parenting when the younger children were at risk. The mother’s rejection of C1 ‘s attempts to help could have the effect of her not feeling good enough.

C11: Now. (Pause). Where are the scissors. (Note of impatience in his voice). (Mother leans back and points behind her).
Mother: Here. (Mother reaches out for them and puts them on the table in front of C11, who picks them up and starts to go back to his original position at the table. He pauses and looks at what C11 is doing. He then goes over to her and takes the other pair of scissors from her).
C11: Here y’are mum. (He then goes around the table and gives them to C1). These are your scissors. (Mother continues to cut out her own picture and then takes the large piece of paper and begins to glue her picture).
C1: An’ I’m going too fast.
Mother: Hmmmph.
C1: Look at it. (Mother does look, then goes back to gluing. C11 has picked up the scissors again. C11 makes impatient sounds as he becomes frustrated at trying to cut out his picture. He looks over at his mother gluing).
C11: (Tensely) Can someone please help me?
**Mother:** I’ll help you.

The therapist and the team remained extremely concerned about the lack of interaction they witnessed from the mother, who seemed preoccupied in meeting her own needs to the detriment of her children. The lack of the mother’s involvement, and lack of interest in her family, was remarkable. There were clear safety issues arising from her withdrawn state, where as a result her children were being placed at risk. It was evident that C1 had stepped into a pseudo parental role, particularly in regard to C11 and both C1 and C11 seemed to look out for C111, who just roamed the room as if lost.

Later,

**C1:** *(To C11)* Just stick it on. *(C1 holds out her hand for the glue)*

**C11:** Wait.

**C1:** Just do zig zag. *(C11 continues to cover the paper with glue as C1 waits)*

**Mother:** Look! *(Takes glue of C11 and does it for him, he watches and then takes the picture back of her so that he can glue it on the larger piece of paper)*

*(Yell from C111, mother glances at her, then turns back to gluing her picture, C111 yells again, walks toward mother and grabs some discarded paper)*

*(C1 puts her picture on the large piece of paper, which already has mother stuck in the centre of the paper, with C111’s picture to the right of mothers. Mother takes C11’s and sticks it just below, slightly to the left of her picture)*

**C11:** *(As C1 attempts to find a place for her picture)* There is no room for you!

**C1:** It’s a dumb and stupid game.

Once the family had finished the interactive art exercise the therapist entered the room, whilst the rest of the team remained behind the one-way screen. The therapist then explored various themes in more depth that had arisen from the multi-disciplinary team’s observations and discussions behind the one-way screen.

The therapist invites C1 to begin talking about the family picture.

**Therapist:** *(To C1)* …and what’s mum doing in the middle?

**C1:** Dunnow.

**Therapist:** *(To C1 again)* What do you think, have a guess. What do you think she would actually be doing?

**C1:** Dunnow.

**Therapist:** What do you think it feels like to be stuck in the middle?

This conversation appeared to confirm the hypothesis that C1 was unclear about the role of her mother, and worried about safety, had stepped into the mother role. The artwork was used in a later session to encourage a conversation where the different roles of mothers and children were explored in more depth.

**Therapist:** *(To C1)* …What did it feel like when C11 said to you that there was not any room for you? Do you remember when he said that when you were doing this that there wasn’t any room for you? What was that like? *(Pause)*

**Therapist:** How did it feel?

**C1:** Sad.
Therapist: Does this sometimes happen at home, when actually there is no room and it is always C11 that…
Mother: They do it to each other.
Therapist: Right, in the picture C11 did it to C1.
Mother: Yes, yes.
Therapist: … We also noticed what C1 did after, you know after he said there’s no room for you. Did you notice some of the comments that she started making about the picture?
Mother: Mmmmm.
Therapist: What kind of things did you notice?
Mother: Dumb. Stupid game.
Therapist: So mother, what kind of sense have you made of why she might um kind of after she’s been told that there’s no room for her in the family, that um she might start making those comments?
Mother: She feels like she doesn’t belong.

The artwork acted as a bridge to some very painful discussions, that could be continued in later family art therapy sessions, about belonging and having a place in the family, a theme that continued throughout the assessment. The therapist attempted to help to reframe C1’s behaviour in terms of her place in the family and feelings that might arise from her relationship with her mother and brother.

Therapist: (To C11). So can you tell me a little about this person here? (Indicating to the drawing of C11).
C11: It’s me.
Therapist: And what’s that person doing here?
C11: Nothing.
Therapist: Nothing! …And if he could be anywhere else in the picture where would he be?
(C11 points to the centre of the picture).
Therapist: I thought that might be the case actually. What would it be like if you were in the middle?
C11: Happy.
Therapist: C1 would be in the middle, too? (C11 nods yes).
Mother: No. She’d be out on the end.
Therapist: Oh, I see. Right. So actually, being in Mum’s position causes you two to have fights. (Pause). Is that right? … (The therapist talking out aloud). …I wonder where mum would go when you actually kind of end up having fights to get into mum’s position. Where would mum go if you and C1 were in the middle?
C11: Mum would be on the side.
Therapist: So who would be in control if she’s on the side?
C11: Mummy needs to be in the middle doesn’t she?

The therapist and team’s hypothesis was that C1’s behaviour directly correlated, to not only her experience of abuse, but as a result of a reversed family hierarchy, which left C1 feeling very unsafe. The artwork permitted the dysfunctional family structure to be explored in a non-confrontational manner, including C1 and C11’s contributions. C11 was able to recognise how his mother had stepped back from her role as mother and ‘boss’. The space left had led to him and C1 fighting to take control. C11’s desire to be in the centre also suggested to the therapist and team that his need to be in the centre, surrounded by his family, was also about safety, as well as, developmentally appropriate.
Therapist: *(To C11)* …just stand over her and show me on the picture where you think mummy should be.
C11: Mum could move to here. *(Indicating nearer to where his drawing is placed).*
Therapist: Nearer to you? What would C1 think if Mum were to move closer to you?
C11: Oh, she couldn’t fit in there.
Therapist: *(Pointing to a space in the page)*. C1 could fit in there. So what would C1 think if mummy moved over here nearer you?
C11: Er…aah.
Therapist: Would she be happy or angry?
C11: Happy.
Therapist: About what?
C11: That she moved over.
Therapist: That mummy is closer to you.
C11: *(Nods in agreement).*
Therapist: Do you think that C1 would be happy if you and mummy were closer and she was further away? *(Pause). Mmmm?
C11: Yes. *(C11 tilts his head and widens his eyes, displaying a coy strategy).*
Therapist: Those eyes, You’re trying to persuade me into your way of thinking, but I’m sorry. *(Laughter).* Why do you think he says that mum?
C11: I couldn’t understand it.
Therapist: …Mummy was asked that question, Maybe her name is C1.
Mother: I maybe wrong. No. He wants to be really close to me.
Therapist: And where does he want C1.
Mother: Away from me.
Therapist: Yeah, and why does he want that? …
Mother: Probably because when he was little we used to tease, saying I was his mum and that no one could get me, so they were always fighting to get me…
Therapist: Mmmm. ….so do you get that sense that he gives you kinda like the little sort of look, the big eyes sort of sweet, kind of innocent….
Mother: Yeah.
Therapist: So he is very good at keeping you engaged with him and letting C1 be pushed out.

The process, and the discussion of making the artwork, was used to help illustrate how C11 was using the Type C attachment strategy, such as, coy behaviour, to elicit his mother’s attention. At the same time C1 was competing within the sibling group to be noticed by an unavailable mother.

Therapist: So! *(Pause). *(To C1)*. Did you hear what Mum said, about everyone wanting it to be a happy family? *(To C11)*. Would you agree, that you want it to be a happy family?
C11: It is a sad family.
Therapist: Oh why is that?
C11: Because they want it to be happy.
Therapist: Oh … Because Mummy says she wants a happy family. C1 says she’d like a happy family. Notice there’s no sadness in the family *(Indicating the picture)*, but you’d like it to be a sad family.
Mother: Are you saying you don’t want it to change?
Therapist: Yes, but why do you think he’d like the faces to be sad?
Mother: He would keep me all to himself if the family stay sad.

The conversation continued along these lines and concluded with the therapist and team’s hypotheses that sadness keeps the family close and being happy meant for C11 that they might loose that closeness. The positions chosen in the family picture also allowed for the ‘lost’ relationship between C1 and her mother to be explored.

**Therapist:** (To C1). Do you get close to her when you’re happy or when your sad?
C1: None I think.
Therapist: None of them? So when do you … when um, when are you close to mum? *(Pause).* What if you are scared? Is that a time when you get close to mum?
C1: No.

A later discussion

**Mother:** *(Referring to C11).* Yeah, but it’s not only C1 he has to compete with … it’s my parents as well, because if he’s like sitting next to me, giving me a cuddle, my mother will try and push him away from me, touching me, as if it’s not healthy for him to be like that … I dunno, I dunno what they’re thinking…
**Therapist:** So what are they worried about with him? If he has cuddles, and sits close to his mother?
Mother: Probably what people think, I mean…
Therapist: What would they think?
Mother: I don’t know. I don’t have a problem with it but they do.
Therapist: Mother, what would you guess that they might be worried about?
Mother: Probably that something not good’s going on.
Therapist: Yeah. So, do you think that they’re seeing, that if people, that if a mother gets close to her son, that that’s inappropriate?
Mother: Yeah.

During the observations the therapist and team had noticed the high level of hostility in the mother’s tone of voice when she spoke to C1. They also were able to witness C1 continually checking her mother with quick darts of the eyes, as well as, noticing C1 on several occasions smiling at her mother but then rapidly losing the smile as if unsure of the response.
Family picture

![Family drawing](image)

C1  C11  Mother  C11

**Family strengths**

The family wished to work towards a ‘happy’ family and their ability to talk openly about their relationships was underlined. The fact that the family had managed to survive extremely scary times was emphasized and now, as they were beginning to feel safe, it was a time to start to undo some of the hurt, which they all seemed willing to do. The aim of creating a safe family so that they could talk and then leave the hurt behind, was strongly emphasized.

**Formulation**

All three children had experienced an extremely disruptive history in the context of chronic maternal depression, marital disharmony, severe domestic violence, alcohol abuse and ongoing significant financial worries. C1 had also experienced physical abuse at the hands of her father and a family friend sexually abused her. All three children exhibited behaviours and attachment styles associated with been traumatised and having felt unsafe in the past.
Within this context, it is of no surprise that C1 was an overly tense and irritable baby, who did not feed or sleep well. This created difficulties in the bond between her and her mother, although C1 was often her mother’s confident. As a result, C1, and in light of her mother’s depression, has adopted a pseudo independence and parenting role, and therefore her mother is no longer in the position to parent her successfully. C1’s younger brother’s attachment style of ‘Coy’ behaviour, permits him to be close to his mother, whereas C1’s distance leaves her outside of the family, away from comfort and full of sadness and confusion and feeling very unsafe. She gains the attention from her mother by being disruptive.

The concern of the therapist and the team was that the mother needed to consider the impact of her continual contact with the children’s father. If she wished to remain in contact with him then her actions would undermine any potential for therapeutic change.

**Diagnosis**

*The child and adolescent psychiatrist completed the diagnosis below although the family assessment and interactive art exercise contributed to the information available in making the diagnosis it was not solely responsible.*

**D.S.M. 1V**

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<thead>
<tr>
<th>Axis 1</th>
<th>Value</th>
<th>Description</th>
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<tr>
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<td>Post Traumatic Stress disorder</td>
</tr>
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<td>313.89</td>
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<td>Reactive Attachment disorder</td>
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<td>V61.8</td>
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<tr>
<td>Axis 1V</td>
<td></td>
<td>Maternal depression, Domestic violence, inadequacy of social support. Problem with primary support group Problems related to social environment Housing problems Economic problems</td>
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**Axis V**

GAF 55

**Family goals and treatment plan:**

- Weekly family art therapy working on reducing the hostility between C1 and her mother and working towards putting mother back in charge of the family and more evenly distributing her mothering capacity amongst all three children.
- Weekly home visits by psychiatric nursing staff to address behaviour management.
- Regular family weekly admissions to the unit.
- Close liaison with the department of social services.
- Individual art therapy for C1.
- Referral for a psychiatric assessment with the view of individual therapy for Mother.
- Referral of mother to a domestic violence support group.
- The family wanted to have more laughter in their family.
- They all wanted to feel safe.

**Family 4 – Delta**

The Delta family consisted of a mother, father and the referred boy, (D1), a seven-year-old and his younger brother, (D11), two-years-old. The family was living in Local Authority rented accommodation. The referred boy, D1, presented with the following issues:

- D1 had been diagnosed with mild learning difficulties;
- D1 been diagnosed with Aspergers syndrome a mild form of Autism;
- D1 had experienced intra uterine malnourishment and post birth feeding problems;
- a failure of D1 and D11 to bond with their mother, and
- a mother who had suffered from post-natal depression.

At the time of the referral the family was described as being in crisis.

The referred children from Antler and Cettle family, at the time of assessment, both qualified for a diagnosis of post-traumatic stress disorder using DSM IV criteria. All the referred children appeared to have some degree of early attachment difficulties.

**Clinical vignettes of the family assessment and interactive art exercise**

**Genogram**

D1 lived with his mother, father and his younger brother, D11, (two-years- old). D1’s mother described D1 as a difficult baby to feed, screaming and vomiting during feed times, and that she had never bonded with him.
Referral

A community child and adolescent psychiatrist had referred D1, a seven-year-old boy, to the child and adolescent psychiatric unit due to D1’s difficult behaviours, both at home and at school. These behaviours included:

- obsessive behaviours: concerns about people touching his food and if he is touched he becomes extremely upset;
- verbal abuse towards his mother;
- extreme mood swings;
- physically aggressive towards his teachers;
- academic progress was in decline; and,
- oppositional difficulties - will not follow instructions, will tantrum in response to limit setting and has difficulties in settling after a tantrum.

The community child and adolescent psychiatrist described the family as in crisis and the school unable to cope. D1 had been diagnosed with a mild intellectual disability and moderate learning delay.

At the time of assessment the parents reported a long-standing history of difficulties including:

- swearing;
- mood swings;
- learning difficulties;
- not listening;
- not wanting to follow instructions;
- not wanting to be touched; and,
- sibling conflict

The family assessment and interactive art exercise

Present

The mother, father, D1 and his younger brother, D11, all attended the family assessment. The family had initially refused to attend the family assessment. The family wanted D1 to be seen alone, stating that they did not see any value in being assessed as a family. Once given an explanation of understanding the impact of D1’s behaviour on the whole family, they reluctantly agreed to participate.

Process

On the entering the room and without a prompt D1 stated that did not have any worries. Nevertheless, D1 appeared in a highly anxious state throughout the family assessment. It was at times difficult to understand D1’s speech. Unfortunately the transcripts were at times left blank as it was impossible to decipher what D1 had said. When D1 was, however, asked to slow down and given time his speech became clearer. Both parents had a tendency to step in and speak for him.
Even though the family had initially been reluctant to attend on entering the therapy room they immediately gathered around the table on their knees. D11 orchestrated a move that placed him between his parents. It took the parents, with the support of the therapist, quite a while to get D1 settled and engaged in his drawing.

**Mother:** *(To D11 who begins to draw on her paper).* Hey! Draw on your own. That’s yours. This is Mummy’s one. Draw D11.

**D11:** Me, Mum?

**Father:** Yeah, draw D11.

*(Both parents then return to their own pictures leaving D11 to do his picture)*.

The parents’ response to their two-year-old son, left the therapist and team with a hypotheses that the parents who had lost their confidence in understanding the developmental stages and abilities of children after experiencing a child who had developed very differently from his peer group. Any two-year-old child would require some direction and help to understand and encouragement to participate and complete the art exercise.

Later, the therapist and the team repeatedly observed the parents giving confusing messages to the children.

**Mother:** Put it there. *(Puts her picture on the chair behind her).* Finished yours D1?

**Father:** Yeah, right.

**Mother:** Were you going to draw D11, D1? D11 can’t draw … *(D11 is fiddling with his paper, and then leans right across the table).*

**Father:** What! … more rubbish *(Picks rubbish of the floor).*

*(D11 goes to door and tries to open it).*

**Mother:** D11, stop. You can’t go out.

**D1:** *(Indecipherable).*

**Father:** Could be worse, I could be …

**D1:** Yeah. I won’t … I won’t.

 *(D11 goes to his mother’s cut out, she takes it from him).*

**Mother:** Don’t break, don’t break. *(To D1)* You draw … you draw D11?

**D1:** Draw D11? *(D1 is cutting his picture out).*

**Mother:** Don’t cut your legs off.

**D11:** Hey, Mum. Mum.

**D1:** I not Mum!

**Mother:** … blue one. You have blue one.

**D11:** All mine.

**Mother:** All yours? … give D11 …

**D11:** All mine *(Leans over the table).*

**D1:** I cut my legs.

**Mother:** Oh. Don’t worry.

**D1:** Oh …

**Mother:** Don’t worry.

**D1:** *(Indecipherable but sounding distressed).*

**Mother:** Why don’t you cut all around it without having to go in … in between everything.

*(Pause, whilst quietly cut out. D1 is drawing. Mother is watching).*
D11: Oh!
Mother: How you going? That’s pretty good now?
D11: (Very loud and difficult to understand).
Mother: That’s great. Put it down. Put that next to mine.
D1: I finished.
Mother: Do you want to draw a picture of D11? So D11 can be on there too?
D1: O.K.
Mother: Do you want another piece of paper? (Hands him one) That’s dangerous (taking scissors of D11).
D1: (Picking up a small pair of scissors) This, this?
Mother: … that’s just a little one.
(D11 yells, Mum laughs).
Father: What did you think it was?
Mother: I don’t know. Who’s that?
D1: Daddy, (Hands picture to father).
Father: Good boy. Put it over there. (Places with other complete pictures).
D11: Mine, Where’s mine?
Father: Where’s yours? D1’s doing … are you doing D11?

The therapist and team noticed that the management of the two boys was predominately left to the mother. From the therapist and teams perspective, D11 was very keen to participate and be included in the family picture. His efforts were continually ignored and neither parent offered D11 any support in joining the process. In fact, the message he was given was that his contribution was not welcome and that D1 would do it for him. The therapist and team developed a hypothesis that suggested D1’s behaviour was an attempt to take charge of his family, to make sure he was never again left out. This, in the context of: suffering from malnutrition; a breakdown in his relationship with his mother; his parents feeling overwhelmed; and, perhaps feeling accountable have stepped back, given in and permitted him to take charge. Having been thrown by C1’s behaviour and complex needs, the parents then struggle to attend and understand C11’s needs and abilities.

As the family begins to put the family portrait together, there is limited family discussion. Mother indicates that D1 should go first and D1 takes control, letting his father know he will do it for his father.

D11: Come on. (D1 takes the glue of his mother and starts to glue the drawing). … D11 … just mine!
Father: No, D11 can do it himself if he wants to. Is that okay?
Mother: No I don’t think D11 can do it…
D1: Put here D11! (Banging the table).
Father: The other way, D11.
D1: Put here, D11 (Bangs on the table again).
Mother: Turn him round. Right, now …
(D1 bangs the glued picture of D11 onto the paper. Father watches and then grabs D11’s hand when he starts to bang on the table).
Mother: I don’t think there is enough room.

The therapist and team observations appear to confirm their working hypothesis when neither parent intervened to stop D1’s aggressive behaviour. Instead, the parents allowed him to take over and dominate: deciding where his young brother should be placed in the family picture. The
therapist and team wondered if the mother’s comment that ‘there was not enough room’ reflective her feeling of being overwhelmed in managing a very complex child and a toddler.

Mother: Hold on, wait till D1 finishes, then you can have a go. (Pause). (To D1). Where’s Mummy gonna go? Who are Mummy’s …
Father: Mum’s bigger than Dad. Well, he got that right, Mum (Laughs).
D11: (Indecipherable).
D1: (Very loudly, very definite). Next to, D11.
Mother: Want it next to D11?
Father: Oh. Right there.
(D1 places cut out of mother on paper, but draws it back as Mother reaches to help).
Mother: We can help you press it down. (Banging as the drawings are pressed down).
(D1 picks up next cut out, holds it in front of his mother and makes a fierce growl like an animal).
D1: Maybe angry.
Mother: Who’s angry?
D1: Me.
Mother: You?
Father: You look very happy.
Mother: What are you angry for?
Father: You look very happy. If you smiled like that all the time…everybody would be happy.
D11: This?
Father: It’s glue…er…it’s paste.
Mother: Where’s D1 going?
Father: Where’s D1 going, D1?
D11: Dad, Dad?
D1: (Indecipherable).
Mother: You going next to Dad?
D1: No, here.
Mother: (Surprised). You’re going next to Mum?
(D1 sticks down his cut out, but places it next to dad after all).
Mother: Aw … (Mother looks at father and laughs).
Father: I was alone, if you weren’t going to put me there I was going to be left out.
Mother: Right, there we go.

As the therapist enters the room D1 proudly announces that he did it all and when the therapist asks who would like to talk about the picture, the mother suggests D1 as he had put it all together. The therapist then begins to explore the therapist and team’s hypothesis.

Therapist: (To D1). What do you think it is like for D11, if D1 puts it all on? Do you think that was right?
D1: (Does not respond to questions and begins to point to family picture). Mum … me and D1.
Mother: He … he … never …
Father: (Interrupting). D11 couldn’t understand it really.
Mother: He never gets to do anything.
Father: (Protesting what mother has said). Oh, no, no, no …
Mother: Well … a lot.
Therapist: Is this something that happens a lot at home?
Mother: Yes.
Father: I think in the past … over those years, how old are you? D1 is five years older … those five years…
Mother: (Interrupting). D1 wants to do everything.
Therapist: D1 wants to do everything?
Father: He’s very good … protecting him … you know?
Therapist: D1, D1 did you hear what Mum and Dad said?
(F1 shakes his head).
Therapist: They said that sometimes at home, it’s a bit like what happened today. That D1 gets to do everything and D11 misses out because D1 stuck all the pictures on. He even drew D11, didn’t he? Where’s D11’s drawing?
(F1 points to the drawing).
Therapist: (Lifting F1’s picture of D11 and as she looks under it) …another one! The one that D11 did?
Father: (Looking about for the D11’s picture). There was one.
(Mother laughs).
F1: (Loud but no angry). Na, na, na.
Therapist: See if we can get D11 to find it.
F1: (Holding up a picture). See!
Therapist: There it is. Hold on. Hold on. (Looking for D11 to give her the picture).
Therapist: Well done! Wonderful, D11! Because that really was D11’s drawing of D11.
The therapist then explores the picture of the family through D1’s perspective.

Therapist: (To F1). Daddy’s smiling at Mum? Is he? And what is little D11 doing here? (F1 leans over from where he is sitting on mother’s knee, and points, but F1 moves forward and blocks him off, and points to the picture).
F1: Smiling at … at my Da … Daddy.
Therapist: He’s smiling at Daddy?
F1: Me.
F11: Mum. Mum.
Therapist: And if you could be anywhere else in the picture where would you be? (F1 claps his hands together, but his reply in indecipherable).
Therapist: F1, where else would you be. You’ve put yourself next to Daddy. If you could be anywhere else, where would you be?
F1: (Pointing to D11). D11.
Therapist: You’d be D11. Why would you be D11?
F1: He …him little.
Therapist: Because he’s little. What’s good about being little? (F1 goes to D11 and takes his hand and claps).
Mother: F1, Listening.

Later,

Mother: F1, if you took this off here, who would … who else would you like to be next to?
F1: No one.
Mother: No one! Just next to Dad. You wanted to be next to Mum before but you wouldn’t fit.
F1: I didn’t fit.
Therapist: You didn’t fit, that’s right. You didn’t fit next to Mum, there wasn’t enough room.
D1: I too big.
Therapist: That’s right.

The conversation continues and feelings in the family and how people fit together are explored. The therapist uses the smiling face from the family picture as a springboard. The discussion led to where the mother begins to talk about her relationship with D1.

Mother: See, it’s really bad, like ... He (indicating D11). ... is very dependent on me, wants me to do everything so D11 has to wait. So I feel like I’m being pulled away from him (D1), to him (D11) - all the time because he (D11) won’t go anywhere else.
Therapist: So it sounds like it is very hard for Mum to be in the middle. It’s hard to share Mum. (D1 nods in agreement).

The therapist and team’s hypothesis that the mother is consumed by the needs of D1 to the detriment of D11 was reinforced in the conversation that arose from making the family picture. The struggle between the siblings was further demonstrated when the therapist encouraged D11 to have a turn at talking about the family picture.

Therapist: (To D11). Can you tell us. Can you tell us about the picture?
Mother: Who’s on the picture, go and have a look.
Therapist: (Pointing to the picture). Who’s this?
D11: Um. Me.
Therapist: That’s you. What are you doing there?
D1: (Leans over and whispers). Smiling.
Therapist: Oh, you see, that’s another example ... because I think D11 can quite .. is quite old enough to tell us himself. So you can just wait a minute and we’ll come back to you okay?
(D1 moves over towards the door and puts his T-shirt over his head).
Therapist: (to D11). D11, Who’s this?
D11: Um ...
Therapist: Who is it?
D1: Me. (D1 moves towards the table and D11 moves away).
Mother: D1. D1 drew it.
Therapist: Who is this D1?
D11: D1.
Father: Come on, D11.
Mother: It’s all right. Come on.
(D11 refuses to come back to the table).
Mother: Who’s this?
D11: Mum.

The team wondered if D11’s refusal to come back to the table was because of having been acknowledged and received attention, he was then fearful of any negative repercussions from D1, who had been known to be violent towards him in the past.

The family picture also allowed for the family to identify that some of the motivation behind D1’s behaviour was from a need to be in the centre of the family. His early attachment
difficulties had left him anxious, to feel contained and he was orchestrating the family around him to manage his anxiety. His aggression towards D11 was an expression, not only of his difficulties with expressive language, but also a feeling that his central position was under threat. D11’s need to feel contained had caused difficulties in his parent’s marriage and their parenting of the children.

The family picture also permitted the team to access D1’s fine motor control and, in particular, it was noted how well he had managed the scissors.

During the family assessment and interactive art exercise it was evident that neither parent set limits on D1’s behaviour. Mother was dismissive of D11’s attempts to be included in the family picture and in fact both parents allowed D1 to dominate and control the assessment. The mother appeared exhausted and both parents seemed overwhelmed. There was little eye contact, or verbal contact, between the parents throughout the art exercise. D1’s contact with his brother was intrusive and, in fact, he appeared to smother him on several occasions. D11 spent a lot of the assessment sitting on his mother’s lap and when asked to separate, although his mother predicted he would find that extremely difficult he settled after a few minutes.

Family picture

![Family picture](image)

D1 Father D11 Mother

Family strengths

The therapist told the family that there were times in the assessment where the family was able to laugh together. It seemed that the family were very keen to make some changes and recognized that they needed help in thinking how they manage the family as a whole, as well as, rising to the challenge of dealing with a child with extremely complex needs.
Formulation

D1 suffered a difficult start in life, including in utero malnourishment followed by a difficult birth and attachment problems due to his parents being overwhelmed with a variety of difficulties related to feeding, as well as, D1’s apparent lack of affection, difficulties in reciprocal relating and dislike of physical touch. As a result, D1 at age seven years, presented with a number of complex neuro-psychiatric difficulties, including: mild intellectual disability; expressive language disorder; oppositional defiant disorder; difficulties in self regulation; particularly affect regulation; inattention; impulsivity; hyperactivity; symptoms of obsessive compulsive disorder; and, difficulties relating to others.

The attachment difficulties between D1 and his mother were also viewed as paramount.

Diagnosis

The child and adolescent psychiatrist completed the diagnosis below although the family assessment and interactive art exercise contributed to the information available in making the diagnosis it was not solely responsible.

D.S.M. 1V

Axis 1  313.81  Oppositional defiant disorder  
313.89  Reactive attachment disorder  
300.3  O.C.D.  
315.31  Expressive language disorder  
V61.20  Parent Child relational problems  
V61.8  Sibling relational problems

Axis 11  Nil

Axis 111  Nil


AxisV  GAF 60

Family goals and treatment plan

- Family to attend fortnightly family art therapy and address the following:
  • parents to be boss, setting firm loving, consistent limits;
  • D1 to listen to adults;
  • D1 learning to be the big sensible brother;
  • D1 allowing D11 to have his own space;
  • D1 to be allowed to speak for himself with the parents correctly repeating what he says rather than saying it for him, and,
  • The family to talk about the impact on all of them of D1’s difficulties.
- On alternate weeks mother and D1 to attend parent-child art therapy to build positive times in their relationship and strengthen bond.
- D1 to be admitted to the on site school for four days a week for further assessment of learning potential and to remain one day a week at home school, with long term plan to integrate him slowly back to home school.
- Clinical Psychologist to conduct comprehensive psychological examination of D1.
- Ongoing family weekly admissions, to address behaviour management and family interactions.
- Family support services instigated such as regular respite.
CHAPTER TEN

Discussion and conclusions

The family assessment and interactive art exercise was developed to overcome a number of difficulties encountered in assessing traumatised children with complex psychiatric difficulties and their families in a Tier 3 child and adolescent psychiatric hospital.

The study began with a number of clinical challenges and frustrations encountered, particularly from observing how children were being routinely left out of family assessments. The way children were left to play in the corner of the therapy room whilst the adult’s described the child’s difficulties seemed to be unproductive method of assessment. With the adults focusing on the child’s behaviour, often involving a lot of negative descriptions, the child's anxiety would become raised. This increase in anxiety often caused children to continually disrupt the assessment. At times they were noted to withdraw, refusing to talk and at other times they would present challenging behaviours, often to the point where the assessment had to be terminated. Failing to engage children in a family assessment seemed to leave the therapist with minimal information, which was not helpful for the child and family and not conducive to developing first-rate treatment plans.

The pressure from the child and adolescent psychiatric hospital and the referring professional to gain as much information in an efficient and expeditious way had further supported the need for consideration on improving the assessment process.

The research literature also exposed a concern that childrens’ voices were not being heard in family assessments and that consideration had to be given on how to provide a more child inclusive practice. The difficulties in engaging traumatised children was also highlighted, at the same time as underlining the importance of providing an environment that supports the expression of traumatic experiences. In assessing and treating children who have been subjected to psychological trauma, the literature supported adopting an integrative approach. This recommendation for an integrative approach was the impetus to explore different therapeutic models and assessment tools and seemed more conducive to working with a multidisciplinary team at Tier 3 level.

The naturalness of art making

An integrative approach was the over arching theoretical recommendation that appeared to emerge from the literature in treating children suffering from psychological trauma. The family assessment and interactive art exercise therefore was created out of a synthesis of previous assessment tools and theoretical approaches. Spanning the literature on development, and the physiological and psychological impact of trauma, there were strong indications that art was the most appropriate medium to use in the assessment. It was clear that children are comfortable with making art and use art as a natural form of expression. The fact that traumatic memories are stored in the brain in imaged form was an added bonus. The impact of trauma on family relationships, attachment patterns and child development were all essential ingredients in considering how to create an assessment that would begin to help children be more included and feel safe enough to revisit difficult and painful memories. The literature was helpful in underlining the importance of including all family members. Family therapy literature provided insight into how to ask questions, to open up the possibilities of multiple truths while holding a neutral position and developing hypotheses.
The family art therapists’ various assessments techniques helped in the design of a methodology for the family assessment and interactive art exercise.

The eventual simplicity of the family assessment and interactive at exercise made it easy to incorporate into the child and adolescent psychiatric hospital’s assessment process. Children moved out of the corners of the room and became significantly more involved in the assessment process. Trying to capture this dynamic was a challenge. In this context, the families’ permission to use the artwork, videotape and transcripts was welcomed. Being able to review the artwork, the videotapes and subsequent transcripts permitted a closer look and further confirmation that the family assessment and interactive art exercise was more child inclusive, positive and engaging for all family members and was able to elicit complex and, at times, sensitive information at multiple levels. From the live observations, the videotapes and transcripts of the family assessment and interactive art exercise, there was a clear indication of a marked increase in the child’s involvement in the assessment process. All the children in the study, as described in the vignettes, were active participants in the assessment process. This study has illustrated, with the use of vignettes and the behind the screen ideas and thoughts of the therapist and multidisciplinary team how art work can be an important part of the diagnostic process. In this study, the formulation, diagnosis and treatment plan revealed how effectively the family assessment and interactive art exercise can increase child inclusiveness and provide multiple levels of complex information.

**Engagement of the child in assessment**

It can be argued, that the increase in childrens’ involvement is attributed to a number of factors. The fact that children use art naturally to express themselves and art does not depend on verbal skills and cognitive ability, has helped engage the children over the varying developmental stages. This study reveals that including the use of an art exercise and the childrens’ families in the assessment process is demonstrably helpful in engaging and reducing the child’s anxiety and gaining multiple levels of understanding and developing first-rate treatment plans. As highlighted in the literature review, these children avoid trauma related stimuli, which elicit unpleasant physiological hyper-arousal and traumatic memories, many of which are fragmented and emerge in imaged form as pictures or auditory fragments associated with overwhelming unpleasant somatic states. These memories that are repetitive and non contextualized, can be associated with significant distress and are not easily accessible to verbal intervention. The use of art, and its ability to expose both procedural and imaged memory in the assessment of trauma, inherently addresses many of the key concepts that are underlined when assessing and treating traumatised children. The family assessment and interactive art exercise in this study appears to provide a safe enough context where the child and family can re-experience traumatic arousal. In this environment, and by using art, a controllable medium, exposure and the re-experience of the traumatic arousal can be tolerated and safely externalized in the artwork. The traumatic imagery is then available for physical manipulation, conscious consideration and verbal narrative, and with children being active participants in the process. The children and families impressive ability to use art to explore some of their families painful and anxiety-provoking issues in the vignettes, were testament to the family assessment and interactive art exercise being helpful in the expression of trauma and hidden feelings.
By keeping the instructions simple, the family assessment and interactive art exercise had helped create an environment for children and their families to engage in the creative process - enabling them to begin to freely express their inner dialogues and patterns of interaction.

Hyper-arousal – reducing the problem in assessment

It is also noteworthy that none of the children displayed any significant hyper-arousal stress responses or challenging behaviours. This could be attributed to a reduction in the child’s anxiety as the family assessment and interactive art exercise seemed to provide an opportunity to be creative together as a family. In this arena the children and families were able to interact with seemingly quite challenging issues, at the same time as offering an enjoyable family experience from making art and doing something together. This view was further supported by the amount of times that laughter was noted in the transcripts. This supposedly more relaxed environment and playfulness helped reduce anxiety and therefore increased the likelihood of the child’s engagement and offered them an opportunity to feel safe enough to express traumatic memories.

Accessing multiple levels of information

Focusing the family assessment and interactive art exercise around a structured art exercise helped access multiple levels of information. The process of making art, untainted by the therapist, allowed access to information such as family relationships, family interactions/attachment patterns, decision-making processes, symbolic communications, as well as developmental abilities - including, speech, language and physical abilities and the families subjugated stories. These stories, rich in metaphysical and metaphoric language, allowed new or hidden information to become visible, which was at times challenging. New information can possibly change the family’s perspective around the presenting problems. The study also highlights the value in the therapist adopting the position of observer in understanding how child and the family operate as a system, although it has to be acknowledged that the family will to some extent be responsive to the one-way screen.

Time efficiency

By using the family assessment and interactive art exercise, the therapist and multidisciplinary team were able to also gain access to complex information in a time-limited way. Observation time was maximized, within the one and a half hour time frame, which was aided by the structure of the assessment, the involvement of the multidisciplinary team and the use of the one-way screen. The use of the multidisciplinary team and the one-way screen, promoted multiple perspectives and allowed time for the therapist and multidisciplinary teams’ hypotheses to evolve.

Difficult to ‘reach’ families

The family assessment and interactive art exercise also helped to access information from the more avoidant and dismissive families. The simple process of the child and family making art, permitted the child’s behaviour to be viewed in the context of their family. The therapist could highlight the child and families interactions around the problematic behaviour. The focus of
Re-processing traumatic experiences in a therapeutic manner

The use of the family assessment and interactive art exercise is a useful assessment tool to engage traumatised children and their families. The integrative approach of a synthesis of developmental approaches, psychodynamic ways of working to help process traumatic experiences and systemic family interventions to address individual and family dysfunctional patterns of relating, seems to make clinical sense. The family assessment and interactive art exercise that draws upon an integrative framework, helps the therapist and team to organize information from multiple levels from developmental, psychodynamic and systemic perspectives into a well-defined treatment plan. Above all else the family assessment and interactive art exercise clearly provides an assessment environment that promotes child-inclusive practice, which is integral to working with traumatised children.

An overview

Children with a bewildering array of symptoms that follow from exposure to prolonged trauma, repeated abuse and neglect are frequently diagnosed with multiple psychiatric disorders, suffer from an array of problematic behaviours and live with attachment figures who struggle to provide a safe context. Assessing traumatised children with complex psychiatric difficulties and their families in a Tier 3 child and adolescent psychiatric hospital can be achieved in an efficient, effective and expeditious way and involve children in the process. The study highlighted that a child and family assessment does not need to be complicated and time consuming to be able to assess multiple levels of information and create first-rate treatment plans.

The implications from this study are that an effective and expeditious family assessment and interactive art exercise can be designed that promotes child inclusive practice and is responsive to the unique presentation of traumatised children and their families. The use of art with children and their families evidently increases child inclusion, can engage all family members, focuses chaotic families and assists in teasing apart complex information and family interactions, structures and boundaries. Assessments can be simplified and modified to meet the needs of children exposed to psychological trauma yet still create a safe environment to re-visit traumatic memories as well as access multiple and complex levels of information.
Possible impediments that would require further research attention

Although the one-way screen is an effective method allowing a multidisciplinary team to actively contribute to the assessment, some families find the idea of being ‘watched’ uncomfortable. The importance of engaging with the family and the confidence of the therapist, as they explain the practicalities and benefits of using the one-way screen with a multidisciplinary team, are essential in reducing these anxieties. Inviting the family to meet the team and showing the children how the one-way screen operates are also helpful in addressing the families concerns. “Families need to feel welcome and sense that the therapist/s are there to help solve problems in a collaborative fashion” (Kozlowska & Hanney, 1999, p. 65).

Some families that might not benefit from the use of a one-way screen and a multidisciplinary team include: families referred by the department of social services, where there is already a sense of being ‘watched’, families where there has been a breakdown in relationships where professionals have created mistrust, and where one family member might be experiencing a psychotic illness characterized by paranoia.

All four of the families that contributed, some of whom were perhaps initially reluctant, or perhaps simply displaying some anxiety, seemed to end up enjoying the experience of working with the one way screen and the multidisciplinary team.

This study is a first glimpse into the potential benefits when working with children exposed to psychological trauma of adopting an integrative approach as described in the family assessment and interactive art exercise. It would seemingly benefit from more rigorous research over a wider sample to be able to be absolute about the benefits and areas for improvement. It would also be constructive and somewhat illuminative to explore the levels of child inclusion in assessments by comparing family assessments that rely solely on language and those that also include art making in the assessment.
REFERENCES


### APPENDIX 1

Information sheet for participants

<table>
<thead>
<tr>
<th><strong>Name of paper:</strong></th>
<th>Family assessment and interactive art exercise: An integrated model.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of researcher:</strong></td>
<td>Lesley Hanney.</td>
</tr>
<tr>
<td><strong>Purpose of research:</strong></td>
<td>I am currently writing a paper which intends to explore ways to increase children’s involvement in family assessments. I will take a reflective position by reviewing the work with your family and thinking about how I can improve my practice so that I am more inclusive of children.</td>
</tr>
<tr>
<td><strong>Use of videotape:</strong></td>
<td>I hope to make a videotape of your family assessment session, which will help me look closely at how I am working and think about how I could do things differently.</td>
</tr>
<tr>
<td><strong>How results will be used (including publications):</strong></td>
<td>The thoughts and ideas that arise from when I review the videotape will inform the paper I am writing and be used as examples alongside my ideas.</td>
</tr>
<tr>
<td><strong>What is involved for your family:</strong></td>
<td>You will be asked to sign a consent form for me to use the videotape, the art work and information that arises from your family assessment in the research paper and any publications.</td>
</tr>
<tr>
<td><strong>Why your family has been chosen:</strong></td>
<td>Your family has been asked to take part solely because your family is currently undergoing an assessment.</td>
</tr>
<tr>
<td><strong>Confidentiality:</strong></td>
<td>All information will be treated confidentiality and anonymity will be guaranteed. All information that could identify your family will be removed and your names and occupations will be changed.</td>
</tr>
<tr>
<td><strong>Withdrawal at any stage:</strong></td>
<td>Your family can withdraw your consent at any time without giving reason and this will not affect your assessment or treatment.</td>
</tr>
</tbody>
</table>
APPENDIX 2

Northern Sydney Health
better health: from the Harbour to the Hawkesbury
ARDENEL CHILD & FAMILY UNIT
Cnr Badajoz and Twin Roads
North Ryde NSW 2113
Telephone: (02) 9887 5830
Facsimile: (02) 9887 2941

8th February, 1999.

CONSENT FORM TO PARTICIPATE IN A RESEARCH PROJECT

Jill Westwood (Supervisor)  
Lesley Hanney (Researcher)  
(02) 9678-7187  
(02) 9887-5830

I, ___________________________ being the ___________________________
(name of participant) (state relationship e.g. son/wife)

of ___________________________ of ___________________________
(name of patient) (street)

_________________________
(suburb/town/ State and postcode)

have been asked to consent to my child and family’s participation in a research project
entitled: Family Assessment and Intervention Using An Interactive Art Task.

In relation to this project I have been informed of the following point:

1. Approval has been given by the Human Research Ethics Committee (HREC) of
the Royal North Shore Hospital.

2. The aim of the project is to evaluate whether drawings help family assessment
in child psychiatry.

3. The results obtained from the study may or may not be of direct benefit to my
medical management.

4. The art assessment tool is part of the current child and family assessment and
treatment at Arndell. The procedure will involve a thirty (30) minute interview
where the family will be asked to complete a picture using the crayons provided
whilst being observed by the researcher. The researcher will then ask questions
about the completed picture.

5. The interview will be video taped. The client can at any time request erasure of
material they wish not to be recorded. I understand that this tape will be used
for the researcher to review the session to ensure that important information is
not lost.

6. There are some possible adverse effects or risks related to this project which may
include psychological stress or distress. My child and family will be provided
the opportunity to raise any concerns or issues that may arise from the art
assessment tool in ongoing weekly interviews.

7. Should my child or family develop a problem which I suspect may have resulted
from their involvement in this project, I am aware that I can contact:

Dr. Bev Turner or Martin Baker on 9887-5830 at Arndell Child &
Family Unit, Cnr. Twin & Badajoz Roads, North Ryde, 2113.
8. Should I or my child/family have any problems or queries about the way in which the study was conducted, and I or my child/family do not feel comfortable contacting the researcher, I am aware that I or my relative/child may contact the Patient Representative who is an independent person within the hospital on 9926-7612 or co-ordinator of Research Administration on 9926-8106.

9. My child/family can refuse to take part in this project or withdraw from it at any time without affecting their assessment or treatment. I can also refuse on their behalf.

10. Participation in this project will not result in any extra medical and hospital costs to me or my child/family.

After considering all these points, I accept my child ___________________________

(state relationship)

and ________________________________ family’s participation in this project.

(family name)

Date: ________________________________ Witness: ________________________________

(please print name)

Signature: ______________________ Signature: ____________________________

(of participant) (of witness)

Investigator’s signature: ________________________________

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