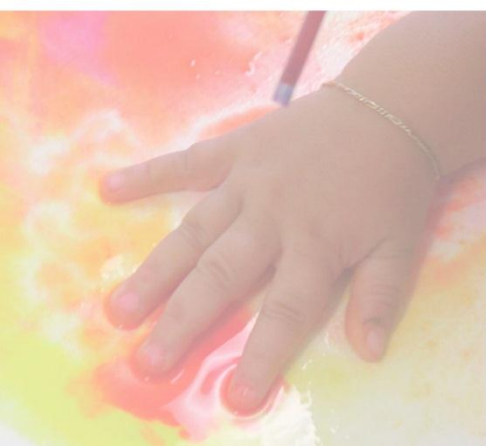




# Evaluation of BoysTown's Expressive Therapies Intervention

## 2012-2014





## Acknowledgements

BoysTown would like to acknowledge and sincerely thank:

- \* the children and parents who participated in the expressive therapies intervention and agreed to their images, observations, feedback and/or assessment data being included in the current evaluation, and;
- \* the Margaret Pemberton Foundation which funded the Expressive Therapies intervention from 2011-2015 and without which none of this work would have been possible.

## Report cover

All artwork and images used in the report cover design are included courtesy of children and parents who participated in BoysTown's Expressive Therapies intervention.

Report written by Jenni Southwell on behalf of BoysTown, 2014.



BoysTown

# **Evaluation of BoysTown's Expressive Therapies Intervention**

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## **Abbreviations**

BCIMS	BoysTown Client Information Management System
CBCL	Child Behaviour Checklist (Achenbach & Rescorla, 2000; 2001)
CCPT	child-centred play therapy
CPRT	child-parent relationship therapy
ET	expressive therapies/expressive therapy

## **BoysTown's Expressive Therapists**

The Expressive Therapists who were employed by BoysTown to deliver the Expressive Therapies Intervention during the 24-month evaluation period are as follows:

Kate Finnila  
Lauren Johnson  
Veronica Kirkman  
Jasmin Roberts

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## **Executive Summary**

This report describes BoysTown's Expressive Therapies Intervention and presents findings from a two-year evaluation regarding its effectiveness in enhancing the social and emotional wellbeing of young children with complex needs as a result of their traumatic life and family experiences.

### **Background**

Many of the children entering BoysTown's child and family support programs display the emotional and behavioural traits of insecure, disorganised or disrupted attachment and other traumatic exposure. While some will have experienced direct abuse or neglect, many will have experienced unpredictable, insensitive or unavailable caregiving which for a young child can be extremely stressful to the point of traumatising (Perry & Szalvitz, 2006). Others will have witnessed violence against their primary caregiver or other family members and be traumatised by those experiences. And some will be traumatised by being dependent on a primary caregiver who is chronically impacted by their own victimisation. Many of these families are also affected by entrenched poverty, housing instability, disability and physical and mental health difficulties that can contribute to stressful caregiving environments and additional challenges for developing secure attachment relationships between caregivers and infants.

### **Impacts of childhood trauma and attachment problems**

A wealth of research points to the serious long-term negative impacts of childhood trauma and attachment difficulties on children. Exposure to trauma in childhood, particularly that of a sustained or chronic nature, has been found to potentially compromise every aspect of brain development associated with normal child development (Cook *et al.*, 2005; Streeck & van de Kolk, 2000; Schore, 2001). This is because chronic fear and stress prevent the regulation of the brainstem and thereby interfere with the development of all higher order regions of the brain and the integration of brain systems (Perry, 2006; Perry *et al.* 1995). Pervasive impacts of chronic childhood trauma that have been noted in the research literature include: "chronic affect dysregulation, sleep problems, exaggerated startle response, destructive behaviour against self and others, learning disabilities, hypervigilance, dissociative problems, somatisation, generalised anxiety, and distortion in concepts of self and others" (Klorer, 2004: 12).

Insecure, disorganised or disrupted attachment can have similarly serious long term negative impacts on children's social and emotional functioning and wellbeing. Secure attachment with a caregiver has been found to facilitate many critically important steps in early child development. If children are prevented from undertaking these steps in early childhood because of relational trauma or insecure attachment, they are at high risk of developing complex emotional and behavioural problems stemming from difficulties with emotional self-regulation, impulse control, learning delays, low self-esteem and shame, poorly developed and negative sense of self and others, and/or difficulty understanding, trusting, and relating to others (Cairns, 2002; Schofield & Beek, 2006; Stien & Kendall, 2004). Without effective intervention, these problems can persist and deepen through childhood and adolescence and undermine social and emotional wellbeing throughout the life course (Stien & Kendall, 2004).

### **BoysTown's Expressive Therapies Intervention**

BoysTown developed the Expressive Therapies Intervention for implementation in two of its existing sites for the delivery of services to disadvantaged families – a regional child and family support centre and a domestic and family violence refuge, both located in south east Queensland. BoysTown recognised that in both of these service contexts there had been a significant gap in the response to children with emotional and behavioural problems resulting from attachment difficulties and/or developmental trauma. It saw this initiative as a means by which to offer a more holistic and ultimately effective response to the therapeutic and developmental needs of these children, and thereby potentially circumvent the long term negative impacts associated with developmental trauma and insecure, disorganised or disrupted attachment.

The implementation of this initiative was made possible through the provision of funding from the Margaret Pemberton Foundation.

## **Practice contexts**

The BoysTown's Expressive Therapies Intervention is integrated within case-managed support programs for disadvantaged or vulnerable families. These programs are aimed at responding holistically to the multiple and complex presenting needs of participant families. All relevant program staff, including the expressive therapist, are involved in regular case-reviews for each family or child. The significance of this is that the work being undertaken with children and/or their parents in therapy can be supported and informed by other interventions, activities and services available in these programs.

BoysTown's Deception Bay Child and Family Service Centre comprises a group of specialist child and family support programs including the Glugor Young Parents Program, the Starfish Family Mental Health Program, and the CARE early intervention program for children experiencing difficulty at school, and their families. Each of these case-managed support programs refer children for expressive therapies, with most referrals coming from the Glugor Young Parents Program. This program provides a combination of support, therapy and education for young parents aged up to 25 years who require assistance with effectively parenting children up to 5 years of age.

BoysTown's domestic and family violence refuge provides secure accommodation and individualised and group support to women and their children escaping domestic and family violence through a therapeutic case management framework. Families can be accommodated for up to 12 weeks and during this period children up to 16 years may participate in expressive therapies. When the refuge is busy, priority is given to children aged under 6 years in line with current research and funding priorities.

## **Therapeutic framework**

BoysTown's Expressive Therapies Intervention is an *intermodal* or integrated arts approach to therapy. That is, it purposefully integrates a number of creative arts and play therapy modalities, emphasising the interrelatedness of the arts, to achieve its therapeutic objectives (Malchiodi, 2005). These therapeutic objectives are informed primarily by a trauma-attachment theoretical understanding of the needs of the children referred for therapy and include improvements in children's:

- emotional and social wellbeing and competence
- behavioural adjustment
- quality of attachment relationships with parents, and their
- self-concept/self-esteem.

To achieve these objectives, BoysTown's expressive therapists draw on a specific set of conceptual frameworks for their practice that are described in this report. These frameworks include:

- Pearson and Wilson's (2009) intermodal model of expressive therapies
- Child-centred play therapy (Axline, 1974; Landreth, 2002)
- Sandplay therapy (Lowenfeld, 1939; Kalff, 1980; 1991)
- Filial therapy (Guerney, 1964; Guerney & Ryan, 2013; Landreth & Bratton, 2006; Van Fleet, 2002; Edwards, 2007), and
- the neurosequential model of therapeutics for work with maltreated children (Perry, 2006; Gaskill & Perry, 2014).

In addition to these key overarching conceptual frameworks, BoysTown's expressive therapists bring to their practice a range of complementary theoretical and practice frameworks pertaining to their individual professional training in specific disciplinary areas, including art and art therapy, music and music therapy, symbol work, and mindfulness and meditation.

## **Therapeutic process**

Expressive therapy sessions are usually held weekly for between 30 and 60 minutes depending on the child's interest and capacity. Four different types of therapy sessions may be offered depending on the child's needs and the goals of therapy:

- individual therapy
- parent-child therapy
- sibling therapy, and
- family or group therapy.

Therapy sessions are generally held in a dedicated therapy room, equipped with a range of themed toys; painting and drawing materials; clay or playdough; sandtray with miniature figurines on adjacent shelving; puppets, dress-up and drama materials; musical instruments; and interactive electronic devices, including an iPad. In therapy sessions, therapists introduce children to means of accessing unexpressed concerns and exploring possible solutions. The expressive therapist works with each child to find the medium(s) s/he more readily responds to, e.g. drawing, painting, music, sandplay, movement, storytelling, drama or fantasy enactment. In some cases the therapist will suggest or introduce a medium. This is especially where a child is unfamiliar with being given a choice and appears overwhelmed.

There is no set number of therapy sessions for children. Following a period of therapy, the therapist will review the child's goals in consultation with the parent/carer and make a collaborative decision with the parent/carer as to whether or not to continue the therapy.

Expressive therapists routinely provide one-on-one parent education and mentoring sessions to interested and engaged parents/carers of the children enrolled in expressive therapies to support the development of skills and knowledge to enhance the security of attachment between parent/carer and child. Expressive therapists typically undertake this work in partnership with other relevantly skilled program staff and where possible integrate this with other program activities focused on parenting development, like workshops on healthy relationships, child development, etc.

When a child exits therapy, effort and care are taken to prepare them for this event wherever possible and to link the child and/or parents/carers to appropriate support and further therapy.

BoysTown employs skilled and experienced expressive therapists with relevant tertiary qualifications and a range of personal attributes considered important for effective therapeutic work with young children with trauma and attachment difficulties. All therapists receive regular operational and clinical supervision to support their therapeutic work.

## **Evaluation methodology**

In order to assess the effectiveness of the Expressive Therapies Intervention in enhancing the social and emotional wellbeing of young children, various service delivery outputs and expected therapeutic outcomes were specified. Data were then collected from a variety of different sources in relation to these outputs and outcomes for triangulation purposes.

Data sources include:

- BoysTown's Client Information Management System (BCIMS)
- pre and post intervention assessments of children's social, emotional and behavioural functioning using the Child Behaviour Checklist (Achenbach & Rescorla, 2000; 2001)
- a parent feedback survey, and
- a sample of therapists' "end-of-therapy" reports.

## **Evaluation findings**

### **Client characteristic and services delivered**

A total of 153 children and young people were enrolled in expressive therapies over the two year evaluation period (1 July 2012 to 30 June 2014). Of these, 113 children (74%) participated in therapy at the domestic and family violence refuge and 40 (26%) were referred for expressive therapies by child and family support programs based at BoysTown's Deception Bay regional centre.

A total of 981 therapy sessions were delivered to these 153 children and young people over the two years – 74% of these were individual therapy sessions, 15% were parent-child sessions, 7% were group therapy sessions and 4% were sibling sessions.

The vast majority of children who participated in expressive therapies (93%) were aged 11 years or younger and 56% were under 6 years of age. Children were enrolled in expressive therapies for between 0 and 85 weeks with a mean of 10 weeks. Children received between 1 and 42 therapy sessions with a mean of 6 sessions. On average, children participated in one session per week that they were enrolled.

## Client outcomes

Analysis of various client outcome data suggests that participation in expressive therapies is associated with a range of positive impacts on children's social and emotional wellbeing and functioning.

- *Analysis of pre and post intervention assessments using the Child Behaviour Checklist* revealed improvements from intake to exit in children's internalising problems, externalising problems and total problems including improvements in aggressive behaviour, emotional reactivity, attention problems, withdrawn behaviour, anxious/depressed behaviour and sleep problems. Not only were these improvements found to be statistically significant and to reach the threshold for a "large" treatment effect, but they were also found to have clinical significance. A substantial majority of preschool children entered therapy in the clinical or borderline clinical symptom ranges for internalising (67%) and externalising problems (70%) and at exit from therapy, just 13% remained in the clinical or borderline clinical ranges on either of these measures.
- *Analysis of parent survey data* indicated that at least four out of every five respondents observed improvements in their child's emotional wellbeing, their child's emotional regulation, their child's ability to express emotions to them, their child's behavioural adjustment, the quality of their relationship with their child, and their confidence and capacity to parent their children. In addition, more than half indicated improvements in their child's ability to express emotions to others, their social interactions and their confidence and self-esteem.
- *Analysis of therapists' end-of-therapy reports* revealed that at least four out of five reports noted improvements in the child's emotional regulation, emotional wellbeing, social interactions, ability to express emotions to others, and behavioural adjustment. In addition, more than half of the reports noted improvements in the quality of the parent-child relationship, enhanced ability on the part of the child to communicate emotions to the parent, and improvements in the child's self-confidence and self-esteem.

Note that the preschool-aged children for whom outcome data were available were enrolled in expressive therapies for longer on average than all expressive therapy clients in this age group (i.e. between 17 and 23 weeks on average (means) compared with a mean of 9 weeks for all preschool-aged expressive therapy participants). Treatment effectiveness is likely to be related to length of time in therapy so caution should be applied in generalising these findings to all expressive therapy participants.

## Significance of the findings

The findings of the current study strongly suggest that BoysTown's Expressive Therapies Intervention delivered in the context of holistic case-managed support programs for vulnerable families has immediate positive impacts on children's development of secure attachment relationships and healing from chronic childhood trauma. These findings are particularly significant given what we know about the serious long term negative impacts of developmental trauma and insecure, disorganised or disrupted attachment. They suggest children participating in therapy may have increased opportunities in the future as a result of therapy to circumvent the entrenchment of complex emotional and behaviour problems, to achieve normal developmental milestones and to experience greater emotional and social wellbeing into the future.

While the evaluation findings are encouraging, it is important to acknowledge the limitations of the research. Due to a range of practical and ethical constraints, it has not been possible for BoysTown to implement an experimental or quasi experimental research design; nor has it been able to conduct follow up assessments of participants once they have exited therapy. As a result of these constraints, it is not possible to say how much of the observed effects would have occurred naturally or as a result of other program elements. Nor is it possible to say how sustainable the observed changes are likely to be over time. However, given the timeliness of the intervention in terms of children's developmental stages and the fact that the intervention appears very often to involve not only developmental and intrapersonal transformations but also fundamental transformations in family and parent-child relationships, it would be reasonable to hypothesise that the positive impacts observed on children will have valuable repercussions well into the future. Further research is recommended to investigate this hypothesis.

# Program and evaluation background

## 1.1 Introduction

This report describes BoysTown's Expressive Therapies Intervention and presents findings regarding its effectiveness in achieving its central objective: to enhance the social and emotional wellbeing of young children with complex needs as a result of their traumatic life and family experiences.

BoysTown's Expressive Therapies Intervention has been in full operation for two years (2012/2013 – 2013/2014) following an initial pilot in 2011/2012. Over these three years, the intervention has been funded by a private donor, the Margaret Pemberton Foundation, which requested that its funds be used to improve the wellbeing and life chances of disadvantaged young children. BoysTown developed the Expressive Therapies Intervention for implementation in two of its existing sites for the delivery of services to disadvantaged families – a regional child and family support centre and a domestic and family violence refuge, both located in south east Queensland. BoysTown recognised that in both of these service delivery contexts there had been a significant gap in the therapeutic response to children with emotional and behavioural problems resulting from attachment difficulties and/or developmental trauma. It saw this initiative as a means by which to offer a more holistic and ultimately effective response to the therapeutic and developmental needs of these children.

The evaluation of the intervention is an initiative of BoysTown and co-resourced by BoysTown and the Foundation. BoysTown is strongly committed to evidence-based practice and undertakes to evaluate all the programs and services it delivers in the community to ensure that they are effective in achieving their intended outcomes. In the case of the Expressive Therapies Intervention, BoysTown had three main objectives in evaluating the initiative:

- to assess the intervention's effectiveness in enhancing the social and emotional wellbeing of young children with complex needs as a result of their traumatic life and family experiences, and thereby provide an evidence base for the ongoing funding of the intervention
- to inform ongoing therapeutic practice and service development, and
- to contribute to the evidence base regarding effective therapeutic interventions with traumatised and attachment-disturbed preschool-aged children to inform practice development across community-based children's programs.

This last objective arises from the fact that very few creative arts or play therapy interventions with preschool-aged children have been formally evaluated. While the evidence base for such interventions with school-aged children is more considerable (see for example, Baggerly, Ray & Bratton, 2012), relatively little is known about their effectiveness with very young children.

Before describing the evaluation framework and methodology and presenting the findings of the evaluation, the report provides some important background information that frames the evaluation. This information includes:

- an explanation of the rationale for developing the Expressive Therapies Intervention given contemporary theoretical understandings of the likely therapeutic and developmental needs of the children who present at BoysTown's child and family support programs
- a definition of what expressive therapies are and the evidence for their effectiveness in addressing the kinds of therapeutic and developmental needs of these children
- a description of the programmatic contexts within which the Expressive Therapies Intervention operates that shape the way therapeutic services are delivered to children, and
- key elements of the therapeutic framework that BoysTown has adopted in delivering the Expressive Therapies Intervention.

After defining the scope and purpose of the evaluation, outlining the evaluation methodology and presenting the findings of the evaluation, the report concludes with a discussion of the findings and recommendations for future directions.

## **1.2 Rationale for expressive therapies**

Many of the children who come into BoysTown's child and family support programs have experienced early caregiving environments that have been chronically stressful and in many cases traumatic, including exposure to family violence. A growing body of research suggests that these kinds of environments can have highly negative consequences for normal child development and the achievement of mental and emotional wellbeing later in adulthood (Perry *et al.*, 1995; van de Kolk, 1994; Cook *et al.*, 2005; Streeck-Fischer & van de Kolk, 2000; Schore, 2001). Trauma, attachment and neurodevelopmental theories and research together provide a valuable framework for understanding the impact of these environments on children and for devising early interventions that may be effective in enabling children to heal and develop.

This theory and research are a starting point for understanding the needs of the children presenting at BoysTown's child and family support programs and underpin BoysTown's rationale for a creative arts and play therapy intervention to address their therapeutic and developmental needs.

### **1.2.1 The needs of children affected by developmental trauma and insecure attachment**

#### **The impacts of chronic trauma on child development**

Trauma theory and research have much to offer in terms of understanding the needs of children presenting at BoysTown's child and family support programs. It is well-established that when humans are exposed to highly stressful and frightening experiences that overwhelm their ability to cope, certain neurobiological adaptations to that stress can take place which can seriously compromise normal social, emotional and cognitive functioning in an ongoing way (Herman, 1992; Stien & Kendall, 2004; van de Kolk, 1994).

Chief amongst these adaptations are:

- *dysregulation of the individual's stress arousal system* so that they are constantly in a heightened state of stress arousal which can manifest as hyperarousal, dissociation or both (Perry *et al.*, 1995; van de Kolk, 1994)
- *sensitisation of the amygdala, the part of the brain that unconsciously registers threat*, such that the individual sees threat everywhere. Due to an already heightened state of arousal, the perception of such "threats" can result in the individual rapidly escalating into acute states of stress arousal – the flight/flight/freeze effects (van de Kolk, 1994), and
- *incomplete coding and storage of traumatic memory* so that the person constantly experiences intrusive and disturbing fragments of traumatic memory – typically sensory memories – arising in conscious awareness which can also trigger rapid escalation into acute states of stress arousal (Stien & Kendall, 2004; van de Kolk, 1994).

Collectively these adaptations have serious impacts on normal social, emotional and cognitive functioning. This is because, due to the hierarchical structure of the brain, the more fully the body's stress response system is engaged, a role performed by the lower regions of the brain (brainstem and diencephalon), the more difficult it is for the higher-order parts of the brain, such as the cortex, to operate and for the various systems of the brain (e.g. sensory, motor, cognitive, emotional, etc.) to function in an integrated way (Perry, 2006; Stien & Kendall, 2004). Amongst other things, this means that the individual's ability to think and reason, solve problems, regulate emotions, control behaviour, and reflect on and learn from experience can be compromised (Perry, 2006; Streeck-Fischer & van de Kolk, 2000).



While traumatic experience can have serious negative long-term consequences for adults, trauma that occurs in early childhood, particularly that of a sustained or chronic nature, has been found to be even more profoundly damaging (Perry, 2006; Schore, 2001). This is because it fundamentally interferes with normal child development. Perry (2006) notes that the brain develops in a sequential and hierarchical way in infancy such that the individual's ability to develop more complex and higher-order regions and functions relies on first being able to develop and regulate lower-brain systems and functions. Being in a chronic state of stress and fear, as occurs when children are traumatised, means that these lower regions of the brain are perpetually in a state of poor regulation, compromising potentially every aspect of brain development associated with normal development (Perry, 2006; 2009; Perry *et al.* 1995; Perry & Pollard, 1998).

Core developmental tasks that have been found to be inhibited by the fear state include identity formation, regulation of emotional states, cognitive processing (for example, the integration of sensory, emotional and cognitive information into a cohesive whole), moral and spiritual development, ability to control behaviour, experience of bodily integrity, trust of self and others, and forming affective relationships characterised by mutuality, empathy and emotional connectedness (Cook *et al.*, 2005; James, 1994; van de Kolk, 2005; Perry, 2006; 2009; Perry *et al.* 1995; Perry & Pollard, 1998; Schore, 2001; Stien & Kendall, 2004; Streeck-Fischer & van de Kolk, 2000). Klorer (2004: 12) summarises some of the pervasive impacts of chronic childhood trauma documented in the research literature. These include: "chronic affect dysregulation, sleep problems, exaggerated startle response, destructive behaviour against self and others, learning disabilities, hypervigilance, dissociative problems, somatisation, generalised anxiety, and distortion in concepts of self and others".

Because chronic childhood trauma can have such diverse behavioural, social, physiological and cognitive consequences, the common traumatic origins of these issues is often overlooked (Bloom, 2005). It has also been noted that individuals who are suffering the psychological and developmental impacts of chronic childhood trauma often do not meet the diagnostic criteria for post-traumatic stress disorder and are instead given and treated for multiple co-morbid psychiatric diagnoses including conduct disorder, oppositional defiant disorder, somatisation disorder, borderline personality disorder, multiple personality disorder, ADHD, depression, anxiety and/or other mood disorders (Cook *et al.*, 2005; Herman, 1992; Perry *et al.*, 1995; Stien & Kendall, 2004; van de Kolk, 2005; Thomas, 1995).

A growing number of influential traumatologists have argued that this is counterproductive because it fails to capture the complexity of the problems these individuals experience. Van de Kolk (2005: 401), for example, has stated that "approaching each of these problems piecemeal, rather than as expressions of a vast system of internal disorganisation runs the risk of losing sight of the forest in favour of one tree". Along with his colleagues (Cook *et al.*, 2005) he has argued in favour of the term *complex trauma* to describe this symptomatology and proposed a new diagnosis of *developmental trauma disorder* with a view to more effectively understanding and treating the complex interrelated effects of chronic childhood trauma.

### **The role of secure attachment relationships in early development**

Attachment theory and research also provide a valuable conceptual framework for understanding the needs of children presenting at BoysTown's child and family support programs. The central proposition of attachment theory, developed half a century ago by John Bowlby (1969) and later Mary Ainsworth (1978), is that responsive nurturing relationships with caregivers are essential for a child's emotional and cognitive development. This proposition is widely accepted today following decades of extensive empirical investigation and theoretical development (Sroufe, 1988; Rofe, 2004). Influential support for this proposition has also emerged in the last two decades from neurobiological research which has found that secure attachments "produce a growth-facilitating environment that builds neuronal connections and integrates brain systems" (Stien & Kendall, 2004: 7).

Some of the core tasks of child development that are understood to be facilitated by having a sensitive, responsive, nurturing relationship with a caregiver include the following:

- development of the ability to *self-regulate emotional states* and keep arousal at a level that is comfortable so that the individual can achieve their goals (Rolfe, 2004). This is achieved initially through an attuned caregiver co-regulating the child's emotional states and over time the child developing the capacity to self-regulate emotional states and cope with stressful events (Schoore, 1996).
- development of the ability to *inhibit impulses* that are dangerous or socially proscribed and in this process learn to *regulate feelings of shame*. Schoore (1996) theorises that this is achieved by caregivers temporarily breaking their attunement with the child in response to such behaviour, causing the child to experience the uncomfortable affect of shame. Provided that experiences of shame are routinely followed by re-establishing attunement, so that the child is not overwhelmed by stress, the child gradually learns to regulate their impulses.
- development of a *sense of self-efficacy*. This is achieved because such relationships provide the child with a *secure emotional base* from which to explore the world and through such explorations gradually achieve a sense of autonomy and effectiveness (Rolfe, 2004; Schofield & Beek, 2006). The child's explorations also support rapid and rich brain development reflected in the achievement of a range of competencies – cognitive, social, emotional and physical (Stien & Kendall, 2004). Such achievements in turn support the child's emerging sense of identity, self-worth and self-efficacy (Cairns, 2002).
- development of a *positive sense of self and others*. According to attachment theory, we develop concepts of self and others (often referred to as our "internal working models") as a result of patterned interaction with caregivers (Stien & Kendall, 2004). Where a child's needs are routinely responded to with sensitivity, the child gradually develops a sense of self as being loved and cared for, of the world as a reliable and safe place, and of relationships as trustworthy and supportive.
- development of a *coherent sense of self*. Part of developing a sense of self involves achieving a sense of coherence across time and experience (Blaustein & Kinniburgh, 2010). This involves being able to integrate different parts of self and lived experience into a cohesive whole – our emotions, sensations, thoughts and actions. Children who have attuned caregivers are supported in building connections between these aspects of self in a whole variety of ways, which in turn aids the integration of brain systems (i.e. motor, sensory, cognitive, and emotional systems) (Stien & Kendall, 2004). When these connections do not exist, it is hard for children to understand themselves and to process and learn from their experiences (Streeck-Fischer & van de Kolk, 2000).
- development of *capacities for trust, empathy and relating effectively to others*. Attachment theory posits that through the model of caring responsive relationships developed with caregivers, children learn how to relate effectively to others in their worlds – how to trust, connect emotionally, communicate their needs, experience empathy and be discerning about in whom they place their trust (Schofield & Beek, 2006).

Children can be prevented from undertaking these core developmental steps in early childhood when they are exposed to chronic neglect or abuse from caregivers, or when their caregivers do not know how to meet their needs or cannot meet their needs due to their own victimisation (Rolfe, 2004; Schofield & Beek, 2006). Because these developmental steps underpin so much of later development, if children are prevented from undertaking them for whatever reason, they are at high risk of developing complex emotional and behavioural problems stemming from difficulties with emotional self-regulation, impulse control, learning delays, low self-esteem and shame, poorly developed and negative sense of self and others, and/or difficulty understanding, trusting, and relating to others. Without effective intervention, these problems can

persist and deepen through adolescence and undermine social and emotional wellbeing throughout the life course (Stien & Kendall, 2004).

### **1.2.2 Therapeutic objectives in responding to developmental and attachment trauma**

Many of the children entering BoysTown's child and family support programs display the emotional and behavioural traits of insecure, disorganised or disrupted attachment and other traumatic exposure. While some will have experienced direct abuse or neglect, many will have experienced unpredictable, unavailable or insensitive caregiving which can for a young child be extremely stressful to the point of traumatising (Perry & Szalovitz, 2006). Others will have witnessed violence against their primary caregiver or other family members and be traumatised by those experiences. And some will be traumatised by being dependent on a primary caregiver who is chronically impacted by their own victimisation. Many of these families are also affected by entrenched poverty, housing instability, disability and physical and mental health difficulties that can also contribute to stressful caregiving environments and additional challenges for developing secure attachment relationships between caregivers and infants.

Based on a trauma-attachment theoretical understanding of the needs of these children, the implied objectives of therapeutic intervention arguably include the following:

- enhancing the child's capacity to form secure attachment relationships
- enhancing the child's capacity to self-regulate emotional states and cope with stress and painful emotional issues
- assisting the child to process and integrate traumatic experience
- changing behaviours that have negative consequences
- developing a unified identity by helping the child achieve a sense of congruence with regard to thoughts, emotions and behaviours
- bringing about positive changes in the child's sense of self and others
- developing the child's ability to relate effectively to others
- increasing the child's sense of self-efficacy, and
- enabling the child to function adaptively and comfortably in the wider environment and achieve key developmental milestones.

Many of these are standard objectives of therapeutic work with traumatised and attachment-disturbed children articulated in the therapeutic and research literature (Jenkins, 2004; James, 1994; Stien & Kendall, 2004; Streeck-Fischer & van de Kolk, 2000; Cairns, 2002; Blaustein & Kinniburgh, 2010).

### **1.2.3 How expressive therapies can help achieve these objectives**

#### **Defining "expressive therapies"**

The term "expressive therapies" is generally used in two ways. The first is as an umbrella term for the full range of creative arts and play approaches used in psychotherapy and counselling (for example, Malchiodi, 2005). Malchiodi (2005) identifies seven individual approaches:

- arts therapy
- music therapy
- drama therapy
- dance/movement therapy
- poetry therapy and bibliotherapy
- play therapy
- sandplay therapy

Each one of these therapeutic modalities has its own historical development, range of preferred theoretical and practice frameworks, and specific techniques for pursuing psychotherapeutic transformations in individuals. Nevertheless, there are certain commonalities across these modalities that allow for a broad conceptual grouping of them together into what Malchiodi (2005: 2) calls "a unique domain of psychotherapy

and counselling". Amongst other things, these commonalities include an activity focus, techniques aimed at integrating experiences of mind, body and emotions, sensory processing, externalisation of internal processes and narratives, use of imagination, and (in many cases) non-verbal expression of thoughts, feelings and sensations (Malchiodi, 2005, 2008b, 2014).

The second way that the term "expressive therapies" is used is to refer to therapeutic approaches that purposefully integrate two or more creative arts or play therapy modalities (see for example, Pearson & Wilson, 2009; Knill, Levine, & Levine, 2005). Malchiodi (2005) notes that these are also called "integrated arts approaches", and "intermodal" or "multimodal" therapies. Intermodal therapy, she says, is grounded in ideas about *the interrelatedness of the arts*.

Wilson and Pearson's (2009) model of expressive therapies is one example of intermodal therapy. This model involves the integration of all seven expressive therapy modalities described by Malchiodi (2005), at least to some extent. Core techniques used by Pearson and Wilson include:

self-awareness and somatic awareness exercises, emotional release processes, energy release games, individuation processes, body focus, emotional mapping, expressive writing and use of journals, self-discovery worksheets, expressive artwork, process drawing, use of mandalas for integration, sandplay therapy, symbol work, bioenergetics, movement exercises, use of music, role-play, dreamwork, visualisation, relaxation and simple forms of meditation. (Pearson & Wilson, 2009: 14)

The integration of these modalities occurs at the level of theory and intent. The core principles and objectives underlying Wilson and Pearson's approach concern encouraging the individual's interest in self-discovery because change is viewed as the result of intra-personal processing. In particular, Pearson and Wilson's approach emphasises "working through challenging emotional distress as a way to develop emotional resilience" (Pearson & Wilson, 2009: 14). According to Pearson and Wilson, these principles and objectives are drawn from Jungian psychology, sandplay therapy, Gestalt psychology, bioenergetics therapy, transpersonal psychology, emotion-focused therapy, and humanistic psychology. Collectively, these theoretical frameworks support the seven focal areas of the therapeutic practice framework: building connection, developing self-awareness, processing emotions, transformative self-learning through use of symbol and metaphor, enhancing self-esteem, supporting integration, and developing emotional literacy and inner life skills (Pearson & Wilson, 2009).

### **The contribution of expressive therapies to children's recovery from trauma and attachment difficulties**

With the exception of child-centred play therapy (Axline, 1974; Landreth, 2002), none of the individual expressive therapy modalities, or indeed many intermodal therapy models, emerged specifically for working with children or to address childhood trauma and attachment problems. However, the last decade has seen a rapid growth in interest in the application of trauma, attachment and neurodevelopmental theories to expressive therapies for the purpose of helping children recover from childhood trauma and insecure, disorganised or disrupted attachment. Three recently published collections, *Expressive and Creative Arts Methods for Trauma Survivors* (Carey (Ed.), 2006), *Creative Arts and Play Therapy for Attachment Problems* (Malchiodi & Crenshaw (Ed.), 2014) and *Creative Interventions with Traumatized Children* (Malchiodi (Ed.), 2008a) are evidence of this movement in counselling and psychotherapy and bring together some of the emerging practice wisdom from across these diverse fields of expressive therapy. The establishment of the Expressive Therapies Institute of Australia which has a strong focus on training and publications relevant to working therapeutically with children and adolescents who have experienced trauma, is also evidence of this movement in expressive therapies (see, for example, Pearson & Nolan, 2004; Pearson, 2004; Pearson & Wilson, 2008).

In order to understand what expressive therapies may contribute to children's recovery from trauma and attachment difficulties, it is helpful to look at some of the main

therapeutic objectives identified above and outline for each one the relevance of particular expressive therapies principles, processes and/or techniques.

#### *Lowering fear/stress arousal and regulating lower-brain functions*

Bruce Perry's influential neurosequential model of therapeutics for working with maltreated and traumatised children (Perry, 2006; Gaskill & Perry, 2014) emphasises that the first goal of therapeutic intervention must be to lower the child's chronically elevated stress-arousal and stress reactivity. He argues on the basis of his research and practice that no higher-order therapeutic work can be undertaken successfully until the lower regions of the brain are regulated.

All the best cognitive-behavioural, insight-oriented, or even affect-based interventions will fail if the brainstem is poorly regulated. Extreme anxiety, hypervigilance, and a persistently activated threat response will undermine academic, therapeutic and socioemotional learning opportunities... The child must feel safe to start to heal. (Perry, 2006: 39)

Perry, along with other child trauma therapists, advocates the cultivation around the child of a warm, soothing, non-threatening environment without trauma-triggers which allows them gradually to reduce their inclination to hypervigilance and dissociation (Perry & Szalavitz, 2006; Barton *et al.*, 2012; Cairns, 2002; Foderaro & Ryan, 2000; Streeck-Fischer & van de Kolk, 2002). He also advocates the use of routine rhythmic sensory activities, like drumming, yoga, dance, and massage, which are all believed to help regulate the brainstem (Perry, 2006).

Child-centred play therapy, originally popularised by Virginia Axline in the 1940s and more recently developed and promoted by Landreth (2002), emphasises practice principles that are designed to generate exactly the kind of non-threatening environments Perry promotes. Indeed, Perry himself uses non-directive play therapy as a technique for cultivating this sense of safety with his child clients (Perry & Szalavitz, 2006; Gaskill & Perry, 2014). The eight principles of play therapy originally articulated by Axline are as follows:

- The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
- The therapist accepts the child exactly as he is, without *judgment*.
- The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
- The therapist is alert to recognise the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behaviour.
- The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
- The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
- The therapist does not attempt to hurry the therapy. It is a gradual process and is recognised as such by the therapist.
- The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of this responsibility in the relationship. (Axline, 1974: 73-74)

Similarly, sandplay therapy reflects these non-directive, non-threatening principles, as Lyons (n.d., para. 7) notes:

Sandplay is intrinsically respectful of trauma survivors' inner wisdom and inner processes as they are in complete control of their own sandplay creations and the uniquely individual meanings of their creations. The sandplay itself is usually experienced as non-threatening and relaxing. There is no therapist agenda imposed, nor any pressure to "do" anything (just an invitation to play/create a picture). The safety of this modality can help the client create a sense of safe containment of

traumatic material within the boundaries of the tray. By readily allowing for change in the representation of the inner reality, over time sandplay can also facilitate the ability to transform the experiential reality, whenever ready.

Not all expressive therapies adopt non-directive practice principles, however, and some specifically take a more directive approach, such as Theraplay, where structure and guidance are seen as key in some instances to fostering traumatised children's (and caregivers') sense of safety, regulation, organisation and containment (Booth, Lindaman & Winstead, 2014).

Whether directive or non-directive, expressive therapies all work with the senses and can be applied to activate the body's relaxation response and lower stress arousal. Malchiodi (2014: 8) notes, "Depending on the individual, experiences with art making, music, and/or movement can have a comforting and calming affect that decreases anxiety or fear". This claim is supported by a growing body of research, particularly in the area of music therapy, pointing to the power of expressive therapies in regulating stress arousal and autonomic nervous system functioning (examples of such evidence in the music therapy domain include: Pelletier, 2004; Hammer, 1996; Hernandez-Ruiz, 2005; Hartling *et al.*, 2013). Sensitivity to an individual's "trauma triggers" is nevertheless essential in this work as all kinds of sensory experience may be associated for an individual with traumatic events, even those activities that are typically associated with relaxation (Cairns, 2002).

#### *Building capacity for secure attachment and for relating effectively to others*

There is a strong consensus in the trauma-therapeutic literature that neither emotional nor cognitive therapeutic work can be undertaken successfully without a nurturing therapeutic relationship with a therapist and/or caregiver (James, 1994; Herman, 1992; Hughes, 2006; Stien & Kendall, 2004; Cairns, 2002; Perry & Salavitz, 2006; Perry, 2001; Perry, 2006; Barton *et al.*, 2012; Blaustein & Kinniburgh; Foderaro & Ryan, 2000). It is only in the context of a responsive and nurturing relationship that the child's emotional distress can be contained and ultimately confronted (Herman, 1992; James, 1994). And it is only in the context of such a relationship that the child can begin to undertake core developmental steps they have been prevented from undertaking due to insecure or disorganised attachment which underpin many of their emotional and behavioural difficulties (Stien & Kendall, 2004).

Most trauma-attachment informed approaches to working with children therefore emphasise the importance of the child-therapist or child-caregiver relationship as a mechanism for (re)building the child's capacity for secure attachment (e.g. James, 1994; Herman, 1992; Hughes, 2006; Stien & Kendall, 2004; Cairns, 2002; Perry & Salavitz, 2006; Perry, 2001; Perry, 2006; Barton *et al.*, 2012; Blaustein & Kinniburgh; Foderaro & Ryan, 2000). As with a caregiver, the therapist needs to build attunement with the child, learning to read their emotions and needs and respond to them sensitively. This relationship contributes to the child's sense of safety and their ability ultimately to process and integrate traumatic experience.

Child-centred play therapy, as indicated by the principles outlined above, has a strong relational focus. Similarly, filial therapy (Guerney, 1964; Guerney & Ryan, 2013; Landreth & Bratton, 2006; Van Fleet, 2002; Edwards, 2007), which involves therapists teaching child-centred play therapy principles to parents or caregivers, is focused on building the parent's capacity to form secure attachment relationships with their child. Malchiodi (2014: 9) argues, however, that all creative arts therapies are inherently relational therapies, involving "an active, sensory-based dynamic between practitioner and individual". Through such activities as "mirroring, role-play, enactment, sharing, showing, and witnessing", these therapies may be helpful, she states, "in repairing and reshaping attachment through experiential and sensory means".

For example, mirroring is commonly used to establish and enhance the relationship between the individual and the therapist. The goal of mirroring is not merely to have the client imitate movements, postures, facial expressions, and gestures, but to achieve a sense of connection and understanding between the client and practitioner.



This is also a form of nonverbal, right-hemisphere communication that naturally occurs in secure attachment relationships through shared gestures, postures, and facial expressions between a caregiver and child. (Malchiodi, 2014:9)

Dance/movement therapy is most often used to address attachment issues, according to Malchiodi (2014) because of its focus on the body (see, for example, Devereaux, 2014). The potential of music therapy for promoting attachment between caregivers and children is also increasingly being theorised (see Edwards, 2011) and demonstrated (see, for example, Creighton *et al.*, 2013).

### *Enhancing the child's capacity for emotional self-regulation*

Chronic childhood trauma and/or insecure attachment can result in children failing to develop or losing the capacity to self-regulate their emotional states and cope with difficult or overwhelming emotions. A key focus of therapy is therefore to build the child's capacity for emotional self-regulation.

Emotional self-regulation can be assisted by many expressive therapy processes and techniques. As already noted, expressive therapies are relational therapies that facilitate the development of a nurturing responsive relationship between the child and therapist. According to attachment theory and research, children first learn to regulate their emotional states by having their emotions co-regulated by an attuned caregiver (Schoore, 1996). So the therapeutic relationship provides a mechanism for facilitating this development in the child. Also previously noted, expressive therapies work with the senses and can be applied to activate the body's relaxation response and lower stress arousal. This is valuable in terms of making therapy possible, but it is also valuable for teaching children techniques for managing stress and overwhelming emotion into the future. Malchiodi (2014: 8) notes that expressive therapies can help individuals "find activities that are effective in tapping positive sensory experience, that can be practiced over time, and that eventually become resources for regulating overwhelming emotions". Moreover, "through carefully chosen opportunities for self-expression, individuals are able to exhibit and practice novel and adaptive behaviours, including the ability to induce calm feelings and self-soothe". Montello and Coons' (1998) study on the effects of music therapy with children with emotional, learning and behavioural disorders demonstrates this phenomenon. Music therapy clients significantly improved on the Aggression/Hostility scale of Achenbach's Teacher's Report Form, suggesting, according to the study's authors, that music therapy can facilitate self-expression and provide a channel for transforming difficult and overwhelming emotional experience into an experience of creativity and self-mastery.

One of the ways that children ordinarily learn to regulate emotions and behaviour is through the development of language to communicate their feelings effectively to others (Stien & Kendall, 2004). In the absence of such language, children will tend to act out their feelings or react to the physical sensations of those emotions without understanding. Attuned caregivers typically assist children with developing emotional literacy and understanding the relationship between their feelings, bodily sensations and thoughts. This also helps with building a unified or coherent sense of self (Stien & Kendall, 2004). In much the same way that attuned caregivers facilitate this development in children, expressive therapists teach children emotional literacy. As stipulated in Axline's (1974) play therapy practice principles, the therapist's role is to identify and reflect back to the child the feelings they are experiencing to help them gain insight into their emotional world and behaviour. An emphasis in expressive therapies on body awareness also naturally facilitates the child's growing self-knowledge and (intrapersonal) emotional intelligence, as Pearson and Wilson describe:

Counsellors can support this strengthening [of the capacity to self-reflect] through increasing client alertness to somatic responses, helping them become more receptive to acknowledging affect, and becoming more aware of beliefs and cognitive patterns. Specific self-awareness activities include use of relaxation, body focus with emotional mapping, expressive writing prompts, exploring dreams, and use of symbols and metaphor to illustrate internal states. (Pearson & Wilson, 2009: 23).

### *Trauma processing and integration*

It is widely accepted in the trauma therapeutic literature that trauma recovery ultimately involves the individual articulating what happened to them, making sense of their experiences, and finding a way to integrate it into their lives. As Herman states:

In the second stage of recovery, the survivor tells the story of the trauma. She tells it completely, in depth and in detail. The work of reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivor's life story. (Herman, 1992: 173)

This is often a very difficult process for trauma survivors because traumatic memories are generally not integrated into conscious narrative memory like other experiences (Stien & Kendall, 2004). Instead, they are left in an unintegrated, unconscious and fragmentary form, often as images, sounds, smells and sensations with few associated thoughts (Stien & Kendall, 2004). This incomplete coding and storage of traumatic memories results in perpetual troubling disturbances in trauma survivors' conscious awareness, including constant intrusion of memory fragments such that the individual feels they are endlessly reliving the trauma (Stien & Kendall, 2004; van de Kolk, 1994). Young children face a further barrier to telling their trauma stories, and that is the lack of vocabulary to capture what they have experienced.

Malchiodi (2014) notes that expressive therapies are uniquely positioned to assist with the externalisation of traumatic experience for at least two reasons. One is that they work primarily with the senses and focus on sensory processing which can help "tap the limbic system's sensory memory of the event and help bridge implicit and explicit memories of it", but also because expressive therapies are not dependent on words to tell the trauma story (Malchiodi, 2014:15). Expressive therapies have a wide range of tools, techniques and modalities available for story-telling and emotional release, and the child can choose the modality that feels comfortable for them. It has been widely observed that children (and other trauma survivors) will naturally tend to re-enact traumatic experience as a way of processing it, typically through repetitive posttraumatic play (Herman, 1992; James, 1994). Often this "trauma play" is initially repetitive, rigid and fixated without emotional expression. The role of the therapist is to facilitate the child's meaning making processes around the experience and their ability to explore and be present with the powerful emotions that sit behind their experiences that may otherwise manifest in a range of problematic behaviours.

### *Enhancing the child's self-efficacy*

Herman (1992) has noted that trauma is definitively an experience of powerlessness, of being overwhelmed by terror and being unable to escape and exert control. She notes that the lasting effects of traumatic events can themselves be overwhelming and the trauma survivor feel as if they have little control over what is happening to them, including their feelings and behaviours. Locked into recurring and oscillating states of hyperarousal and dissociation, these individuals find it very difficult to think about a timeframe beyond the present or the past. As a result, they struggle to plan and typically approach new experiences with fear (Herman, 1992).

A sense of powerlessness can also arise from having unmet attachment needs. Attachment problems impact on children's developing sense of autonomy and competence (Schofield & Beek, 2006). Insecurely attached children, and especially children with disorganised attachments, are burdened by unresolved stress and anxiety in their explorations of the world. They often do not find these explorations enjoyable and struggle to achieve a sense of themselves as autonomous and competent. This can leave them feeling powerless and without hope (Cairns, 2002).

Expressive therapies nurture children's sense of self-efficacy in a number of ways. The therapist (or the caregiver in a filial therapy context) works intentionally to create a secure emotional base for the child, so that over time the child feels safe enough to explore their physical and emotional worlds (Stewart, Whelan & Pendleton, 2014). Techniques of "co-creating", which involve the therapist partnering with the child in their play, are particularly valuable for supporting traumatised and insecurely attached

children's explorations. Through explorations in therapy, the child gradually develops a sense of competence, autonomy and mastery. One example of such mastery is developing a vocabulary to communicate emotions and sensations. This enables the child simultaneously to feel understood and understandable, and also less at the mercy of overwhelming emotional and sensory experience (Stien & Kendall, 2004).

Being supported to tell one's story, is another way that expressive therapies facilitate children's sense of empowerment, as Geldard and Geldard explain:

Enabling the child to tell their story in an environment where the child is accepted and believed, with understanding and without judgment, is an important part of the empowerment process... Empowerment involves gaining mastery over issues so that the child will no longer be excessively troubled by thoughts and memories which create anxiety and interfere with normal adaptive responses. Consequently, the child will start to have a different view of self so that self-esteem and social relationships are enhanced. Thus the child is able to integrate with more comfort into the social and emotional world. (Geldard & Geldard, 2008: 52)

Fall (2010) picks up on this theme of non-judgment and validation in child-centred play therapy as devices for building self-efficacy.

The idea that everything a child does in the play therapy session is successful is perhaps the most important source of the child's increased *judgment* of self-efficacy... There is no judgment from another person, just the present moment following of the child's feelings, behaviours, and thinking. [A] second source of efficacy information... is present when a counsellor models acceptance of the child's efficacy and effective coping strategies. A therapist might say "You did it. You made it go just where you wanted it". (Fall, 2010: 40)

This acknowledgement and validation support the child to manage anxiety physiologically, which in turn consolidates a sense of coping and being able to achieve things (Fall, 2010).

#### **1.2.4 Formal evidence base for expressive therapies**

Some of the ways that expressive therapies may support trauma-attachment therapeutic work, such as by assisting individuals to lower their stress arousal and cultivate a sense of calm and safety, have been well researched and evidenced (for example, the impact of music and art therapy on the regulation of the autonomic nervous system functioning: Ellis & Thayer, 2010; Pelletier, 2004; Hammer, 1996; Hernandez-Ruiz, 2005). However, the non-linear, non-directive and dynamic interpersonal nature of many expressive therapy approaches does not lend them easily to experimental or quasi-experimental evaluation design which is generally regarded as the standard evidentiary benchmark in the field of mental health. Accordingly, much of the evidence supporting the effectiveness of expressive therapies for treating trauma and attachment problems in children is qualitative in nature and takes the form of case presentations by therapists, what Pearson and Wilson (2009) refer to as "practice-based evidence" (for example, Perry & Szalavitz, 2006; Birnbaum, 2013; Felsenstein, 2012; and numerous examples published in collections by Malchiodi (2008a) and Malchiodi & Crenshaw (2014)). These case studies typically discuss the application of theoretical principles to practice with an individual based on their presenting history and needs and then record qualitative and sometimes quantitative changes in the individual's psychological and/or physiological characteristics in the course of therapy.

Some models or modalities of expressive therapies have been subject to more systematic controlled research, however. Two such areas are now noted: Child-Centred Play Therapy (CCPT) and Child-Parent Relationship Therapy (CPRT).

##### **Child-centred play therapy**

CCPT was originally developed by Virginia Axline in the 1940s who applied Carl Roger's person-centred therapy and non-directive therapeutic principles to her work with children (Ray & Bratton, 2010). Axline's (1974) eight principles of CCPT were noted earlier. More recently, CCPT has been promoted and refined by Landreth (2002) who has written extensively about the role of the therapist in "the art of relationship" and attempted to

systematise and define elements of practice. Numerous controlled studies of CCPT in the last decade can be seen to use Landreth's specification of playroom features and materials and therapist training and personal qualities (for example, see contributors to Baggerly, Ray & Bratton, (Ed.) 2010).

In 2000, Ray and Bratton conducted a systematic review of research on play therapy (reported in Ray & Bratton, 2010). This review examined six decades of play therapy research. Each decade, 16 to 17 studies were conducted on average and most of these compared a play therapy intervention with a control or comparison group. Participants ranged in age from 3 to 17 and play therapy sessions ranged from 2 to 100 with a median of 12 sessions. The review found positive effects of play therapy across a large number of variables including social maladjustment, withdrawn behaviour, conduct disorder or aggression, maladaptive school behaviour, anxiety, fear, self-concept, speech or language problems, depression, post-traumatic stress, ADHD and locus of control. Ray and Bratton concluded from the review of twenty century research that:

While the majority of studies were limited by small sample size, findings were favourable in support of the effectiveness of play therapy with a wide range of mental health issues. (Ray & Bratton, 2010: 5).

In 2010, Ray and Bratton undertook a meta-analysis of play therapy research focusing on studies published in peer-reviewed journals over the first decade of the twenty-first century. For selection, studies needed to demonstrate at least some aspect of experimental design and to explicitly employ a child-centred approach to play therapy. A total of 25 studies met the selection criteria. Ten studies specifically explored and demonstrated the positive effects of play therapy on children's disruptive behaviours. Six studies explored and demonstrated positive effects on children's relationships with either parents or teachers. Internalising problems, anxiety, and sexual abuse and trauma issues were explored in five studies, while other issues like ADHD, depression, self-concept, language skills, moral reasoning and social behaviour were investigated in one to three studies. Positive effects of play therapy were observed in relation to all these research areas with the exception of sexual abuse, which provided mixed result in two studies.

One controlled study of particular relevance to the current evaluation (Kot, Landreth and Giordano, 1998) investigated the use of intensive CCPT with child witnesses of domestic violence aged 4 to 10 years. Children in the experimental group received daily CCPT sessions for two weeks while those in the control group received no intervention. Significant findings for children in the experimental group include increased self-concept, decreased externalising and total behaviour problems, increased play behaviour and physical proximity to the therapist, and increased nurturing and creative play themes in children play behaviour.

### **Child-parent relationship therapy**

Child-parent relationship therapy is a form of parent-child attachment therapy, originally developed in the 1960s by Bernard and Louise Guerney (Guerney, 1964), which involves caregivers being taught child-centred play therapy principles and skills to use with their own children (Bratton & Landreth, 2010). The 20-week program aims to promote and deepen parent-child attachment relationships, change children's emotional and cognitive responses to their parents, and enable parents to become sources of emotional security for their children (Guerney & Ryan, 2013). The Guerneys called their approach "filial therapy". More recently, Landreth and Bratton (2006) have endeavoured to streamline the Guerney's model into a 10-session format, complete with a treatment manual, naming this model "child-parent relationship therapy" (CPRT).

A meta-analysis of play therapy research published in 2005 by Bratton *et al.* (reported in Bratton & Landreth, 2010) included 26 studies measuring the effects of play therapy conducted by paraprofessionals, primarily parents but also on occasion teachers and peer mentors, who were trained in play therapy procedures and supervised by a mental health professional. The authors observed that across these filial therapy studies, stronger evidence of treatment effectiveness (effect size) was found compared to traditional play

therapy, and in fewer sessions. Those studies involving parents revealed even stronger treatment effects.

In 2010, Bratton and Landreth reviewed 32 studies published since 1995 that used a control group design. Almost all (28) studies employed Landreth and Bratton's (2006) CPRT treatment protocol, which requires caregivers to attend 10-weekly two-hour group training sessions and to conduct 7 weekly 30-minute play sessions with their child using child-centred play therapy principles and skills. These studies investigated the effects of CPRT with a variety of issues and populations, including sexually abused children, children with incarcerated parents, children living in domestic violence shelters, children diagnosed with learning difficulties, autism, chronic illnesses, and a broad range of internalising and externalising behaviour problems. Outcomes observed include reductions in internalising and externalising behaviour, improvements in self-esteem, self-concept and social-emotional functioning, improvements in parent's acceptance of their child and their ability to recognise and accept their child's need for autonomy and independence, reductions in parent-child relationship stress, increased empathic interactions between parents and their children, and improvements in children's anxiety and emotional adjustment.

One controlled study of particular relevance to the current evaluation (Smith & Landreth, 2003) investigated the use of filial therapy as a treatment intervention with child witnesses of domestic violence while residing with their mothers in a shelter facility. An intensive 12-session filial therapy parenting training group was conducted within 2-3 weeks. Results revealed that child witnesses in the experimental group significantly reduced behavioural problems prevalent in child witnesses and significantly increased their self-concept as compared with child witnesses in the non-treatment comparison group. Mothers who facilitated treatment of the experimental group scored significantly higher after training on both their attitudes of acceptance and their empathic behaviour.

### **1.3 Practice contexts of BoysTown's Expressive Therapies Intervention**

BoysTown's Expressive Therapies Intervention is integrated within case-managed support programs for disadvantaged or vulnerable families. In this regard, the intervention is possibly unique as therapeutic interventions of such a nature are more likely to be delivered as standalone services by private practitioners. The case-managed support programs in which the Expressive Therapies Intervention is embedded are aimed at responding holistically to the multiple and complex presenting needs of participant families. All relevant program staff, including the expressive therapist, are involved in regular case-reviews for each family or child. The significance of this is that the work being undertaken with children and/or their parents/carers in therapy can be supported and informed by other interventions, activities and services available in these programs.

The specific elements of each program shape the boundaries of the Expressive Therapies Intervention and the role of the expressive therapist at each site to some extent. The following sections offer a description of each program to help provide this important context.

#### **1.3.1 Deception Bay Child and Family Service Centre**

The Deception Bay Child and Family Service Centre (the Deception Bay centre hereafter) comprises a group of specialist child and family support programs including the Glugor Young Parents Program, the Starfish Family Mental Health Program, and the Communities for Children Program that incorporates the CARE early intervention program for children experiencing difficulty at school, and their families. Each of these programs refer children for expressive therapy.

##### **Glugor Young Parents Program**

The principal program at Deception Bay referring clients to expressive therapies is the Glugor Young Parents Program. This program was established by BoysTown in 2004 in recognition of high levels of social disadvantage in the Deception Bay community,

significant numbers of young single parents residing in the region, and the limited access to transport and support services. The program is fully-funded by BoysTown.

The target group for the program is young parents aged up to 25 who require assistance with effectively parenting children up to 5 years of age. The program offers a combination of support, therapy and education for young parents and their children in a purpose-built facility with the aims of helping participants achieve the following:

For parents:

- increased awareness and development of individual strengths
- increased knowledge and confidence in safe parenting
- improved positive interactions between parents/carers and children through interactive sessions (e.g. play, shared meals, community based activities)
- increased capacity to recognise and meet the basic needs of children and self, and
- enhanced connection with family/carers, peers and support within the community (e.g. knowledge of and access to health, employment, training, accommodation and income support).

For children:

- improved physical health and wellbeing (e.g. improved nutrition and hygiene)
- enhanced age appropriate skills, including being assisted to reach all developmental milestones, in readiness for school or childcare.

To achieve these objectives, the program offers a range of in-house and outreach services focused variously on the family, parent or child.

*Family-focused* services include:

- casework – focused on living skills, health/wellbeing, parenting and safety
- planned activities – focused on social skill development, building community connections and relationship development through play, and
- access to a range of health and other professional and community services.

*Parent-focused* services include:

- workshops on parenting including attachment, child development, bonding and play, using recognised programs like Circle of Security
- workshops on life skills, including healthy eating, budgeting, self-care, healthy relationships, communication, cooking and craft
- personal support, both on site and through outreach, and
- continuing education and/or training for early school leavers.

*Child-focused* services include:

- child development program that aims to improve the social, emotional and cognitive skills of young children through playful exploration, using the Early Years Learning Framework
- visiting/brokered services – including speech therapy, child health, librarian and specialist workshops, and
- access to expressive therapies.

### **Starfish Program**

Starfish is a family mental health support service for children and young people in the Moreton Bay region who are at risk of developing or being impacted by mental health issues, and their families. It is funded by the Australian Government Department of Social Services.

The Starfish Program works to raise awareness of issues that may lead to poor mental health outcomes and reduce the stigma associated with mental health related issues. By increasing connections to support and reducing family stress, program participants are better able to reach their full potential.



Services offered are free and include the following:

- assessment and identification of individual and family needs
- practical assistance and home-based support
- links and referrals to other local services and resources
- targeted therapeutic groups and counselling, including access to expressive therapies
- community outreach
- mental health education
- information workshops, and
- community development

### **Communities for Children – CARE Program**

The Coordinated Advocacy and Referrals for Early Intervention (CARE) Program is delivered by BoysTown at two primary schools in the Deception Bay area as part of the Commonwealth-Government funded *Communities for Children* initiative.

CARE aims to create a safe and accessible unit of support for vulnerable children and families as a natural part of their school experience. Through case management support, practical skills development and referral to specialist services, including expressive therapies, CARE assists children and their families to function more effectively on a day to day basis and works to enhance children's self-esteem, resilience and mechanisms to cope with emotional issues and events.

CARE focuses on the best interests of the child and on enhancing their social and emotional wellbeing and school participation. Working within a welcoming and respectful environment, CARE seeks to strengthen connections between home, school and the community.

### **1.3.2 BoysTown's domestic and family violence refuge**

BoysTown's domestic and family violence refuge is fully self-funded. It was established in 2004 in response to community need for supported crisis accommodation services for women and children escaping domestic and family violence.

The target group for the program is women with children escaping domestic and family violence. The refuge offers independent-living units and houses that can accommodate large families. All families are assessed prior to entry to the service so that dynamics between families are managed. Adolescent male children when accompanied by their mother are assisted. The refuge can securely accommodate up to seven families at a time for up to 12 weeks.

The program provides strengths-based trauma-informed case management within a therapeutic framework. This includes the provision of both individualised and group support to women and their children. The refuge team approach case-management and support work holistically and collaboratively, including assessment, safety planning, facilitation, advocacy and referral in relation to a broad range of issues including income, medical, legal, parenting, mental health, drugs and alcohol, housing and social skill development needs. Services also include counselling for women, expressive therapy for children, workshop facilitation (healthy relationships, social skill development, technological safety, parent-child relationships) as well as transportation to appointments, school, etc. Outreach support, predominantly provided by telephone, is offered when families exit the program until they engage with appropriate referral services.

Program objectives include to:

- assist women and children to transition from a family violence home/living environment to a safe and secure living environment (i.e. both secure long-term accommodation and personal and inter-personal safety)
- assist women and children to begin the healing from family violence [support women's and children's emotional and social development needs]

- contribute to the domestic violence sector and advocate for the delivery of high quality, evidence-based services for women and children escaping family or domestic violence
- maintain responses, service standards and relevant legislative requirements that support work to address abuse and violence against women and children (e.g. Domestic Violence Standards for Working with Women and Children; Community Service Standards; Case Management Standards of the organisation informed by the National Standards; QLD Child Protection and Domestic Violence Acts and Federal Privacy Legislation), and
- work collaboratively with internal and external support services that contribute to addressing family and individual support needs, while on site and through appropriate outreach.

A range of services is provided to assist families and individuals to achieve their goals. These services are focused variously on the family, parent or child.

*Family-focused services* include:

- safe, secure emergency accommodation
- casework (income, medical, legal, immigration, housing, mental health, drugs and alcohol), and
- group work – educational/process workshops and residents meetings.

*Parent-focused services* include:

- individual support to address goals
- housing support and advocacy to address barriers, identification of options for tenancies, and support to transition from refuge to safe affordable housing, and
- workshops – rights and responsibilities as a tenant, *Rent it Right*, etc.

*Child-focused services* include:

- access to expressive therapies
- *Bonding to Grow* (interactive parent-child group), and
- social skills activities – across families.

## 1.4 Therapeutic framework

### 1.4.1 Therapeutic objectives and conceptual frameworks for practice

BoysTown's Expressive Therapies Intervention is an *intermodal* or *integrated arts approach* to therapy. That is, it purposefully integrates a number of creative arts and play therapy modalities, emphasising the interrelatedness of the arts, to achieve its therapeutic objectives (Malchiodi, 2005). These objectives are informed primarily by a trauma-attachment theoretical understanding of the needs of the children referred for therapy and include improvements in children's:

- emotional and social wellbeing and competence
- behavioural adjustment
- quality of attachment relationships with parents, and their
- self-concept/self-esteem.

To achieve these objectives, BoysTown's expressive therapists draw on a specific set of conceptual frameworks for their practice.

- *Pearson and Wilson's (2009) intermodal model of expressive therapies* (described in section 1.2.3) which integrates a wide range of creative arts and play therapy modalities to nurture individuals' interest in self-discovery and working through of challenging emotional distress as a way to achieve mind-body integration and emotional resilience. It emphasises the individual's inbuilt drive towards healing and growth, the importance of client-led and directed practice, and the critical importance of the therapeutic alliance.

- *Child-centred play therapy* (Axline, 1974; Landreth, 2002), which emphasises play as children’s natural medium of expression and thus the appropriate medium for therapy with children. It also emphasises the critical role of the therapeutic relationship in achieving therapeutic objectives and operates from a view of children as having an inherent tendency towards growth and maturity and as capable of positive self-direction.
- *Sandplay therapy* (Lowenfeld, 1939; Kalff, 1980; 1991). BoysTown’s expressive therapists draw on both Jungian and Gestalt approaches to working with symbolic objects in a sandtray. Kalff (1991: no page) explains: “Through free creative play, unconscious processes are made visible in a three-dimensional form and a pictorial world comparable to the dream experience”. This externalisation of unconscious emotions and thoughts in a safe and contained environment is thought to facilitate the individual’s meaning-making processes and the processing and integration of unresolved and/or traumatic experiences.
- *Filial therapy* (Guerney, 1964; Guerney & Ryan, 2013; Landreth & Bratton, 2006; Van Fleet, 2002; Edwards, 2007), which emphasises the potential to shift patterns of attachment in children’s relationships with their parents/carers through parent education and coaching, and with those shifts bring about significant transformations in children’s emotional wellbeing and problematic behaviours, their patterns of relating to others, including their siblings, and their implicit self-concept. The model of filial therapy that chiefly informs BoysTown’s Expressive Therapies Intervention is *Emotional Fitness for Children* (Edwards, 2007). This is a concise adaptation of Van Fleet’s (2002) filial therapy program for parents focusing on the development of four key play therapy skills – structuring, empathic listening, child-centred imaginary play, and limit-setting and choice-giving.
- *The neurosequential model of therapeutics* (Perry, 2006; Gaskill & Perry, 2014) which emphasises a “bottom-up” neurological approach to therapeutic work with traumatised children, starting with somatosensory processes to establish some moderate self-regulation of stress and affect arousal prior to pursuing cortically-mediated therapeutic tasks, like trauma processing and affect enhancement. It also strongly emphasises working with children in a manner appropriate to their developmental age rather than their chronological age given the pervasive and profound negative impacts that trauma and insecure attachment can have on normal child development.

While a number of these conceptual frameworks emphasise non-directive and client-led practice, and these are indeed defining aspects of BoysTown’s therapeutic framework, BoysTown’s expressive therapies framework simultaneously recognises the therapeutic value of providing direction, structure and organisation in therapeutic work with traumatised children. Structure and guidance can be essential for supporting children’s initial sense of safety and containment without which therapeutic work cannot successfully proceed. Providing structure and guidance are also often a practical necessity in the context of time-limited interventions, and this is a common reality of therapeutic work at both the refuge and the Deception Bay centre.

In addition to these key overarching conceptual frameworks, BoysTown’s expressive therapists bring to their practice a range of complementary theoretical and practice frameworks pertaining to their individual professional training in specific disciplinary areas, including art and art therapy, music and music therapy, symbol work, and mindfulness and meditation. It should be noted, moreover, that therapeutic work undertaken with an individual child is additionally shaped by the presenting needs, personality and interests of the child.

## **1.4.2 Therapeutic process**

### **Referral and intake**

Participation in expressive therapies at the refuge is open to any child aged up to 16 years who is residing at the refuge. When the refuge is busy, priority is given to children aged under 6 years in line with current research and funding priorities. At Deception Bay, children with relevant emotional and behavioural presentations are referred for expressive therapies by the Glugor Young Parent's Program, Starfish and CARE programs. In addition, external community agencies may also refer a child for therapy. Referrals from these various programs are considered if the child is within the age range (0 to 5 years for all programs apart from CARE which can refer children up to 8 years of age), if the child/family is receiving suitable case management from the referring program/agency, and if the expressive therapists have capacity within their caseloads.

The intake process involves an initial interview between the expressive therapist and the child's parent or caregiver. In this session, important background information is gathered about the child – their family and living situation, any child protection involvement, significant relationships, significant childhood events, social, emotional and behavioural issues of concern, strengths and interests, sleeping/eating patterns and other health issues, things the child and caregiver enjoy doing together, and whether other services are involved in the child's life.

The therapist provides the parents/carers with information about expressive therapies – what it involves, why it can be helpful for children, what information they will be given about what their child discloses in therapy, and the importance of caregiver feedback on whether or not therapy is helpful for their child. The parent/carer is also informed about the evaluation/research study being conducted by BoysTown on the Expressive Therapies Intervention and how their child's information might be used in that context.

The parent/caregiver's hopes for the child in participating in the program are then explored and documented. If the parents/carers consent to their child's participation in expressive therapies, the child is enrolled in the intervention.

### **Assessments and case reviews**

#### *Therapist assessment reports*

After two to four individual sessions, a formal assessment of the child's needs is completed by the therapist. This assessment documents the therapist's initial observations of the child and connects these to information presented in the intake interview. The therapist then identifies a set of goals for the child's therapy, taking into account both the parent/caregiver's stated hopes for the child as a result of participating in therapy and the therapist's emerging understanding of the child's difficulties.

Following a period of therapy, usually eight weeks at the Deception Bay centre, the therapist will review the child's goals in consultation with the parent/carer and make a collaborative decision with the parent/carer as to whether or not to continue the therapy.

#### *Case reviews*

At the refuge, the expressive therapist attends fortnightly case reviews with the client services team including the refuge manager, client services co-ordinator, caseworkers, social skills/activity workers and the domestic and family violence counsellor. The expressive therapist provides basic information about the child's progress in therapy, discusses any risks, highlights particular attributes/needs of the child and any areas where growth could occur with support from other team members. Goals are defined and reviewed within the team with joint strategies discussed to assist the children/families achieve their goals.

At Deception Bay, two different types of case reviews occur. The first are expressive therapy-specific child case reviews. A case review is conducted by the expressive therapies team for each child enrolled in expressive therapies each quarter. The purpose of the review is to ensure the quality of therapeutic processes delivered to children.

Feedback from this review process is provided to the case management team of the broader program in which the child or child's parent/carer is enrolled (i.e. Glugor Young Parents Program, Starfish or CARE). The second type of case review that takes place at Deception Bay is a family case review for the child or child's parents/carers or child's family undertaken by the case management team of the broader program within which the child, the child's parents/carers or the child's family are enrolled. These reviews generally take place each quarter for Glugor Young Parents Program and Starfish, while formal case reviews in the CARE program have only recently commenced. The child's expressive therapist either attends these meetings or provides information to inform relevant sections of the case review. Prior to CARE case reviews commencing, the relevant CARE worker was invited to the expressive therapy-specific case review instead to support coordination and collaboration in case management.

### **Child therapy sessions**

Therapy sessions are generally held in a dedicated therapy room, equipped with a range of themed toys (including the three categories of toys specified by Landreth (2002) – *real life toys* that the child can use to represent reality, *acting-out aggressive-release toys*, and *toys for creative expression and emotional release*); painting and drawing materials; clay or playdough; sandtray with miniature figurines on adjacent shelving; puppets, dress-up and drama materials; musical instruments, and interactive electronic devices, including an iPad. In some cases, when the therapeutic relationship is well-established and available to act as a container for the child's emotions and expression, therapy sessions may take place outside the therapy room in another private space that enables self-expression and learning, like, for example, the onsite vegetable garden at the Deception Bay centre. Sometimes sessions or parts of sessions may be held on an enclosed trampoline at the Deception Bay centre where this rhythmic somatic activity is useful for enabling the child to lower their stress arousal.

In therapy sessions, therapists introduce children to means of accessing unexpressed concerns and exploring possible solutions. The expressive therapist works with each child to find the medium(s) s/he more readily responds to, e.g. drawing, painting, music, sandplay, movement, storytelling, drama or fantasy enactment. In some cases the therapist will suggest or introduce a medium. This is especially where a child is unfamiliar with being given a choice and appears overwhelmed. Guiding an activity may include introducing the use of toys, even the idea of play, and may need to be modelled and introduced to the parent/carer within the same process.

Therapy sessions are held weekly where possible. In some cases therapy sessions may be conducted more frequently where the child's needs dictate; however, this frequency of therapy is generally exceptional and time-limited, particularly at the Deception Bay centre.

Four different types of therapy sessions may be offered depending on the child's needs and the goals of therapy.

- The most common type of session and the foundation for treatment is *individual therapy*. This is where the therapist works one-on-one with the child for 30-60 minutes depending on the child's capacity and interest.
- Where a therapist believes it would be therapeutically beneficial for a child, and the child's parent/carer is willing, interested and able, therapy sessions may be extended to include parent-child sessions, or *filial therapy*. Therapists provide support and modelling to parents/carers in these sessions to build their capacity to recognise and respond appropriately to their child's various attachment needs in the context of play. These sessions are usually supported by separate education and mentoring sessions conducted by the therapist with the parent/carer on their own to build the parent's skills and knowledge for undertaking this therapeutic work with their children.
- Where there are a number of children in the child's family who may have been affected by shared traumatic experiences, or where there are relationship issues

between siblings, *sibling therapy* may be offered as an adjunct or alternative to individual therapy.

- Where the therapist believes it would be therapeutically beneficial for the child, therapy may also be extended to include *family group* sessions, which include at least one parent/carer and one other sibling or family member of the child. As with sibling therapy, the general objective of these sessions is to support the healing and strengthening of family relationships after trauma, and the resolution of resultant conflict. On occasions, group sessions may also be conducted with non-family members or members of multiple families, to educate, normalise and process common traumatic experiences. Capacity to provide family group sessions is currently more limited at Deception Bay with age-constraints on sibling participation.

There is no set number of therapy sessions for children. Following a period of therapy, the therapist will review the child's goals in consultation with the parent/carer and make a collaborative decision with the parent/carer as to whether or not to continue the therapy.

### **Parent/carer education and support**

Whether or not a child's parent/carer is formally engaged in filial therapy, expressive therapists routinely provide one-on-one parent education and mentoring sessions to interested and engaged parents/carers of the children enrolled in expressive therapies to support the development of skills and knowledge to enhance the quality of attachment between parent/carer and child. This learning may be supported by the provision of written course materials for parents/carers taken from *Emotional Fitness for Children* (Edwards, 2007). Expressive therapists typically undertake this parent education and support work in partnership with other relevantly skilled program staff and where possible integrated with other program supports focused on parenting development, like workshops on healthy relationships, child development, conflict resolution, Circle of Security training (see Marvin, Cooper, Hoffman & Powell, 2002), etc.

### **Ending therapy**

#### *Planned exit*

When the exit of a child from therapy is known in advance, the therapist is able to support the child to process and prepare for the upcoming changes over a period of weeks. For children exiting the refuge, this will involve preparing for a new home, and discussing the child's fears as well as resources for coping. Children exiting therapy at the Deception Bay centre are not generally moving home, so preparation focuses more on emotional supports and strategies for getting support if needed. It is common for therapists and children to undertake an exit-focussed activity that gives weight and value to the time shared between therapist and child and symbolises the transition about to be made. There may also be a ceremonial transfer to the child of their art folder.

The therapist will also meet with the child's parents/carers to prepare them for possible changes (for example, in the child's behaviour) and to advocate on behalf of the child (e.g. communicate to the parents/carers the child's fears about the transition). The therapist will also make referrals to appropriate therapy for the child if necessary. At the refuge, outreach support may be provided to the child until links with these services are sufficiently established.

#### *Unplanned exit*

When a child exits therapy at short notice, efforts are still made to provide the child with a sense of closure wherever possible, and to link the child and/or parents/carers to appropriate support and further therapy. At the refuge, outreach support may also be provided. In some cases, however, where an exit is very sudden or, at the Deception Bay centre, where the exit follows a prolonged period of absence from therapy, such closure processes may not take place. Whether or not the exit is planned or unplanned, the therapist will prepare an end-of-therapy or exit report summarising the therapeutic work undertaken and the outcomes observed.

### 1.4.3 Staffing

#### Selection criteria

Expressive therapists employed by BoysTown are expected to provide appropriate therapeutic assessment and interventions to traumatised children using a range of expressive arts modalities. To this end, therapists are required to have a tertiary qualification in Psychology, Social Work, or Behavioural Science or an equivalently relevant tertiary qualification, with a minimum of three years' experience working as an expressive therapist. In addition, they are expected to:

- maintain professional membership of a relevant professional association, such as the Australian and New Zealand Arts Therapy Association
- be able to communicate effectively with pre-school aged children, children transitioning to school, parents and other stakeholders
- demonstrate knowledge and understanding of child-centred practice
- demonstrate knowledge and understanding of child protection and domestic violence issues, particularly impacts on children
- demonstrate experience in co-case management, and
- demonstrate a range of personal attributes, including:
  - resilience, integrity, flexibility, enthusiasm and positive attitude
  - a genuine interest in, and empathy for disadvantaged children
  - a professional and approachable demeanour, and
  - work effectively within a team.

At present, BoysTown employs three expressive therapists. Each is professionally trained in a specific set of creative/expressive arts modalities, namely:

- Music, Music Therapy and Creative Arts Therapy
- Fine arts, Creative Arts Therapy and symbol work/Sandplay Therapy, and
- Art, Art Psychotherapy and symbol work/Sandplay Therapy.

#### Supervision

Expressive therapists receive both clinical and operational (line management) supervision. All therapists receive one hour of clinical supervision each month provided on site by a BoysTown clinical practice supervisor. At the refuge, operational supervision is provided by the refuge manager on an informal basis as required. At Deception Bay, operational supervision is provided for 60-90 minutes per month by the therapists' line manager. The operational supervision provided includes systematic reflection on practice issues, administrative issues, education/development needs and on identifying and managing other staff support needs.

### 1.4.4 Key differences in the Expressive Therapies Intervention across sites

The preceding description of programmatic context highlights various differences in the delivery of expressive therapies across the two sites where the intervention is being delivered. Two key differences that are especially relevant in interpreting evaluation data are differences in target group and in the length of therapy provided. These differences are restated here. A further difference – the provision of a group expressive therapies workshop at Deception Bay to enrich parent-infant attachment– is also noted.

#### Target group

Participation in expressive therapies at the refuge is open to any child aged up to 16 years who is residing at the refuge. When the refuge is busy, priority is given to children aged under 6 years, in line with current research and funding priorities.

At Deception Bay, expressive therapies are generally targeted at children aged 18 months to 5 years who display emotional or behavioural traits of insecure or disorganised attachment and/or other traumatic exposure. Children referred from the CARE program may be aged up to 8 years.

### **Length of therapy**

Families can stay at the refuge for a maximum of 12 weeks; however, many families will depart after just a few weeks in the refuge if alternative housing and support become available or the family returns to their home or is transferred to another refuge. Often families will exit the refuge at short notice, resulting in therapy being discontinued prior to its natural conclusion or the achievement of planned therapeutic goals.

At Deception Bay, it is also common for families to exit child and family support programs at short notice due to relocation, family law or child protection issues. However, on the whole, time constraints are not as prevalent and children are generally enrolled for, and parents/caregivers are asked to commit to, an eight-week period of therapy including an initial assessment period of two to four weeks. At the end of this period, a review of the child's progress is undertaken with the parents/caregivers before the therapy concludes or is extended for another eight week block. Therapy may continue if the child's needs warrant further therapy and if the parents/caregivers and child continue to commit to participation.

### **Site-specific therapeutic services**

At Deception Bay, the Expressive Therapies Intervention has an additional component. Expressive therapists run a 10-week expressive therapies workshop to enrich parent-infant attachment ("Itsy Bitsy Calm") for small groups of young mothers with babies under 9 months of age. This workshop aims to support the development of secure attachment through sensory stimulation and creative engagement between the parent/carer and child in a supportive, calming, playful environment. The activity also aims to build young parents' peer support network (see Box 1).

#### **Box 1. "Itsy Bitsy Calm" – a group expressive therapies workshop to enrich parent-infant attachment**

##### ***Background***

The Itsy Bitsy Calm workshop series evolved during the current evaluation period as a response to a recognised gap in service delivery to young mothers of newborns. The services currently provided at Deception Bay cater for children up to 5 years of age, and these programs can be very noisy with older children taking the lead in many activities. In addition, it was observed that often the youngest children receive little stimulation or access to exploration. This can be because of their mother's fear of exposing the child to anything dangerous, their lack of knowledge about what young babies can safely be exposed to, a lack of motivation to engage with their baby, and/or ease in leaving the baby unattended in a cot or stroller. Through consultation with staff and parents, it was decided that a quieter engagement opportunity for very young children (under 9 months of age) and their parents would be useful for nurturing secure attachment between children and their caregivers and simultaneously enhancing the sensory stimulation received by these infants that is critically important for their early learning and development.

Secure attachment is best achieved in a state of calm, through sensory stimulation and creative engagement with the child's caregiver(s). Secure attachment formation in early stages of development has many positive outcomes later in life in social, emotional and cognitive wellbeing of the child. Forming these attachments with the child helps the caregiver be more attuned to themselves and the child, have a greater awareness of the child's needs, and develop a more nurturing and positive relationship with the child through their developmental stages.

##### ***Aims and objectives***

Itsy Bitsy Calm aims to provide a nurturing and supportive, safe and calming space for babies and their mothers to gently bond, interact and grow together. Based on therapeutic principles, this 10 week group program aims to be emergent and collaborative in structure, harnessing a joint discovery approach. It also aims to support the development of the child through these early developmental stages while nurturing the parent connection and bond with their children.



Objectives for the program include:

- increase and nurture the bond between baby and mother
- increase self-awareness of mother in relationship to the baby
- provide a calm and safe space for both baby and mother to experience
- provide social support and opportunity for interaction between babies, mothers and the group as a whole
- provide creative opportunities for babies and their mothers to co-create together
- provide optimal sensory stimulation for the baby's learning and development, and
- provide opportunities for active and sensory communication styles between mother and baby.

### **Activities**

Some of the activities incorporated into the program include shaving cream painting, sensory activities (e.g. bubbles, heat, cold, soft textures, smells, natural elements), developmental songs and lullabies, making scrunch mobiles, rainbow watercolour mixing, baby massage, baby body mapping, movement and trampoline interactions, collaborative painting, interactive games/play (e.g. puppets). In addition, there is a continual focus on parental reflection and observation of their child.

### **Observations from Series # 3**

The workshop series has been conducted three times to date, each time evolving slightly in structure and processes to achieve its intended objectives more effectively. In the most recent series, conducted in mid-2014, much of the interaction took place in a "lounge-room" space where mothers and children could sit on the floor or on couches. This more relaxed approach meant that mothers could allow their children more freedom to explore (rather than sitting up at a table) and the babies had more access to each other to interact.

This series continued to focus on providing a space for mothers to be supported in increasing their awareness of and connection with their baby; however, this time it also allowed for mothers to be more hands-on with babies who were not their own during the floor interaction time.

Facilitators guided the mothers to reflect on their babies' attempts for interaction, expression of feelings and needs, and movements and growth. They were also encouraged to reflect on their capacity to parent protectively and creatively, and the impact of each others' moods, actions and reactions on each other (mother and child), as well as the impact of events occurring in the wider environment.

Many other helpful and therapeutic conversations took place between participants in this series, as participants considered:

- their relationships with their own parents and how they were parented
- how these early experiences shaped them as mothers themselves
- the difficulties of parenting solely for whatever reason
- the contrasts in parenting behaviours between themselves and their partners, and
- the challenges of being young while parenting (including trying to balance their own identity with being a mother).

Facilitators observed that the group process was valid for these parents as they were able to open up these conversations and feel supported by parents in similar situations. In particular, two mothers with partners involved in the criminal justice system were able to reflect similar feelings of frustration and responsibility for also having to try and keep their partners out of jail.

Interactions between mothers and children improved noticeably and at times dramatically, with mothers more attentive to the cues of the babies. Mothers were responsive to their child's needs, and became more comfortable at 'getting down' to the child's level in interactions. Mothers managed their own anxieties around mess well, and were able to debrief with facilitators and the group around managing their expectations, and the frustrations, of not being able to control a curious baby. In particular, one mother who was quite mess-avoidant at the start of the program, was seen to embrace her baby and his curiosity with paint and allow him to explore freely. When it came time to feed, this mother held her child (covered in paint) and allowed him to breast-feed freely without worrying about how he was transferring paint to her body. It is a major change for this mother to feel relaxed and at ease with mess.

During the parent feedback session with the therapists post-program, the following statements from parent participants were recorded.

*"She really enjoyed the different textures and has opened up to experiencing different feelings"*

*"She's a lot more confident and content. She hasn't been crying much lately".*

*"I've sorta got to be more willing to do the things I see she enjoys. I hate mess so I've learnt to be more willing to try to do these things at home 'cause she loves it!"*

*"The closeness and bond has definitely strengthened. The more time we share together the more our relationship develops and grows".*

*"She really likes music. I probably wouldn't have noticed that until later (without Itsy Bitsy). She didn't have any musical toys and now we've just bought her some."*

*"We are a lot closer now, she is not shy around me any more. She will smile more and open her arms to me".*

*"She is more happy I think, and more secure with me. She is now able to interact with me on a different level."*

*"Yeah, I feel like we connected more on a different level with each other. Doing things like singing along, you grow a different bond and a different way of connecting with your child. It was really good being together. I feel like our relationship has changed since the program, and being able to do different activities together with other people was really good."*



*Calm descends at the end of the session*

### 1.4.5 Case vignettes

Four case vignettes are now presented to complete the description of the therapeutic model developed by BoysTown. Amongst other things, these case presentations demonstrate some of the ways that broader program elements support the achievement of therapeutic outcomes for children, typically by supporting, resourcing and educating children's parents/carers.

Each presentation reflects the therapeutic journey of a real-life expressive therapies client or clients. All names and identifying characteristics of these individuals have been altered, however, to ensure their anonymity.

## Box 2. Case vignette – Glugor Young Parents Program

### “Charlie” (aged 3 years)

Charlie attended the Glugor Young Parents Program with his mother, Lucy, for just over 24 months. Glugor case management and child development programs supported Charlie to increase his language output, engage socially with other children and temper his emotional regulation skills. Lucy engaged in case management to be supported in housing, furthering her education at TAFE, engaging socially with other parents, finding new social networks, and parenting support.

Lucy was very motivated to access expressive therapy (ET) for her son and attempted to enroll him in the program twice in late 2012, succeeding finally in early 2013. Charlie's father had Asperger's Syndrome and the household, although loving, could be chaotic at times. As result, Charlie tended to be emotionally reactive. This was clearly evident in his participation in Glugor program activities. The Glugor case manager, in consultation with the Glugor child development worker, referred Charlie for ET in relation to rapid fluctuations in mood and emotion, hyperactive behaviours, difficulty in following directions, lack of self-awareness, especially when around other children, and attention-seeking behaviours. He was referred as having strengths in engaging with other children and adults, being generally fearless of situations, being motivated to play and explore, and for being exceptionally motivated by music (especially the didgeridoo).

In total, Charlie received 19 ET sessions (7 individual sessions and 12 parent/child sessions with Lucy) towards the end of his Glugor Program enrollment. Goals for his program focused on:

- his abilities to communicate his emotions and needs effectively
- his capacity for understanding choices and the consequences or rewards of these decisions
- to develop his own sense of boundaries and ability to respond to limits set by others
- increasing his capacity for self-awareness, and
- supporting his natural and keen sense to explore and be creative.

Charlie engaged with energy, vigor and happiness through mixed mediums to address his goals. Therapeutic progress was evident across all goal areas with notable achievements in relation to increased frustration tolerance, decreased anxiety and hyperactivity, increased abilities to self-soothe, increased parent-child interaction, and increased self-concept and self-esteem.

Lucy was jointly supported by Glugor Young Parents Program and ET to become more aware of: Charlie's natural communication and play styles; his triggers and cues; need for structure and predictability in relationships and interactions; his preference for preparation and choice; her own emotional responses to Charlie's actions, therefore increasing her own tolerance and patience; and the level of understanding Charlie had for the interactions (both positive and negative) in the household. Lucy became more attentive to details in their relationship and was able to find new ways to communicate Charlie's needs to her partner (Charlie's father) so that co-parenting was smoother and better structured for Charlie. Lucy provided feedback at the end of the program to state:

*“Charlie is able to express his feelings more and interact with other children better. I find he is able to stop and listen more. I think he sees me more like a 'toy' now, which is great because I never thought about it that way before and I'm able to respond in a more playful way. He is responding very well to choice and this definitely has helped stop tantrum behaviours”.*

### **Box 3. Case vignette – BoysTown’s domestic and family violence refuge**

#### **“Henrietta” and her two sons “Samuel” (aged 9) and “Jackson” (aged 5)**

Henrietta and her two sons entered the refuge after an event at the family home. The boys’ father was making threats, stating that he wanted Henrietta to die, and throwing things around the house. Two years prior to this event, Henrietta had left her partner and her two boys in an attempt to improve her mental health and build her self-esteem. She stated that at this time in her life she believed her children would be better off with their father because she “thought I was a horrible Mum”. Henrietta saw her children at weekends and as her confidence improved she began to realise that her children would be safer with her. The family home was abusive and the children’s environment was overly controlled by their father. Samuel has Asperger’s Syndrome and struggled to respond to direction in a conventional manner. He was frequently forced by his father to stay in his bedroom for being “disobedient”, sometimes isolated in this way all weekend long. Samuel also had an insecure attachment with Henrietta who struggled with her mental ill health after his birth. Samuel wet the bed routinely 2-3 times every night, he was frequently constipated, struggled to make friends, and struggled to regulate his emotional expressions, sometimes becoming aggressive toward his mother.

When arriving at the refuge, Henrietta reported that Samuel was exhibiting some sexually inappropriate behaviours. She shared her own experience of sexual abuse with the expressive therapist and discussed how she was being emotionally triggered by her son’s non-verbal communication. Henrietta and the therapist worked together to form new ways of responding to Samuel, so that a line of communication could begin to be built between mother and child that would allow Samuel to share any worries without fear of judgment or rejection.

The therapist offered individual expressive therapy sessions to both children to help build for them a safe and supportive relationship with someone external to the family. Once this relationship had been established, she then began to run family group sessions focussed on addressing the topic of healthy versus unhealthy relationships. This group work unsettled Samuel and he struggled to engage in the activities, often being aloof. Although Samuel remained on the periphery of the therapy room, he continuously monitored the discussions happening between the other group members and provided his own input. Jackson responded to the activities well and provided valuable reflection that helped the group explore important topics. Hearing his mother’s and brother’s input helped Samuel to process some of these uncomfortable topics in a safe, supportive environment.

Samuel’s relationship with the therapist improved over time and Samuel became more able to sit with and reflect on his uncomfortable feelings. Samuel’s sexualised behaviours ceased and Henrietta reported that her son was happier and calmer than he had ever been. Samuel’s relationship with his mother and brother also improved. Samuel was now approaching them and seeking affection, was more able to verbalise how he felt without becoming distressed, and was able to enjoy playing games, singing, and dancing – activities he had previously been unable to enjoy.

On entry to refuge, Samuel and Jackson’s father applied for a recovery order. Henrietta’s case worker supported her with legal matters – assisting her with a Domestic Violence Order application, and parenting response to the recovery order.

During her stay at refuge, Henrietta completed nine healthy relationships workshops, four social skills development workshops and the eight-week Circle of Security parenting program (Marvin, Cooper, Hoffman & Powell, 2002 – a program that teaches parents to recognise and respond appropriately to children’s different attachment needs). The housing case worker and support staff assisted Henrietta to move into transitional housing and supported her to furnish her entire home – from furniture and white goods, to bed linen and utensils in the kitchen.

Henrietta’s children were supported by the refuge social skills activity workers to enrol in school and were transported by them to school daily. Henrietta and the children engaged in social outings and activities on a regular basis and social skills workers collaborated with the family to set and work towards their individual goals.

#### **Box4. Case vignette – Glugor Young Parents Program**

##### **“Duke” (aged 4 years)**

Duke and his mother Marion were referred to the Glugor Young Parents Program in late 2010 when Duke was only 8 months old and Marion had just celebrated her 18<sup>th</sup> birthday. Marion engaged with case management for 18 months at this time to address goals in: finding housing; obtaining her license and purchasing a car; finding social contacts; increasing parenting knowledge; gaining qualifications for employment; and being supported in regard to her relationship with Duke's father. At that time Marion completed her goals and exited the program.

Marion and Duke were referred to Glugor again in September 2013 after the birth of Duke's brother, Aidan. At this time Marion and her children had been living in difficult circumstances with Marion's mother (who was reported to be verbally and emotionally abusive towards Marion). Marion received support to find alternative accommodation; however, this move was one of six or seven within the previous twelve months. Marion presented positively but found it difficult to address problems unless they were extremely obvious, meaning that generally change for her family was reactive, rather than preventative.

The Glugor case manager and child development worker referred Duke for expressive therapies in October 2013 as he often displayed attention-seeking and aggressive behaviours towards his mother and other children. Marion described that over the previous year he had been very demanding of her attention, was controlling and impatient towards her often punching and scratching, would routinely demand to be carried, would throw tantrums and end up vomiting, and would display much difficulty separating from her. His social skills were reported to be limited and he had difficulty sharing with other children, preferring to seek out adult attention. Duke was also observed in Glugor child development sessions to be difficult to engage and to refuse to engage in any new or unfamiliar tasks.

Marion attributed Duke's obvious lack of feeling secure to the frequent household changes. Shortly after referral to expressive therapies, Marion secured more permanent housing with her brother; however, over time this placement also proved limiting and constrictive as her brother was reported to be intolerant of noise and the house was not particularly child-friendly. Marion would often express exhaustion from not getting a break; however she also demonstrated various self-imposed limitations for change. The family had regular contact with Duke's father but were not living with him. Duke's father had been reported by Marion to parent very differently to how Marion desires to parent, and for that reason, amongst others, Marion decided to live separately from Duke's father.

Duke received a total of 23 expressive therapy sessions comprising a mixture of both individual and filial therapy sessions. Goals for Duke's therapy focussed on supporting his capacities for: self-expression; understanding and better regulating his emotions, experiences and relationships; adhering to boundaries and limits; dealing with intense emotions appropriately; working within structure and calm environments; self-soothing and mindfulness. He demonstrated achievements in all these areas. Considerable support was provided to Marion by both the expressive therapy and Glugor teams to develop the *Emotional Fitness for Children* skills (structuring, emotional listening, imaginary play and limits/choice setting (Edwards, 2007)). As a result, Marion concentrated on creating a strong, calm and responsive bond between herself and Duke, and modelled appropriate play and interactional skills within this creative, one-on-one relationship in expressive therapies. Marion also did extensive work on routine setting in the home to create predictability for Duke and his brother, using visual cards and time lines.

At times, Marion's own anxiety became a trigger for Duke's challenging behaviour and support was provided to Marion to become more aware of the impact of her own emotions. Marion had not been in a space to address the sources of her own anxiety throughout her time in Glugor, however has stated she is aware of these influences. At the time of exiting therapy, Marion had turned her focus to school readiness and a speech/language assessment for Duke. Both Glugor and expressive therapy teams saw improvement in Duke's emotional regulation although could clearly identify spikes in anxiety when Marion's focus was turned towards her other son, Aidan, and away from Duke. The dependence Duke showed for Marion was clearly reciprocated at times, and this inability to separate calmly created problems for Marion when parenting two children. The family will exit the Glugor program at Christmas this year (2014).



## Box 5. Case vignette – BoysTown’s domestic and family violence refuge

### “Jacob” (aged 4 years)

Four-year old Jacob presented as extremely shy and nervous in new situations and around other people, often hiding behind his mother and older sister, clinging to their clothes. He expressed huge fear when leaving the house, pulling at his mother and begging her to stay inside. On one occasion, when a staff member entered the family home, Jacob panicked, pulled all of his clothes off in desperation, and hid from staff. Jacob had good English language capabilities but used his words very little, often communicating non-verbally, too fearful to speak. When he did speak, he often whispered under his breath.

Jacob’s father, the accused perpetrator, was described as paranoid and jealous. Jacob, his siblings and mother were rarely allowed to go out, and so Jacob had very little contact with children his own age. His father would return home and begin arguments, sometimes hitting Jacob. Jacob and his other family members would run and hide in another room in fear.

When Jacob presented for his first therapy session, he appeared anxious, oversensitive to visual stimulation, extremely shy and desperate to have the play items close to him. Jacob struggled with direction, moved chaotically around the room, and struggled with containment.

The therapist simplified the sessions, reducing stimuli. She began with early intervention work, focussing on the exploration of sensory stimuli such as sound, movement, sand, water, and paint, adding play items gradually so that exploration was not too overwhelming. The therapist simplified her directions via visual prompts, to more clearly communicate important boundaries within the therapy space and develop a feeling of safety and security for the child. The therapist provided regular containment and holding of the child’s messy chaotic expressions.

Jacob became gradually more familiar and comfortable with the stimuli, and the therapist’s presence. In time he explored each texture with immense pleasure, experiencing such stimuli freely for the first time. Jacob’s confidence grew and he began using his voice, no longer whispering. After many weeks, Jacob began naturally to search for new experiences. The therapist began introducing him to more age appropriate play, such as structured activities and imaginary play (abilities of the pre-frontal cortex) – areas where the child had previously shown limited ability. Jacob moved between developmental stages during each session, using the room to meet his needs.



*Examples of tactile exploration*

His fear of the outdoors gradually disappeared and he embraced his new-found freedom, making new friends and wanting to play with others all of the time, complaining to his mother when having to go home.



*Imagination: Tea party with 'all my friends'*



*Focus & Planning: Completion of a craft activity*

### **Conclusion:**

Neurodevelopmental research indicates that a child is unable to develop the cognitive, rational pre-frontal cortex of the brain (responsible for concentration, inhibition, and learning) without the healthy development of the lower regions of the brain (emotion and survival). Jacob's brain was continuously flooded with stress hormones, hindering his ability to concentrate and learn, with fear preventing him from speaking and using his voice until he came to refuge. By being at the refuge, Jacob had the opportunity to begin to feel safe.

Jacob's sensitivity to threat was heightened as a result of growing up in a context of domestic and family violence with his experiences of the outside world limited. Jacob perceived almost everything, including new experiences, as dangerous. If left unattended, Jacob may have struggled with confidence to explore the world around him, socialise with others and learn from his environment, reducing his development across all spectrums. Therapy offered Jacob the opportunity to experience his fears in a supported trusting relationship at his pace. The structure of the space provided important boundaries to maintain containment of Jacob's overwhelming feelings, whilst also encouraging exploration and freedom. Once Jacob's brainstem had stabilized and he no longer felt constant threat, his movement, emotional and cognitive brain regions were able to begin taking in information and making sense of his traumatic experiences.

## **1.5 Purpose and scope of evaluation**

### **1.5.1 Purpose**

BoysTown has three main objectives in evaluating the Expressive Therapies Intervention:

- to assess the intervention's effectiveness in enhancing the social and emotional wellbeing of young children with complex needs as a result of their traumatic life and family experiences, and thereby provide an evidence base for the ongoing funding of the intervention
- to inform ongoing therapeutic practice and service development, and
- to contribute to the evidence base regarding effective therapeutic interventions with traumatised and attachment-disturbed preschool-aged children to inform practice development across community-based children's programs.

This last objective arises from the fact that very few creative arts or play therapy interventions with preschool-aged children have been formally evaluated. While the evidence base for such interventions with school-aged children is more considerable (see for example, Baggerly, Ray & Bratton, 2012), relatively little is known about their effectiveness with very young children.

## **1.5.2 Scope**

### **Period of evaluation**

Almost all data analysed in this evaluation pertain to the period of 1 July 2012 to 30 June 2014. This corresponds to the first two years of the intervention's operation which followed the pilot in 2011/2012. A small number of parent surveys completed immediately prior to the start date of the evaluation (April to June, 2012) have been included in the analysis to increase the survey sample size and thereby the reliability of survey findings.

### **Target population**

The evaluation will provide general descriptive data in relation to the entire cohort of children and young people enrolled in the Expressive Therapies Intervention during the period of the evaluation. The primary target for the intervention, however, is children aged 0-5 years, and the central objective of the intervention concerns improvements in the social and emotional wellbeing of "young children"; accordingly, outcome analysis will focus primarily on data pertaining to children who were aged 0-5 years at intake to therapy.

### **Exclusions**

The current evaluation excludes the 10-week group expressive therapies workshop "Itsy Bitsy Calm" being run at the Deception Bay site. It is recommended that a dedicated evaluation methodology be developed for this initiative in the future.

## **Methodology**

In order to assess the effectiveness of BoysTown's Expressive Therapies Intervention in enhancing the social and emotional wellbeing of young children, various service delivery outputs and expected therapeutic outcomes were specified. Data were then collected from a variety of different sources in relation to these outputs and outcomes for triangulation purposes. This section first outlines the outputs and outcomes that were specified and then describes each of the data sources drawn upon.

## **2.1 Outputs and outcomes**

### **2.1.1 Outputs**

The evaluation will consider a range of outputs relevant to assessing the scope and nature of service delivery to children in the Expressive Therapies Intervention. These include the:

- number of children engaged in expressive therapies
- number of individual therapy sessions with children
- number of filial therapy sessions
- number of group sessions with clients
- average number of sessions per client
- age profile of children engaged in expressive therapies, and
- number of child clients with goal plans.

### **2.1.2 Outcomes**

In order to assess the effectiveness of the Expressive Therapies Intervention in enhancing the social and emotional wellbeing of young children with complex needs as a result of their traumatic life and family experiences, the evaluation will consider evidence of the following expected outcomes for young children:

1. Improved behavioural adjustment
  - a. reduced behavioural problems



2. Enhanced social and emotional wellbeing
  - a. reduced internalising behaviours
  - b. enhanced social interaction
  - c. increased emotional literacy
  - d. improved emotional regulation
  - e. enhanced/increased expression of emotion
3. Enhanced self-concept and self-esteem
4. Increased strength of parent-child relationship
  - a. enhanced interactions
  - b. enhanced quality of attachment
  - c. increased communication
  - d. increased emotional expression of child to parent

## 2.2 Data sources

### 2.2.1 Mapping outcomes/outputs to data sources

Data were gathered from a variety of sources to evidence these outputs and outcomes, including:

- BoysTown's Client Information Management System
- pre and post intervention assessments of children using the Child Behaviour Checklist (Achenbach & Rescorla, 2000; 2001)
- parent feedback survey, and
- therapists' "end of therapy" reports.

Table 1 maps the evaluation outputs and outcomes to the various data sources. Each data source is subsequently described, along with the:

- relevant outcomes or outputs that were the focus in analysing the data
- participant sample
- procedures involved in the data collection where relevant, and
- types of analysis undertaken.

### 2.2.2 BoysTown Client Information Management System (BCIMS)

BCIMS stores all client information data, including participation in specific programs and activities. It is the exclusive source of data for reporting on all service delivery outputs relevant to the Expressive Therapies Intervention. Service delivery outputs are reported in relation to the entire cohort of children and young people who have participated in expressive therapies in either program throughout the evaluation period.

### 2.2.3 Pre/post assessments on Child Behaviour Checklist (CBCL)

#### *Description*

The CBCL comprises a suite of standardised instruments for measuring the emotional, behavioural and social functioning of children aged 18 months to 18 years (Achenbach & Rescorla, 2000; 2001). These instruments are widely used for diagnosing a range of behavioural and emotional problems in children, including ADHD, oppositional-defiant disorder, conduct disorder, depression, anxiety and phobias. The two instruments that have been used for the current study are completed by parents/carers. They assess parents' perceptions of their child's behaviour, adjustment, and emotional and social functioning.

The first instrument, the Preschool CBCL/1.5-5 is designed for completion in relation to a child aged 18 months to five years inclusive. The Preschool CBCL/1.5-5 has three main problem scales – internalising problems, externalising problems and total problems. In addition, it has seven behaviour subscales (or "syndrome scales"), comprising

**Table 1. Evaluation outcomes and relevant data sources**

Outcome/output	Target age group for analysis	Data source			
		BCIMS data	Pre/post CBCL data	Parent feedback survey	End-of-therapy reports
<b>1. Service delivery outputs</b>					
a) Number of children engaged in expressive therapies	0-16 years	x			
b) Number of individual therapy sessions with children	0-16 years	x			
c) Number of filial therapy sessions	0-16 years	x			
d) Number of group sessions with clients	0-16 years	x			
e) Average number of sessions per clients	0-16 years	x			
f) Age profile of children engaged in expressive therapies	0-16 years	x			
g) Number of child clients with goal plans	0-16 years	x			
<b>2. Improved child behavioural adjustment</b>					
a) reduced behavioural problems	0-5 years		x	x	x
<b>3. Enhanced child social and emotional wellbeing</b>					
a) reduced internalising behaviours	0-5 years		x	x	x
b) enhanced social interaction	0-5 years			x	x
c) increased emotional literacy	0-5 years			x	x
d) improved emotional regulation	0-5 years		x	x	x
e) enhanced/increased expression of emotion	0-5 years			x	x
<b>4. Increased strength of parent-child relationship</b>					
a) enhanced interactions	0-5 years			x	x
b) enhanced quality of attachment	0-5 years			x	x
c) increased communication	0-5 years			x	x
d) increased emotional expression of child to parent	0-5 years			x	X
<b>5. Enhanced child self concept and self-esteem</b>	0-5 years			x	x

emotionally reactive, anxious/depressed, somatic complaints, withdrawn behaviour, sleep problems, attention problems and aggressive behaviour.

The second instrument, the School-age CBCL/6-18, is designed for completion in relation to a child aged 6 to 18 years. Standardised scores are calibrated slightly differently for children aged 6 to 11 from those aged 12-18. They are also standardised differently for male and female subjects, reflecting gender and age differences in behaviour in the wider population. The School-age CBCL/6-18 also has three main problem scales – internalising problems, externalising problems and total problems. In addition, it has eight behaviour subscales (or “syndrome scales”), comprising anxious/depressed, withdraw/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour and aggressive behaviour.

#### *Outcomes/outputs*

The main problem scales and subscales of the CBCL instruments provide evidence in relation to the child’s behavioural adjustment and emotional and social wellbeing.

### *Participants*

During the evaluation period, complete pre and post intervention assessment data was gathered for 30 children in the 1.5 to 5 year old cohort and 20 children in the 6 to 16 year old cohort.

### *Procedures*

Immediately prior to, or at the time of the first therapy session, parents/carers are asked to complete the CBCL assessment for their child to provide a baseline measure of the child's functioning. At the refuge, this initial assessment usually takes place a week or two after the family enters the facility in order to reduce the likelihood that assessments will be systematically biased by high levels of emotional stress that typically accompany the move into refuge. Parents/carers are then asked to complete the assessment again at the conclusion of therapy to assess progress in different areas of functioning.

The assessment form is either completed by the parent/carer or by the parent/carer with the assistance of the therapist. Such assistance is often provided due to language or literacy difficulties on the part of parents/carers. Therapists are instructed to take care with not biasing parents'/carers' responses, however, focusing them on the instructions given on the form. The form presents respondents with a series of items that describe a child. They are asked to indicate in relation to their child whether the description is "not true" (as far as they know), "somewhat or sometimes true" or "very true or often true". The standard instructions for completion of the form specify a 2 month timeframe of observation, but for the purposes of this evaluation where involvement in therapy may be quite short-term, the timeframe was amended to 2 weeks.

### *Analysis*

Dependent *t*-tests were used to assess statistically significant differences in mean pre- and post-therapy scores on the CBCL instruments where the distribution of the difference in pre and post scores on a scale or subscale was found to be normal. Where the distribution of the difference in scores was found not to be normal, the difference in mean pre and post therapy scores was assessed using a non-parametric difference-of-means test – the Wilcoxon signed-rank test. Treatment effect sizes for all pre-post measures were calculated using Pearson's correlation co-efficient (*r*). An *r* value of .5 or greater is generally considered a large treatment effect size while an *r* value of .3 is regarded as a moderate treatment effect size (Field, 2009).

## **2.2.4 Parent feedback survey**

### *Description*

A survey or interview guide comprising six open-ended questions was developed to elicit from parents/caregivers of children involved in expressive therapies their observations about impacts/outcomes/changes in their children relevant to the desired outcomes of the therapeutic intervention.

Survey data was collected from parents/caregivers to provide a broader qualitative perspective on outcomes achieved than it is possible to obtain from the CBCL or from worker observations.

### *Outcomes/outputs*

The questionnaire was designed specifically to elicit observations in relation to the outcomes of improved behavioural adjustment, enhanced child social and emotional wellbeing, increased strength of parent-child relationship and enhanced child self-concept and self-esteem.

### *Participants*

All parents whose children were enrolled in expressive therapies for a minimum of three weeks were eligible to participate in the survey. However, for the purposes of the current evaluation, only surveys completed by parents/carers in relation to children under 6 years of age are included in the analysis. A total of 22 parent surveys met this criterion. A decision was made to include an additional 6 surveys completed immediately prior to

the evaluation period (April to June 2012) to increase the sample size and resultant reliability of data analysis.

### *Procedures*

The survey was completed as an interview conducted by the therapist with the parent, with the therapist writing down the parent's observations. Therapists provided parents/carers with various prompts included in the questionnaire to help elicit relevant information. Therapists were asked to record the parents'/carers' voice, not paraphrase their responses.

### *Analysis*

Because the survey questions were specifically intended to elicit qualitative information in relation to the achievement of various intended outcomes, each completed survey was analysed to identify whether these outcomes were observed or not. Eleven inter-related and overlapping qualitative outcomes were specified for this purpose as defined in Table 2.

**Table 2. Qualitative outcomes examined in analysis of parent surveys and end-of-therapy reports**

Qualitative outcome explored	Description
1. Increased child emotional wellbeing	Happier, calmer, less emotionally reactive, recovers from upset more quickly, knows how to self-soothe or draw on caregiver to co-regulate emotions
2. Improved child behavioural adjustment	Less internalising problems (anxiety/depression/withdrawn behaviours) or externalising problems (attention problems, aggression, emotional reactivity, rule-breaking/defiance, etc)
3. Improved child social interactions	Shows more empathy, understanding or curiosity about others, increased ability to cooperate, share, tolerate, communicate effectively/express needs, being less physically or verbally aggressive towards others
4. Improved child emotional regulation	Any of qualitative outcomes 1, 2, 3, 5 and 6
5. Enhanced ability of child to express emotions to others	Increased ability to use words to express emotions rather than acting out feelings
6. Enhanced ability of child to express emotions to parent	Subset of qualitative outcome 5 where parent is specifically referred to
7. Increased child confidence/self-esteem	This includes an increased sense of confidence to try new things, an improved sense of self as loved, lovable, deserving of respect (e.g. standing up for oneself if necessary), coming out of one's shell
8. Increased quality/strength of parent-child relationship	This is primarily about improvements in attachment quality or attunement/communication between parent and child – how well the parent and child read each other's emotional states and respond to each other. The parent is better able to comfort the child, play with the child, support the child in their explorations and the child is more willing to rely on the parent, interact with the parent, look to the parent for support and a refuge to return to
9. Increased parenting confidence	Parent notes feeling more confident as a parent, more sure of how to respond to their child, understand or meet their needs, provide appropriate boundaries, comfort, etc.
10. Improved capacity to parent	Parent notes feeling they have improved skills and/or knowledge about how to care for their children and respond to their needs. They see themselves as being more understanding, responsive, reflective, able to come up with relevant strategies for situations
11. Evidence of trauma processing	Trauma processing includes a wide range of things: its initial phase is often repetitive symbolic/behavioural (i.e. non-verbal) re-enactments of the traumatic event(s); with the help of the therapist the child may start to unpack thoughts and emotions around these experiences in words. This can involve making connections between distressing emotions and physical sensations and in time learning how to relieve these physical sensations/emotional states through body work and/or talking/using creative expression, etc. Further steps in trauma processing include grieving about things lost in the process, and coming to build trusting relationships with others, sometimes for the first time if an individual is a child and trauma has been interpersonal and chronic

For each of these outcomes, surveys were coded according to whether the outcome was observed, was not observed or was not commented on by the parent/carer. Coded data were then analysed in terms of frequencies and proportions.

### **2.2.5 End-of-therapy reports**

#### *Description*

At the conclusion of a child's therapy, the therapist completes an end-of-therapy report summarising the therapeutic work undertaken with the child and progress made toward the therapeutic goals established for that child. Accordingly, end-of-therapy reports are a valuable source of data about therapeutic outcomes achieved.

It is important to note, however, that these reports were not designed specifically for collecting outcome data related to the objectives of the evaluation. Accordingly, they do not prompt therapists to comment on particular outcomes of interest to the evaluation as these may not (all) be relevant for a particular child. Therefore observations relevant to these evaluation interests may not be reported. The end-of-therapy reports also inherently focus on the child's progress, rather than the parent's, and therefore are likely to under-report observed changes in the parent, such as improved parenting confidence. Therapists may not see the child in social contexts, moreover, and accordingly may not be able to reflect reliably on improved social interactions. In addition, end-of-therapy reports may be used for a variety of therapeutic or administrative purposes by different therapists which shapes the information that gets recorded. One such purpose can be to provide feedback and closure to a parent/carer whose child has participated in therapy, for example.

These various issues limit the reliability and validity of exit reports as a source of data for evaluating the achievement of therapeutic outcomes in a systematic way. Nevertheless, considered together with other sources of data, they are likely to enrich the overall picture of the intervention's efficacy.

#### *Outcomes/outputs*

It was anticipated that the end-of-therapy reports would provide evidence in relation to the outcomes of improved behavioural adjustment, enhanced child social and emotional wellbeing, increased strength of parent-child relationship and enhanced child self-concept and self-esteem.

#### *Participants*

To be included in the analysis, an end-of-therapy report needed to pertain to a child who was under 6 years of age at entry to therapy and who had been enrolled in therapy for a minimum of 3 weeks during the evaluation period. A total of 33 exit reports met these selection criteria.

#### *Analysis*

As per the parent survey, each end-of-therapy report was analysed to identify whether the 11 qualitative outcomes defined in Table 2 were observed, were not observed or were not commented on. Coded data were then analysed in terms of frequencies and proportions.

## **2.3 Strengths and limitations**

The main strength of the current methodology is its incorporation of multiple triangulating data sources to evidence the desired therapeutic outcomes, including both qualitative and quantitative data. Triangulation increases the likelihood that observed outcomes reflect real outcomes.

Due to a range of practical and ethical constraints, however, it has not been possible for BoysTown to implement a true experimental design which would involve a control or comparison group; nor has it been possible to conduct follow up assessments with participants once they have exited therapy. As a result of these constraints, the current methodology is unable to establish whether observed improvements in children would

have occurred naturally anyway or as a result of other program elements. Nor can it speak to the sustainability of changes over time.

## Findings

### 3.1 Client profile and services delivered

A total of 153 children and young people were enrolled in the Expressive Therapies Intervention over the two year evaluation period (1 July 2012 to 30 June 2014). Of these, 113 children (74%) participated in therapy at domestic and family violence refuge, 26 (17%) were referred for expressive therapies from Glugor Young Parents Program, 10 (6%) were referred from either the Starfish or CARE programs, and four (3%) were referred from external agencies in the Deception Bay area.

BCIMS data indicate that a total of 981 therapy sessions were delivered to these 153 children and young people over the two years – 729 (74%) of these were individual therapy sessions, 145 (15%) were parent-child sessions, 71 (7%) were group therapy sessions and 36 (4%) were sibling sessions.

Table 3 provides a summary of client characteristics and service delivery outputs pertaining to the evaluation period. This information is provided for the total sample (far right hand column); it is also disaggregated by site (refuge and Deception Bay centre) and also by age cohort (0-5 year olds, and 6-17 year olds).

Data for the total sample indicate that the vast majority of children who participated in expressive therapies (93%) were aged 11 years or younger and 56% were under 6 years of age. Children were enrolled in expressive therapies for between 0 and 85 weeks with a mean of 10 weeks. Children received between 1 and 42 therapy sessions with a mean of 6 sessions. On average, children had one session per week that they were enrolled in expressive therapies.

Comparing participants across the two sites (second and third columns from the left in Table 1), children at the refuge were older on average, reflecting the different target populations of the respective programs. Proportionately, there were more males participating in therapy at the refuge (56% cf. 48%). The most notable differences between the two sites, however, are the length of enrolment in expressive therapies and the frequency or intensity of therapy sessions. Children at the refuge were enrolled for between 0 and 14 weeks with a mean of 5 weeks. Children at Deception Bay, on the other hand, were enrolled for between 3 and 85 weeks with a mean of 23 weeks. At the refuge, the mean number of therapy sessions received by children was 5 while at Deception Bay it was 11. On average, children at the refuge received one therapy session per week enrolled in therapy while children at Deception Bay received one therapy session per fortnight on average.

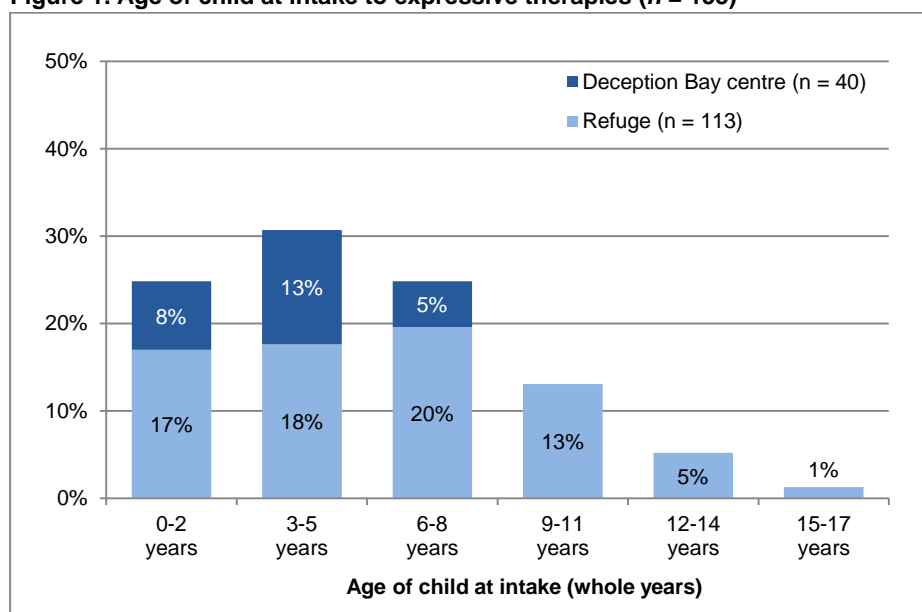
Comparing the two age groups (fourth and fifth columns from the left in Table 1) the major difference evident between the preschool cohort and the school-aged cohort is the length of time enrolled in therapy and the number of therapy sessions delivered. Preschool-aged children were enrolled for longer on average – a mean of 13 weeks compared with 5 weeks for school-aged children. The mean total number of therapy sessions held with preschool-aged children was 5 while for older children it was 3. These differences are substantially attributable to the age-related differences of the refuge and Deception Bay centre target population and the different timeframes for client engagement across these different sites.

**Table 3. Expressive therapies client characteristics and service delivery outputs across the evaluation period – by site and age cohort**

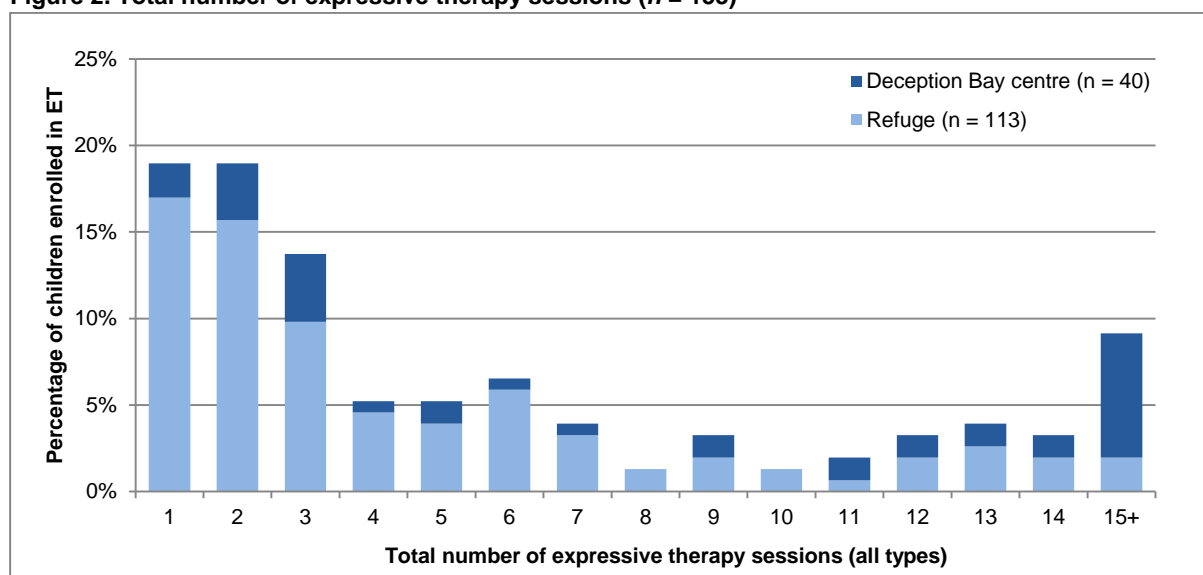
Client characteristic	By site		By age cohort		Total sample (n = 153)
	Refuge (n = 113)	Deception Bay centre (n = 40)	0-5 years (n = 84)	6-16 years (n = 69)	
<b>Site</b>					
Refuge	100%	0%	62%	88%	74%
Deception Bay centre	0%	100%	38%	12%	26%
<b>Year exited program</b>					
2012-2013	47%	21%	37%	48%	42%
2013-2014	50%	68%	60%	46%	54%
Ongoing at 30/6/2014	3%	11%	3%	6%	4%
<b>Age at entry (whole years)</b>					
Median	6	3	3	8	5
Mean (SD)	6.2(3.8)	3.8(2.0)	2.9(1.4)	8.9(2.6)	5.5(3.6)
Range	0-16	1-8	0-5	6-16	0-16
<b>Age group</b>					
0-5 years	47%	80%	100%	0%	56%
6-11 years	44%	20%	0%	85%	38%
12-16 years	9%	0%	0%	15%	7%
<b>Gender</b>					
Male	56%	48%	51%	56%	54%
Female	44%	52%	49%	44%	46%
<b>Weeks enrolled in ET</b>					
Median	4	15	9	5	6
Mean (SD)	4.9(3.9)	23.1(18.5)	13.4(15.8)	5.3(4.9)	9.7(12.8)
Range	0-14	3-85	0-85	0-30	0-85
<b>Number of therapy sessions</b>					
<i><b>Individual sessions</b></i>					
Median	2	5	3	3	3
Mean (SD)	3.7(3.8)	7.8(7.2)	5.3(6.0)	4.1(3.9)	4.8(5.2)
Range	0-16	0-28	0-28	0-21	0-28
<i><b>Parent-child sessions</b></i>					
Median	0	0	0	0	0
Mean (SD)	0.5(1.9)	2.0(4.0)	1.6(3.5)	0.1(0.5)	1.0(2.7)
Range	0-14	0-16	0-16	0-3	0-16
<i><b>Sibling sessions</b></i>					
Median	0	0	0	0	0
Mean (SD)	0.3(0.9)	0.2(0.5)	0.3(1.0)	0.2(0.6)	0.2(0.8)
Range	0-6	0-2	0-6	0-3	0-6
<i><b>Group sessions</b></i>					
Median	0	0	0	0	0
Mean (SD)	0.1(0.4)	1.4(3.3)	0.8(2.4)	0.1(0.3)	0.5(1.8)
Range	0-3	0-16	0-16	0-2	0-16
<i><b>Total sessions</b></i>					
Median	3	9	5	3	3
Mean (SD)	4.7(4.3)	11.4(10.3)	8.0(8.4)	4.5(4.2)	6.4(7.1)
Range	1-20	1-42	1-42	1-23	1-42
<b>Number of sessions per week enrolled in ET</b>					
Median	1.0	0.4	0.8	1.0	0.9
Mean (SD)	1.0(0.5)	0.5(0.5)	0.8(0.5)	1.0(0.6)	0.9(0.5)
Range	0-3	0-3	0-3	0-3	0-3
<b>Goals recorded in BCIMS</b>					
Yes	39%	80%	52%	46%	50%
No	27%	20%	26%	35%	25%
No data available	34%	0%	21%	29%	25%

Figures 1, 2, 3 and 4 present client characteristics and service delivery outputs pertaining to the evaluation period in a visual format. Figure 1 shows the distribution of children's ages. It also shows age distribution by site and highlights the asymmetrical age characteristics of children at the two sites. Figures 2 and 3 show respectively the distribution of the number of weeks children were enrolled in expressive therapies and the distribution of the total number of therapy sessions delivered to children. They also show these distributions by site, again highlighting the asymmetrical participation of children across the two sites. Finally, Figure 4 shows the financial year that children exited expressive therapies by site. Roughly an equivalent proportion of children exited in each year of the evaluation at the refuge, whereas at Deception Bay a much larger proportion (68%) exited in the second year of the evaluation compared with the first year (21%). This reflects shifting staffing levels and program capacity at Deception Bay over the two-year period.

**Figure 1. Age of child at intake to expressive therapies (n = 153)**

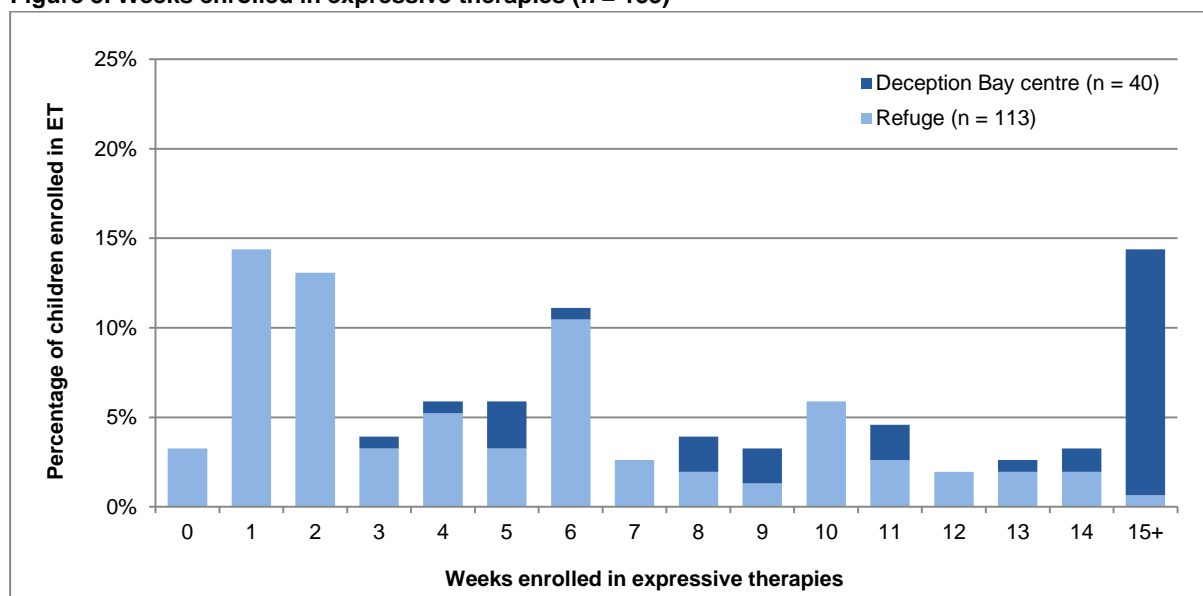


**Figure 2. Total number of expressive therapy sessions (n = 153)**

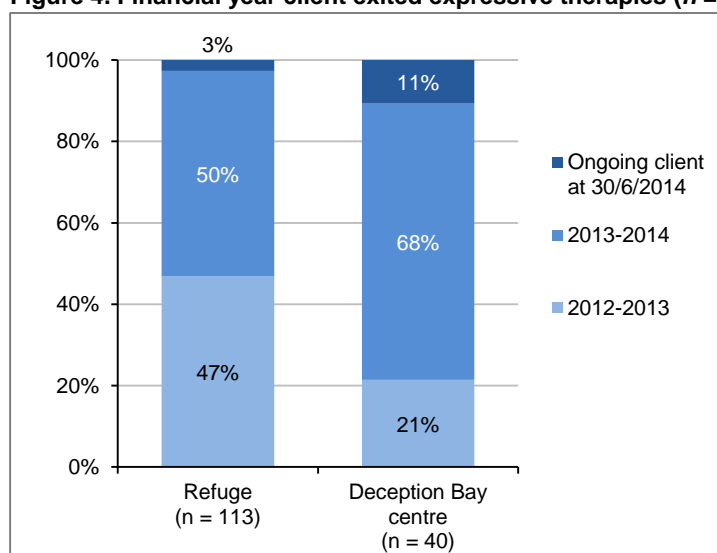




**Figure 3. Weeks enrolled in expressive therapies (n = 153)**



**Figure 4. Financial year client exited expressive therapies (n = 153)**



### 3.2 Pre/post CBCL assessments

Complete CBCL assessments (i.e. assessments completed for a child both at intake and exit from the program) were available for 30 children aged 1.5 to 5 years and 20 children aged 6 to 16 years.

Table 4 compares the characteristics of children for whom complete CBCL assessments were available with all expressive therapy clients in the relevant age group across the period of the evaluation. The data presented highlight that the children in the CBCL samples are not representative of the broader sample in certain key regards. Those in the CBCL samples were more likely to be male than for clients more generally. They were also enrolled for a longer period of time on average and completed more therapy sessions. For example, in the preschool-aged group, those in the CBCL sample had completed a mean of 14 therapy sessions, while all children aged 0 to 5 enrolled in expressive therapies during the evaluation period had completed a mean of 8 sessions. Similarly, for children in the school-age group, those in the CBCL sample had a mean of 8 therapy sessions while all children aged 6 and over enrolled in expressive therapies during the evaluation period had a mean of 5 sessions.

**Table 4. Characteristics of clients with complete CBCL assessments compared with all expressive therapy clients in the relevant age group across the evaluation period**

Client characteristic	Preschool clients (0-5 years)		School-age clients (6-16 years)	
	Clients with pre/post CBCL assessment ( <i>n</i> = 30)	All ET clients aged 0-5 years ( <i>n</i> = 84)	Clients with pre/post CBCL assessment ( <i>n</i> = 20)	All ET clients aged 6-16 years ( <i>n</i> = 69)
<b>Program</b>				
Refugee	57%	62%	90%	88%
Deception Bay centre	43%	38%	10%	12%
<b>Year exited program</b>				
2012-2013	21%	37%	25%	48%
2013-2014	79%	60%	60%	46%
Ongoing at 30/6/2014	0%	3%	15%	6%
<b>Age at entry (whole years)</b>				
Median	2	3	8	8
Mean (SD)	2.7(1.2)	2.9(1.4)	9.0(2.6)	8.9(2.6)
Range	1-5	0-5	6-13	6-16
<b>Gender</b>				
Male	67%	51%	65%	56%
Female	33%	49%	35%	44%
<b>Weeks enrolled in ET</b>				
Median	12	9	7	5
Mean (SD)	23.1(20.0)	13.4(15.8)	8.0(5.6)	5.3(4.9)
Range	5-85	0-85	3-30	0-30
<b>Total number of therapy sessions (all types)</b>				
Median	13	5	7.0	3
Mean (SD)	14.1(8.0)	8.0(8.4)	8.0(4.3)	4.5(4.2)
Range	3-36	1-42	4-23	1-23
<b>Number of sessions per week enrolled in ET</b>				
Median	0.7	0.8	1.0	0.9
Mean (SD)	0.8(0.4)	0.8(0.5)	1.1(0.6)	0.9(0.5)
Range	0-2	0-3	1-3	0-3

Table 5 presents a comparison between mean *t*-scores on each of the main problem scales and subscales of the Preschool CBCL/1.5-5 at intake to therapy and at exit from therapy. The higher the *t*-score, the more symptomatic a child's behaviour is assessed to be. Table 5 shows that on every scale and subscale there is a reduction in children's mean scores from intake to exit from therapy. This difference is statistically significant at the .01 level in every case apart from the somatic complaints subscale (refer to *p* value column). The treatment effect size is reported in the far right column. These data indicate that in all but one case (somatic complaints subscale), the size of the observed change meets the threshold for a large effect ( $r \geq .5$ ). The effect size for changes in score on the somatic complaints subscale is considered moderate.

Table 6 presents the same data for the School-age CBCL/6-18 cohort. It compares mean *t*-scores on each of the main scales and subscales of the instrument at intake to therapy and at exit from therapy. Again, the higher the *t*-score, the more symptomatic a child's behaviour is assessed to be. Examination of this data reveals that on every scale and subscale there is a reduction in children's mean *t*-scores from intake to exit from therapy. This difference is statistically significant at the .05 level in all but three cases (somatic complaints, thought problems and rule-breaking behaviour – refer to *p* value column). The treatment effect size is reported in the far right hand side column. These data indicate that on most scales and subscales, excluding somatic complaints, thought problems and rule-breaking behaviour, the size of the observed change meets the threshold for a large effect ( $r \geq .5$ ).

**Table 5. Preschool CBCL/1.5-5 – mean *t*-scores at intake and exit (*n* = 30)**

Preschool CBCL/1.5-5 scales	Mean <i>t</i> -score Intake	Mean <i>t</i> -score Exit	<i>t</i> -value	<i>df</i>	<i>p</i> value	Effect size ( <i>r</i> value) <sup>3</sup>
<b>Internalising, externalising and total problem scales</b>						
Internalising problems	63.7	55.1	6.312	29	.000**	.76 <sup>^</sup>
Externalising problems	64.7	52.5	5.699	29	.000**	.73 <sup>^</sup>
Total problems	66.4	54.6	6.416	29	.000**	.77*
<b>Syndrome scales<sup>1</sup></b>						
Emotionally reactive	6.6	3.6	5.010	29	.000**	.68 <sup>^</sup>
Anxious/depressed <sup>2</sup>	6.0	3.5	4.168	29	.001**	.63 <sup>^</sup>
Somatic complaints <sup>2</sup>	2.9	2.0	2.020	29	.071	.33
Withdrawn	4.8	2.1	4.521	29	.000**	.64 <sup>^</sup>
Sleep problems	6.2	4.5	2.829	29	.008**	.47
Attention problem	5.4	3.3	4.979	29	.000**	.68 <sup>^</sup>
Aggressive behaviour	19.7	11.5	5.703	29	.000**	.73 <sup>^</sup>

1. Syndrome scale data presented is raw data, not standardised.

2. *p* value and effect size derived from Wilcoxon signed-rank test rather than dependent *t*-test due to non-normal distribution of the difference in pre- and post- scores on these variables

<sup>^</sup> *r* ≥ .5 is considered a large effect

\*\* statistically significant at .01 level

**Table 6. School-age CBCL/6-18 – mean *t*-scores at intake and exit (*n* = 20)**

School-age CBCL/6-18 scales	Mean <i>t</i> -score Intake	Mean <i>t</i> -score Exit	<i>t</i> -value	<i>df</i>	<i>p</i> value	Effect size ( <i>r</i> value) <sup>3</sup>
<b>Internalising, externalising and total problem scales</b>						
Internalising problems	63.0	54.2	5.186	19	.000**	.77 <sup>^</sup>
Externalising problems	62.6	57.8	4.845	19	.000**	.74 <sup>^</sup>
Total problems	63.4	54.5	3.836	19	.001**	.66 <sup>^</sup>
<b>Syndrome scales<sup>1</sup></b>						
Anxious/depressed	7.7	4.1	3.748	19	.001**	.65 <sup>^</sup>
Withdrawn/depressed <sup>2</sup>	4.5	2.8	3.343	19	.003**	.61 <sup>^</sup>
Somatic complaints	2.9	1.7	1.852	19	.080	.39
Social problems	4.8	2.8	3.343	19	.003**	.61 <sup>^</sup>
Thought problems	4.0	3.1	1.342	19	.196	.29
Attention problems	6.1	4.1	2.466	19	.023*	.49 <sup>^</sup>
Rule-breaking behaviour	5.2	4.2	1.846	19	.081	.39
Aggressive behaviour <sup>2</sup>	13.3	9.8	3.663	19	.002**	.64 <sup>^</sup>

1. Syndrome scale data presented is raw data, not standardised.

2. *p* value and effect size derived from Wilcoxon signed-rank test rather than dependent *t*-test due to non-normal distribution of the difference in pre- and post- scores on these variables

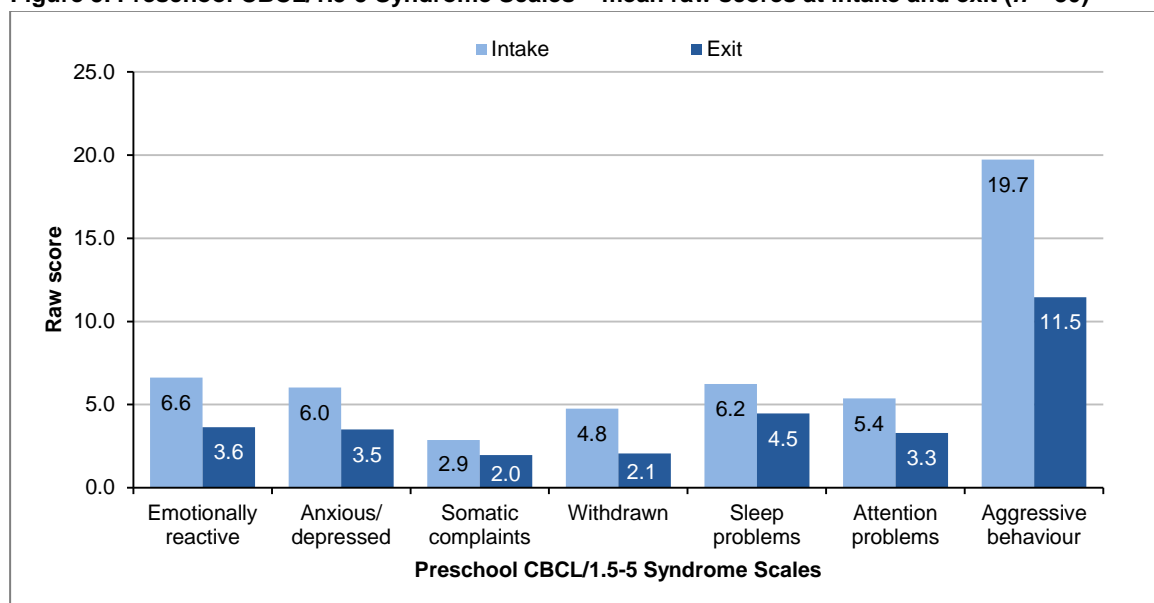
<sup>^</sup> *r* ≥ .5 is considered a large effect

\* statistically significant at .05 level

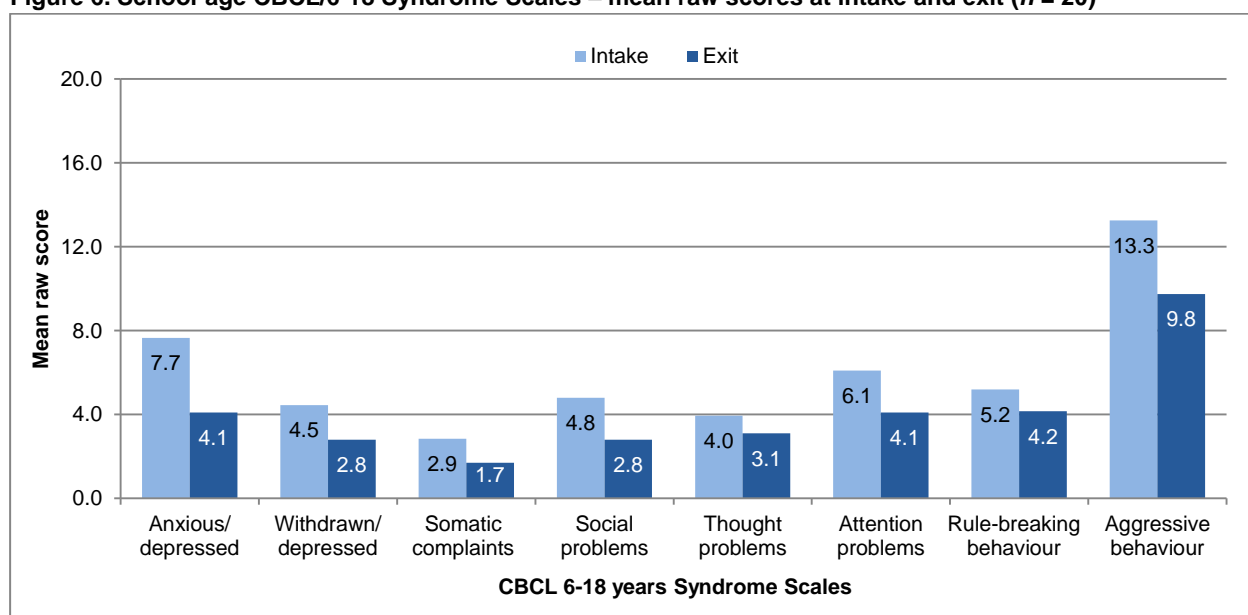
\*\* statistically significant at .01 level

Figure 5 provides a visual representation of the change in raw scores between intake and exit on each of the seven Preschool CBCL/1.5-5 subscales. The reduction in scores on the aggressive behaviour subscale is particularly evident in this representation. Figure 6 provides the same information in relation to School-age CBCL/6-18 subscales.

**Figure 5. Preschool CBCL/1.5-5 Syndrome Scales – mean raw scores at intake and exit ( $n = 30$ )**

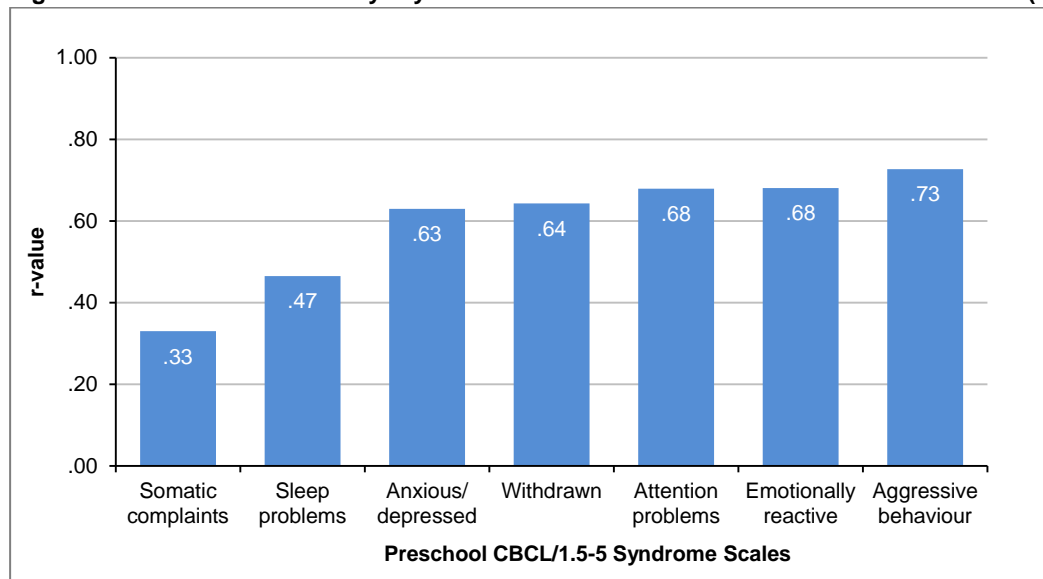


**Figure 6. School-age CBCL/6-18 Syndrome Scales – mean raw scores at intake and exit ( $n = 20$ )**



Effect sizes provide a more objective measure of treatment effectiveness. Figure 7 provides a visual representation of the effect size for each of the subscales of the Preschool CBCL/1.5-5. It suggests that the Expressive Therapies Intervention has greatest impact on reducing aggressive behaviour, emotional reactivity, and attention problems for this age cohort. The kinds of problems it appears comparatively less effective in addressing are somatic complaints and sleep problems.

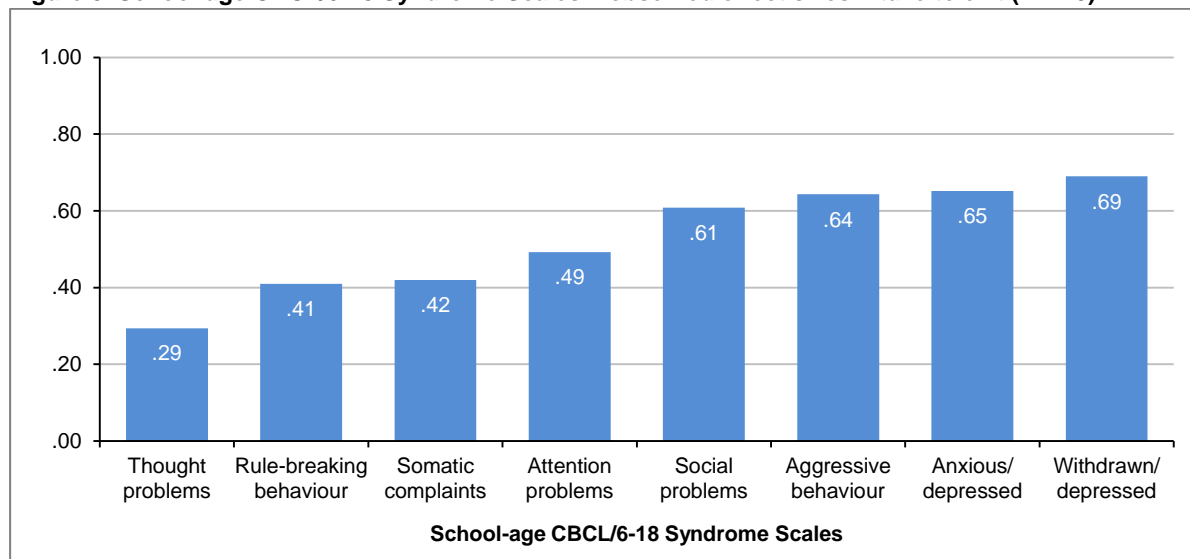
**Figure 7. Preschool CBCL/1.5-5yr Syndrome Scales – observed effect sizes intake to exit ( $n = 30$ )**



NB.  $r \geq .5$  is considered a large effect

Figure 8 provides the same data in relation to the School-age CBCL/6-18 subscales. It suggests that for this older age group the intervention has greatest impact on reducing anxious/depressed and withdrawn/depressed behavioural symptoms, followed by aggressive behaviour and social problems. The kinds of problems it appear to be comparatively less effective in addressing are somatic complaints, rule-breaking behaviour and thought problems.

**Figure 8. School-age CBCL/6-18 Syndrome Scales – observed effect sizes intake to exit ( $n = 20$ )**



NB.  $r \geq .5$  is considered a large effect

Children's scores on the main problem scales of the CBCL (internalising, externalising and total problems) can be classified into three symptom ranges based on standardised population comparisons – *normal*, *borderline clinical* and *clinical*. This is helpful in terms assessing the clinical benefit of the changes observed in children's functioning from intake to exit. Figure 9 shows changes in symptom range classification from intake to exit on the three main problem scales of the Preschool CBCL/1.5-5. What is apparent from this data is that there is a dramatic shift in the proportion of children who are classified in the clinical or borderline clinical range at intake, and the proportion who remain in the clinical/borderline clinical ranges at exit. For example, at intake 67% of children demonstrated internalising behaviour that placed them in the clinical or borderline clinical ranges. At exit, only 13% remained in the clinical or borderline clinical

ranges. This pattern is consistent across the three main problem scales and suggests that the therapeutic intervention has clinically significant impacts.

**Figure 9. Preschool CBCL/1.5-5 Main Problem Scales – changes in symptom range classification from intake to exit (*n* = 30)**

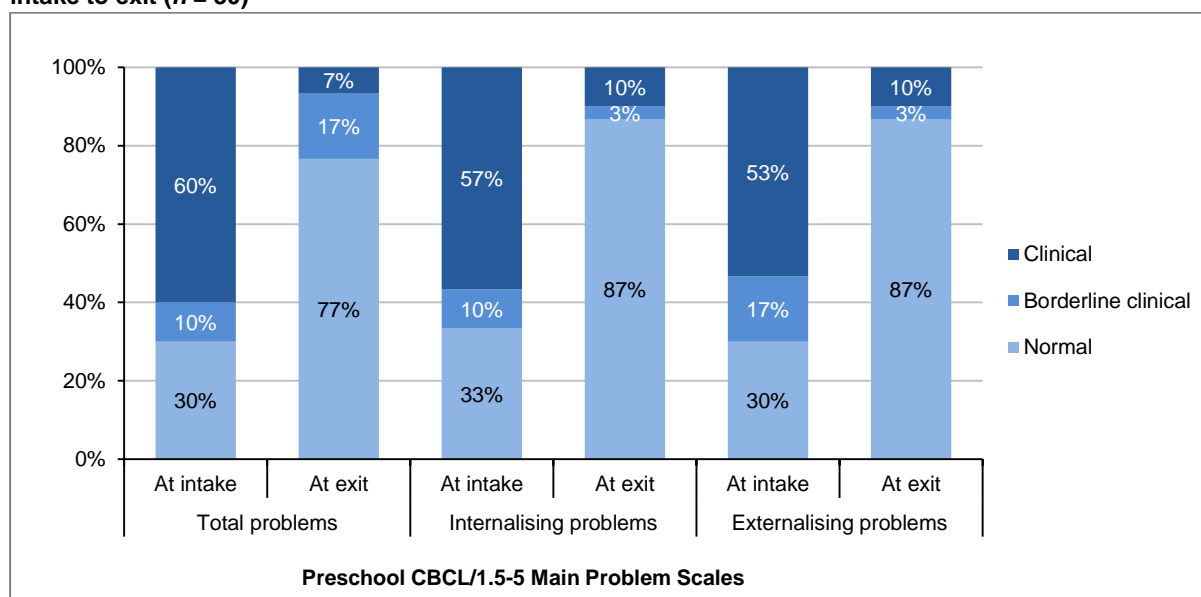
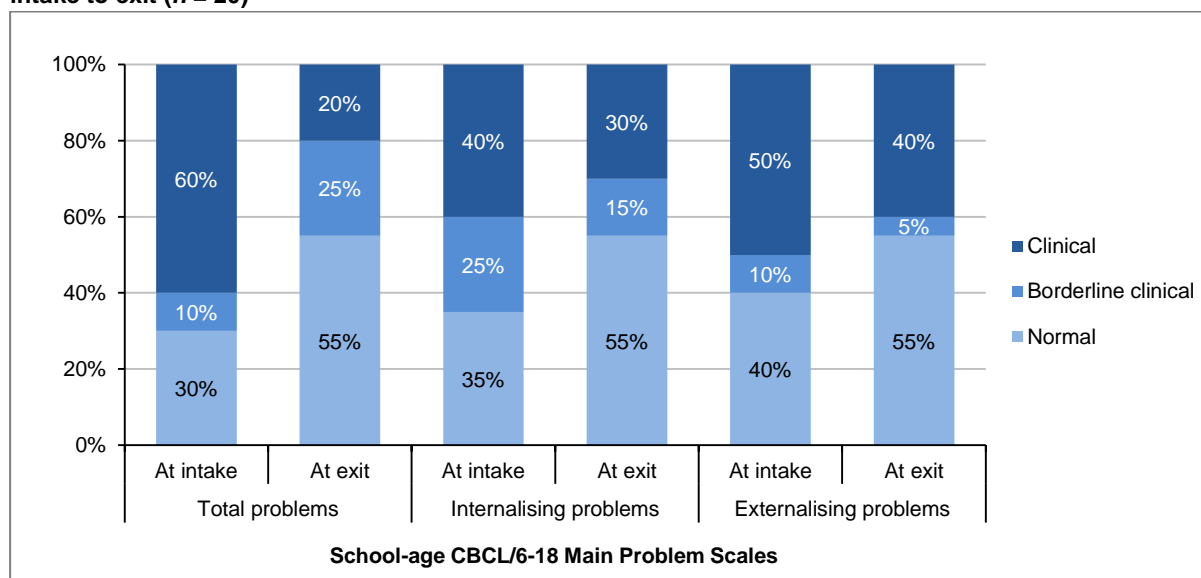


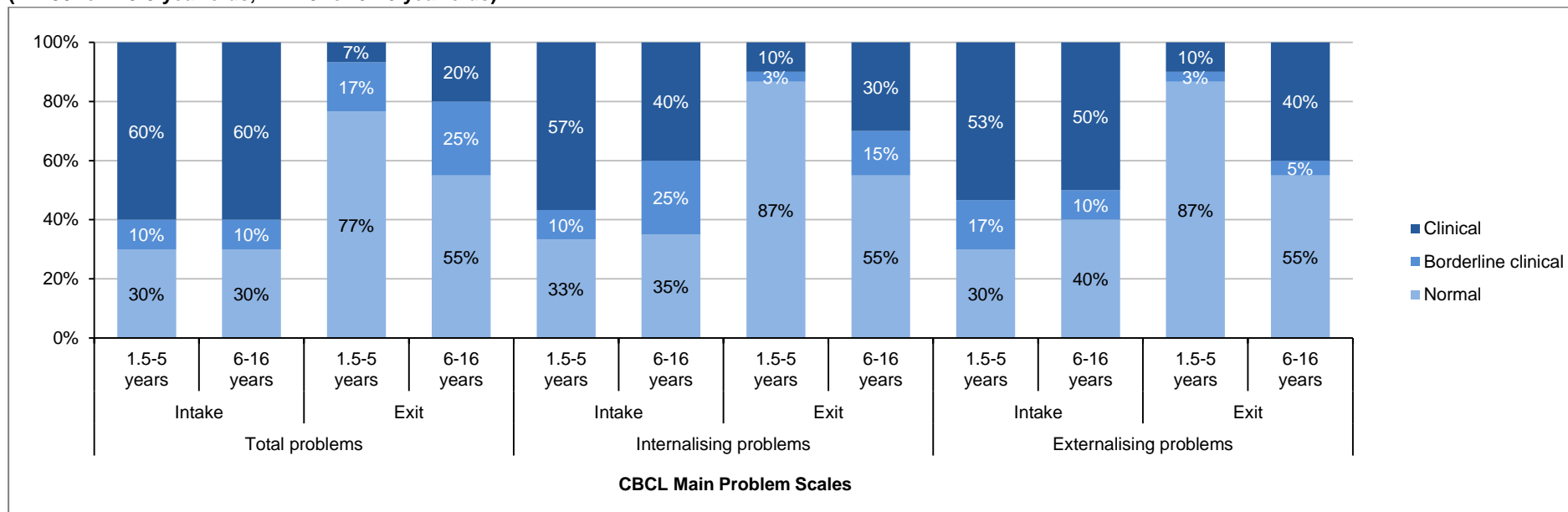
Figure 10 shows the same data in relation to the School-age CBCL/6-18. Again, on each of the main problem scales of the instrument there is a notable reduction in the proportion of children who at exit from therapy fall into the clinical or borderline clinical ranges compared with those who fell into these categories at intake to therapy. For example, at intake, 65% of children were in the clinical or borderline clinical range for internalising behaviours and at exit 45% remain in these categories. The same pattern is evident across the three main problem scales.

**Figure 10. School-age CBCL/6-18 Main Problem Scales – changes in symptom range classification from intake to exit (*n* = 20)**

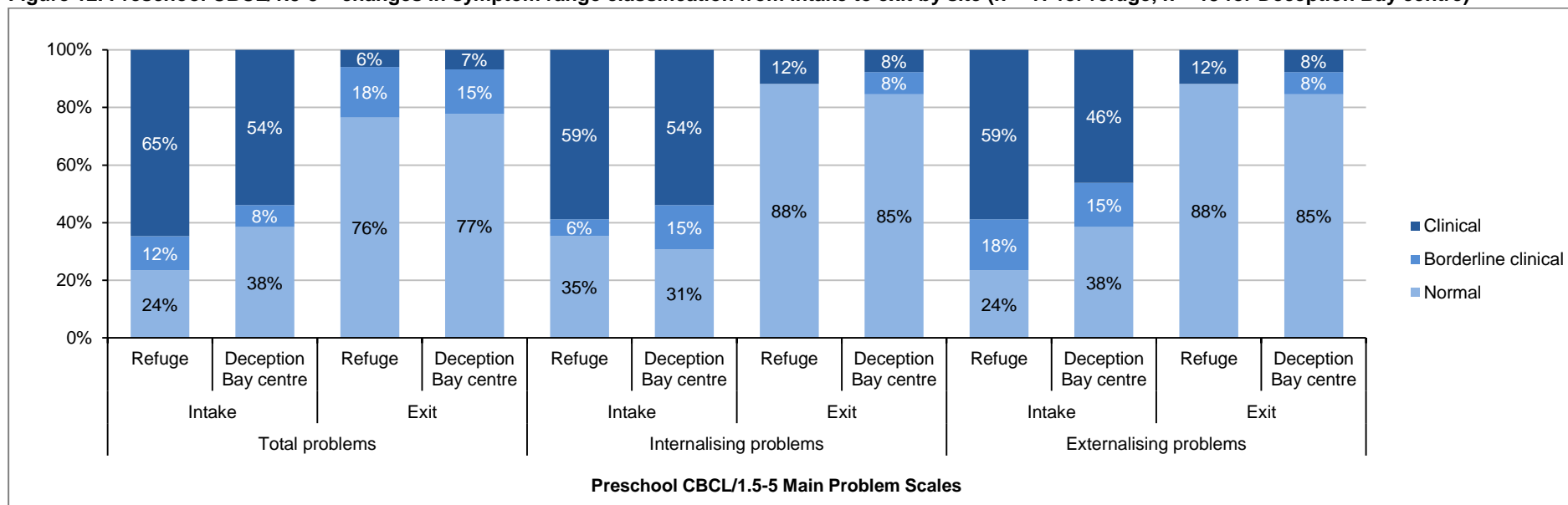


It is interesting to compare the data presented in Figures 9 and 10. Figure 11 assists with this comparison by bringing the data from the two age cohorts together. What is most apparent in this comparison is that while both groups of children commence therapy with roughly the same proportional symptom classifications, children in the older age group do not achieve as dramatic a reduction in symptom classification as do the younger age group. This may suggest that the Expressive Therapies Intervention is more effective in bringing about clinically significant change in the preschool-aged cohort.

**Figure 11. Preschool CBCL/1.5-5 and School-age CBCL/6-18 – changes in symptom range classification from intake to exit by age group ( $n = 30$  for 1.5-5 year olds,  $n = 20$  for 6-16 year olds)**



**Figure 12. Preschool CBCL/1.5-5 – changes in symptom range classification from intake to exit by site ( $n = 17$  for refuge,  $n = 13$  for Deception Bay centre)**



However, it is also important to note that on average the preschool cohort compared with the school-aged cohort completed almost twice as many therapy sessions (mean of 13 sessions cf. mean of 7) which may equally account for the observed difference in symptom reduction.

Figure 12 shows changes in symptom range classification for children scored on the Preschool CBCL/1.5-5 from intake to exit according to the site at which they were engaged in therapy – the refuge or the Deception Bay centre. Caution should be taken with interpreting this data as the sub-samples are quite small and too small for identifying statistically significant differences. However, what the data visually suggest is that children engaged in therapy at Deception Bay may tend to have slightly lower levels of clinically significant behavioural problems at intake compared with children engaged in therapy at the refuge. The other key observation to make is that children exit therapy with similarly dramatic reductions in symptom classification regardless of the site where therapy is undertaken. In fact, the symptom classification breakdown on each of the three main problem scales at exit is almost identical at both sites. This suggests that both sites are achieving equivalently significant results from a clinical perspective despite working in the context of different programs, with different client groups, and different service delivery modalities. It is worthy of note, however, that children in the Deception Bay CBCL/1.5-5 sample ( $n = 13$ ) were enrolled in expressive therapies for a mean of 41 weeks and participated in a mean of 19 therapy sessions while children in the refuge CBCL/1.5-5 sample ( $n = 17$ ) were enrolled for an average of 9 weeks and participated in a mean of 10 therapy sessions.

### 3.3 Parent feedback survey

A total of 28 completed parent surveys pertaining to children aged 0 to 5 years were available for analysis. Table 7 compares characteristics of children with a complete parent survey with the characteristics of all children aged 0 to 5 years enrolled in expressive therapies during the period of the evaluation. These data indicate that children with completed parent surveys are not representative of the broader age cohort in certain regards. For example, a higher proportion of these children are male compared with the broader age cohort (64% cf. 51%). They have also been enrolled in expressive therapies for longer on average (a mean of 22 weeks cf. 13 weeks) and have received more therapy sessions (mean of 14 session cf. 8 sessions). To some extent these last two observed differences reflect selection criteria for participation in the survey which included the requirement to have been enrolled in therapy for at least 3 weeks.

As noted in the methodology section, the parent survey collected open-ended responses from parents/carers about changes they had observed in their children during their time in therapy. This feedback was analysed thematically, using eleven qualitative outcomes described earlier in Table 2 that relate to the evaluation objectives. Figure 13 presents a quantitative snapshot of the thematic coding undertaken. It shows for each of the eleven outcomes, the proportion of parent surveys that:

- specifically noted the outcome
- indicated the outcome had not been achieved, and
- did not comment on the achievement or non-achievement of the outcome.

This snapshot reveals that the most widely reported outcomes concern improvements in children's emotional wellbeing and emotional regulation as well as improvements in parenting confidence and capacity, and improvements in the child-parent relationship. The least commonly noted outcomes were improvements in children's confidence/self-esteem and evidence of their processing of trauma. It is important to note in interpreting this data that parents/carers were not asked to comment on all of these outcomes directly. Trauma processing, for example, was not specifically referred to in the questionnaire but rather questions were designed to explore behavioural and emotional changes that may be indicative of such processing.

To supplement this quantitative snapshot, Table 8 presents examples of parents'/carers' comments reflecting the achievement of each of the eleven qualitative outcomes.

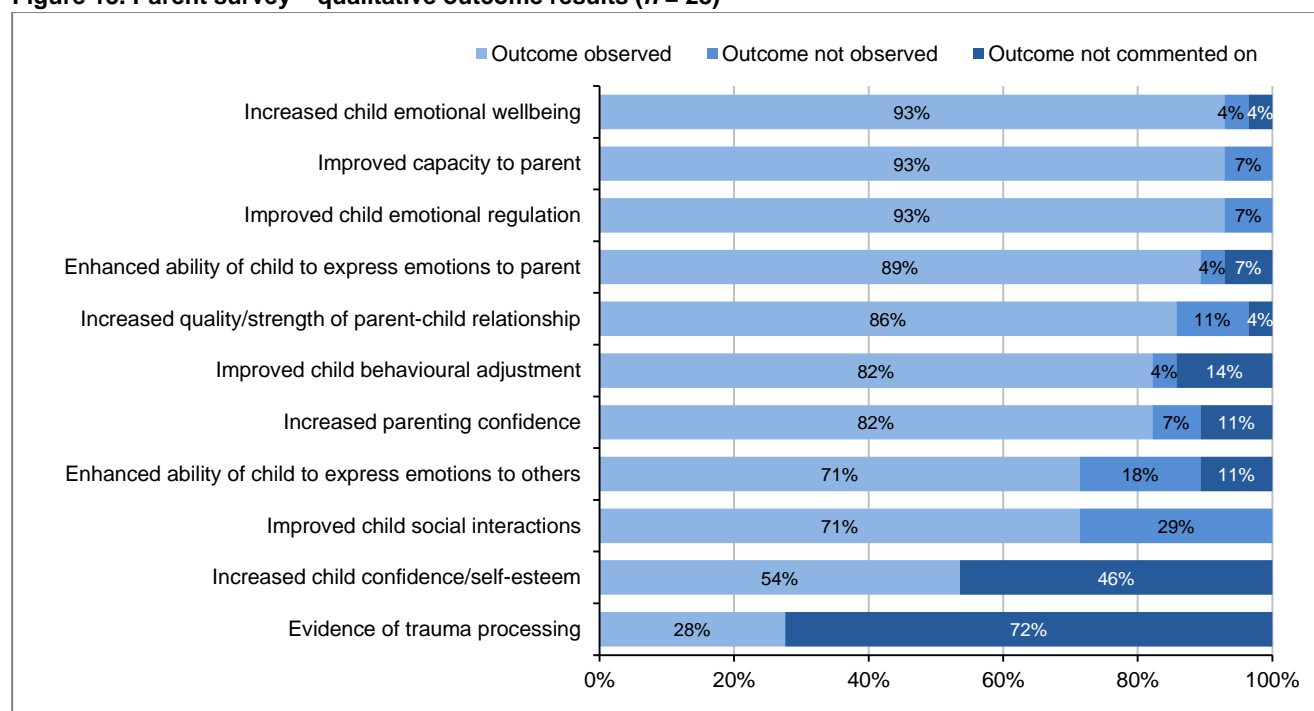


**Table 7. Characteristics of clients with completed parent survey compared with all clients 1.5-5 years enrolled in expressive therapy during the evaluation period**

Client characteristic	Clients with completed parent survey (n = 28)	All ET clients 0-5 years (n = 84)
<b>Program</b>		
Refuge	61%	62%
Deception Bay centre	39%	38%
<b>Year exited program</b>		
2011-2012**	22%	0%
2012-2013	30%	37%
2013-2014	48%	60%
Ongoing at 30/6/2014	0%	3%
<b>Age at entry (whole years)</b>		
Median	3	3
Mean (SD)	2.9(1.2)	2.9(1.4)
Range	1-5	0-5
<b>Gender</b>		
Male	64%	51%
Female	36%	49%
<b>Weeks enrolled in ET</b>		
Median	11	9
Mean (SD)	21.7(21.0)	13.4(15.8)
Range	2-85	0-85
<b>Total number of therapy sessions (all types)</b>		
Median	14	5
Mean (SD)	14.1(9.6)	8.0(8.4)
Range	2-36	1-42
<b>Number of sessions per week enrolled in ET</b>		
Median	0.8	0.8
Mean (SD)	0.9(0.5)	0.8(0.5)
Range	0-2	0-3

\*\* Outside evaluation timeframe but included to increase sample size and data reliability.

**Figure 13. Parent survey – qualitative outcome results (n = 28)**



**Table 8. Examples of parents' comments reflecting therapeutic outcomes achieved by their children**

Qualitative outcome examined	Proportion of surveys where outcome was noted	Examples of parents'/carers' comments reflecting this outcome
Increased child emotional wellbeing	93%	<ul style="list-style-type: none"> <li>"She is happier. She can be aggressive still sometimes, but now I understand that she feels angry about what is happening to her and what she has witnessed. She needs to let that anger out sometimes".</li> <li>"She is happier. She gets so exciting when she enters the therapy room. I think she knows it's her time".</li> <li>"(My daughter) is calmer, happier and more settled".</li> <li>"I noticed that he's not so clingy to me lately and he is more independent. His speech has improved a lot and he's interacting with other kids a lot more".</li> </ul>
Improved child emotional regulation	93%	<ul style="list-style-type: none"> <li>"When he came to the refuge he was always crying and grumpy... (my son) is talking more and able to describe his emotions".</li> <li>"He screams now when he is angry; he didn't do this before. Before (when living with his father), he would not show his emotion. When he was angry he would sit in front of the TV and stare at it. Now he is able to express how he feels clearly".</li> <li>"I haven't noticed any difference in how she expresses her emotions. I can see she is having fun and happy. She tells me sometimes when she's sad".</li> <li>"I noticed that he's not scared of his emotions anymore. He will show me if he is happy or sad now, whereas before he would hide it... I used to have to guess what's wrong and now he will show me".</li> </ul>
Improved capacity to parent	93%	<ul style="list-style-type: none"> <li>"Sometimes I would withdraw from (my daughter); especially when I was angry... I would lie down during the day, physically exhausted. I was avoiding the hard work. Now my emotions are more stable. I notice a lot more, I am more active, more engaged and I have more energy".</li> <li>"When I lived with my husband, every parenting technique I introduced my husband did not support. It was always a challenge to put rules in place. Now there is just me and my son. I have a clearer head and I'm calmer. This means I can provide consistency for my son".</li> <li>"I feel less stressed, more in control. I am able to be the parent I want to be without outside influences. My children have been through a lot."</li> <li>"Before coming to the refuge I put a lot of pressure on myself, believing I had to be perfect for (my son). Now I have more understanding and I realise sometimes you just have to do what you can".</li> </ul>
Enhanced ability of child to express emotions to parent	89%	<ul style="list-style-type: none"> <li>"I think the biggest change that I've seen with (name) is that she can explain her emotions for me, I don't have to guess anymore. (My child) is more happy, where normally, before we started expressive therapies, she was more sad".</li> <li>"My children come up to me now and give me big hugs and tell me they love me. They didn't feel able to approach me when their father was around".</li> <li>"He expresses his feelings verbally which is something he didn't used to do. (My son) will now tell me, "I'm sad" and "I'm crying" or "I'm angry", which makes it easier for me to understand him".</li> <li>"We have more quality time together and can talk more openly with each other".</li> </ul>
Increased quality/strength of parent-child relationship	86%	<ul style="list-style-type: none"> <li>"I reckon (our relationship's) now stronger. He comes to me more than anything. We have a special bond".</li> <li>"(Child's name) and my relationship has changed by us communicating and doing more activities together... She can explain her emotions now, I am able to help her through her emotions".</li> <li>"When I was living with (accused perpetrator) I was distant from my children and I left them alone in his care for some time. This affected the children's ability to trust me. Now I am back to normal and I am focussing on reinforcing the message that I'm not going anywhere".</li> <li>"I thought that he would be more and more full-on as he got older and I was always thinking how I was going to handle it. Now I think I know how – I can communicate with him. This has been huge".</li> </ul>

Qualitative outcome examined	Proportion of surveys where outcome was noted	Examples of parents'/carers' comments reflecting this outcome
Improved child behavioural adjustment	82%	<ul style="list-style-type: none"> <li>"Small changes. They are still difficult to manage because they are constantly in a heightened sense of arousal, but I can see that they are getting better slowly".</li> <li>"His tantrums are shorter and less severe. Now he will apologise quicker. He can tell me why he feels a particular way and now I am acknowledging these feelings".</li> <li>"He knows to calm down now, so I can tell him if he is hurting me to have some 'time out' to calm down and he does. He will tell me that he's more calm, and we can talk about what happened".</li> <li>"Sometimes he expresses frustration with a head bang. I noticed that after expressive therapy now he's communicating more. If he wants something, he doesn't just head bang anymore, he will bring me what he wants and will have a cuddle".</li> </ul>
Increased parenting confidence	82%	<ul style="list-style-type: none"> <li>"I think having BoysTown help me learn to be a better parent really helped me... Some days I feel stronger but I have more knowledge now. I think I always loved them the same amount, but I am much more confident now".</li> <li>"Having all the information has been good and making it fit to how I want to parent. I'm practicing being myself, being calm and being bubbly is helpful. I'm showing them that they don't have to be perfect, which is something I struggled with when I was younger".</li> <li>"It's been a massive change! I feel confident, on top of the world! I felt like I wasn't her mum before; I felt so low that I wasn't even sure I deserved to look after her. Now I know I'm her mum; that's been a massive change for me".</li> <li>"When I first came to the refuge I didn't believe I could do anything. I had no confidence. Now I am full of confidence! I'm so happy, thank you; you have all helped me so much".</li> </ul>
Improved child social interactions	71%	<ul style="list-style-type: none"> <li>"(My son) plays nicer with others now. He asks the children when he wants something, instead of just taking like he used to".</li> <li>"He is nicer to other children and will let them take the lead. The majority of the time he is able to share. He is more interested and respectful to adults".</li> <li>"He is now more open to others and willing to make friends. He used to need me there all the time and didn't look people in the eyes. Now he loves talking to others and making people laugh".</li> <li>"He's been telling me there is a boy at Kindy who pushes, and we've spoken about how to deal with it without being rough back. This is a huge change from his old emotionally reactive ways".</li> </ul>
Enhanced ability of child to express emotions to others	71%	<ul style="list-style-type: none"> <li>"I can now tell what emotion it is (whilst) before, it used to be an explosive rant. He can now identify other peoples' emotions. He is more empathetic and more human. When other people are sad, he feels for them".</li> <li>"He's definitely showing his emotions more – they are finally coming out rather than holding them in. I am finding ways to deal with these new emotions".</li> <li>"(My son) now notices friends and is excited to see them; he can now share special moments with others outside of his family. Before coming to the refuge (he) had no friends".</li> <li>"(My daughter) is expressing herself a lot more in painting and drawing... It's a lot easier for her to tell how she's feeling; before she wouldn't come up to me. She is opening up and telling us what she likes and dislikes. It used to be difficult for anything to come out".</li> </ul>

Qualitative outcome examined	Proportion of surveys where outcome was noted	Examples of parents' comments reflecting this outcome
Increased child confidence/self-esteem	54%	<ul style="list-style-type: none"> <li>"Their emotions are up and down but they are generally happier and seem to have more self-esteem".</li> <li>"He can also play with adults and is confident to talk with them. Before arriving at the refuge, he was terrified of other adults and fearful of me talking with them".</li> <li>"He likes to play with other children. He used to choose to not play with other kids. He's now confident to approach other kids to play".</li> <li>"(My son) is independent and not as clingy. He has started to enjoy going off and doing things with other people, not just me".</li> </ul>
Evidence of trauma processing**	28%	<ul style="list-style-type: none"> <li>"(My child) has shown more anger regarding her past. She has been describing big events in her childhood that she remembers clearly. I understand that talking about these difficult times is important for my daughter and I feel able to listen and support her".</li> <li>"He's been more settled at home and he's much more calm. He doesn't react to the phone ringing anymore (he used to think it was his father)".</li> </ul>

\* Proportions based on sample size of 28.

\*\* Note that survey did not specifically ask parents about trauma processing.

### 3.4 End-of-therapy reports

A total of 33 end-of-therapy reports pertaining to children aged 0 to 5 years who had been in therapy for at least 3 weeks were available for analysis. Table 9 compares characteristics of children in the end-of-therapy report sample with the characteristics of all children aged 0 to 5 years enrolled in expressive therapies during the evaluation period.

These data indicate that children in the end-of-therapy report sample are not representative of the broader age cohort in certain regards. For example, a higher proportion of these children are male compared with the broader age cohort (64% cf. 51%). They have also been enrolled in expressive therapies for longer on average (a mean of 17 weeks cf. 13 weeks) and have received more therapy sessions (mean of 12 session cf. 8 sessions). These last two differences are artefacts of the sample selection process to a large extent as children were required to have been enrolled in expressive therapies for at least 3 weeks to be included in the sample.

The end-of-therapy reports were analysed thematically, using the eleven qualitative outcomes described earlier in Table 2 that relate to the evaluation objectives. Figure 14 presents a quantitative snapshot of the thematic coding undertaken. It shows for each of the eleven outcomes, the proportion of end-of-therapy reports that:

- specifically noted the outcome
- indicated the outcome had not been achieved, and
- did not comment on the achievement or non-achievement of the outcome.

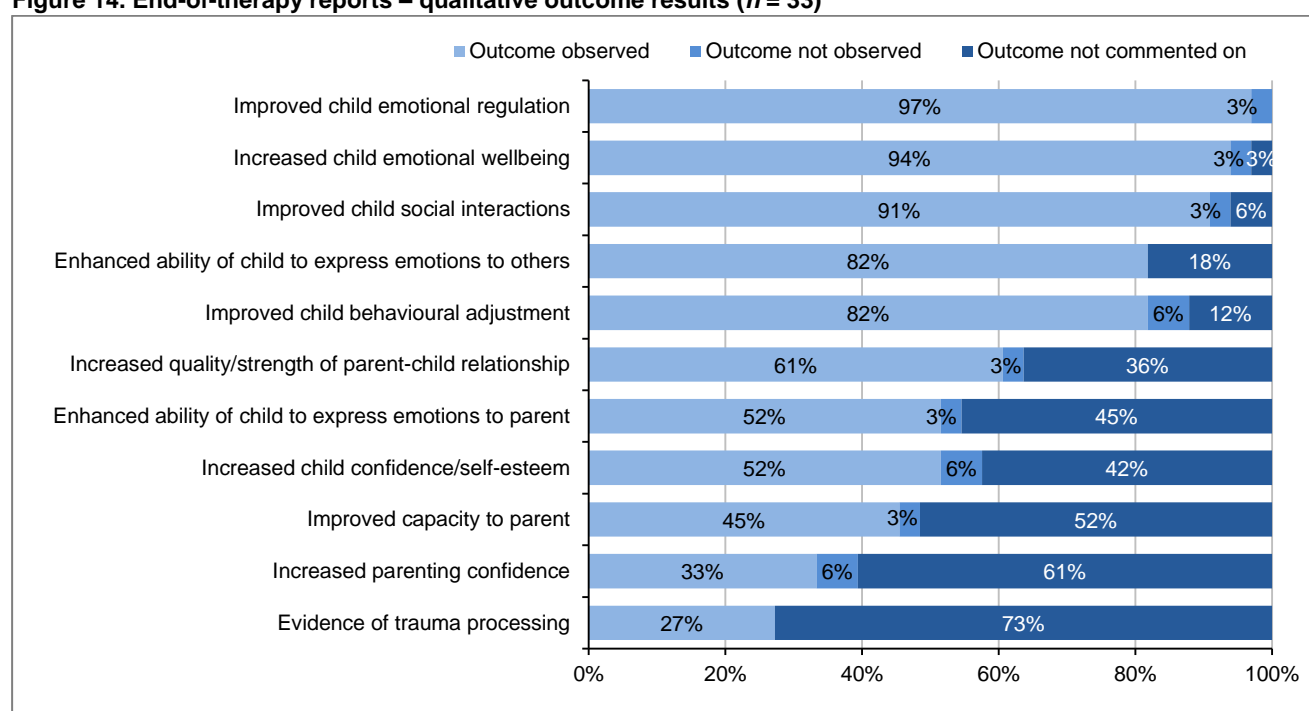
This snapshot reveals that the outcomes most widely noted by therapists concern improvements in children's emotional regulation, emotional wellbeing and social interactions. The least commonly reported outcomes pertain to parenting capacity and confidence, and trauma processing

In interpreting the data in Figure 14, it is important to remember, as explained in the methodology, that these reports were not designed specifically for collecting outcome data related to the objectives of the evaluation. Accordingly, they do not prompt therapists to comment on particular outcomes of interest to the evaluation as these may not (all) be relevant for a particular child. Therefore, observations relevant to these evaluation interests may not be recorded. The end-of-therapy reports are intended to focus on the child's progress, rather than the parent's, and therefore are likely to under-report observed changes in the parent, such as improved parenting confidence.

**Table 9. Characteristics of clients in end-of-therapy report sample compared with all clients 1.5-5 years enrolled in expressive therapy during the evaluation period**

Client characteristic	End-of-therapy report sample (n = 33)	All ET clients 0-5 years (n = 84)
<b>Program</b>		
Refuge	70%	62%
Deception Bay centre	30%	38%
<b>Year exited program</b>		
2012-2013	18%	37%
2013-2014	82%	60%
Ongoing at 30/6/2014	0%	3%
<b>Age at entry (whole years)</b>		
Median	2	3
Mean (SD)	2.6(1.3)	2.9(1.4)
Range	0-5	0-5
<b>Gender</b>		
Male	64%	51%
Female	36%	49%
<b>Weeks enrolled in ET</b>		
Median	11	9
Mean (SD)	16.7(14.1)	13.4(15.8)
Range	2-47	0-85
<b>Total number of therapy sessions (all types)</b>		
Median	11	5
Mean (SD)	12.1(8.0)	8.0(8.4)
Range	1-36	1-42
<b>Number of sessions per week enrolled in ET</b>		
Median	0.9	0.8
Mean (SD)	0.9(0.4)	0.8(0.5)
Range	0-2	0-3
<b>Goals recorded in BCIMS</b>		
Yes	55%	52%
No	27%	26%
No data available	18%	21%

**Figure 14. End-of-therapy reports – qualitative outcome results (n = 33)**



Therapists may not see the child in social contexts, moreover, and accordingly may not be able to reflect reliably on improved social interactions. And finally, end-of-therapy reports may be used for a variety of therapeutic or administrative purposes by different therapists which will shape the information that ultimately gets recorded or excluded. These various issues need to be considered in interpreting the data in Figure 14.

To supplement this quantitative snapshot, Table 10 presents examples of therapists' comments reflecting the achievement of each of the qualitative outcomes examined.

**Table 10. Examples of therapist' comments reflecting therapeutic outcomes achieved by children**

Qualitative outcome examined*	Proportion of reports noting outcome**	Examples of therapists' comments reflecting this outcome
Improved child emotional regulation	97%	<ul style="list-style-type: none"> <li>"(Child's) use of language, body, and facial expressions improved; she began looking at (therapist) directly and asking, instead of demanding, what she wanted. (Child) was also more able to wait for a response, rather than needing (therapist's) attention immediately".</li> <li>"(Child's) vocabulary and use of sounds has increased and (child) now uses her language to communicate with her mother rather than screaming and tantrumming".</li> </ul>
Increased child emotional wellbeing	94%	<ul style="list-style-type: none"> <li>"Visual, books and strengths cards have assisted (child) with expressing how his week or past two weeks have been. Often he talks about being angry, sad and happy and is open to using strategies to assist him. For example (child) learnt to squeeze a stress ball... he chose to paint a postcard for his (relative) who passed away".</li> <li>"(Child) is less reliant on his dummy and his mum for support since starting expressive therapies. At the start of the program, even with his mum in the room, he would say 'mum' many times throughout the session and constantly look to her for support. In the last session he was happy to engage with his mum but did not need or seek this support with any urgency".</li> </ul>
Improved child social interactions	91%	<ul style="list-style-type: none"> <li>"(Child) does not like to share. Wants to play anything that someone else is playing with... As therapy progressed (child) began to listen and was learning to share/be more compassionate towards his (sibling). His increasing ability to share was also recognised by staff and other families in the refuge".</li> <li>"(Child) was unable to mirror the therapist's sounds and movements at first. By the third session however, (child) had begun to dance along when music was played, and made his first new sound; "ooh", copying the therapist while she poured sand".</li> <li>"Overall, individual therapy sessions have assisted (child's) development. More specifically (workers and parent) have highlighted an improvement in (child's) ability to regulate, express and identify her emotions, interact socially, use more eye contact and develop language, fine motor and gross motor skills".</li> </ul>
Improved child behavioural adjustment	82%	<ul style="list-style-type: none"> <li>"(Child) has experienced different mediums (sand, paint, shaving cream, play dough and shells) and has started timid with all mediums and grown to explore and find different ways of interacting. Through sensory exploration, (child) has worked through some difficulties with sensory avoidance, cleanliness and fear of mess".</li> <li>"(Therapist) observed that (child) was able to relax and be calmer during art making; staying with and focussing on these activities longer than any other".</li> <li>"When assessing (the baby's) developmental milestones at the end of therapy, (the baby) achieved all milestones and was advanced in some areas for her age".</li> </ul>
Enhanced ability of child to express emotions to others	82%	<ul style="list-style-type: none"> <li>"Over time (child) became familiar with the therapy space and the therapist's reactions. He began anticipating these reliable responses, smiling and laughing at the therapist and encouraging her playful behaviour".</li> <li>"(Child) was forced to stay quiet when Dad couldn't cope with the children's noise... As therapy continued, (child) became more likely to become aggressive during a therapy session. This suggests (child) felt safe enough to express his emotions with (therapist)".</li> <li>"At the beginning of therapy (child) would make mumbled sounds to communicate. By the end of therapy he was sitting for longer periods of time telling the therapist about the image he had created and how he felt".</li> </ul>



Qualitative outcome examined*	Proportion of reports noting outcome**	Examples of therapists' comments reflecting this outcome
Increased quality/strength of parent-child relationship	61%	<ul style="list-style-type: none"> <li>"At first, (child) treated his mother as if she was a piece of furniture in the room (ignored any emotional connection with her, however used her to hide behind or sit on her)... (Child's) mother was invited back into his sessions from week 9... From this point forward (child's) interactions with his mother were more emotionally-based and were met appropriately through structuring, reflective listening, imaginary play and limit/boundary skills from his mother".</li> <li>"When entering the refuge (baby) and (mother's) relationship appeared fractured... (Baby) appeared distant from her mother, leaning away from (mother) and giving limited eye contact... (During therapy however, the baby) appeared to respond positively to her mother's attention, seeking her affection, returning to her during play, and appearing relaxed in her presence".</li> <li>"After a couple of sessions, (child) has enjoyed many opportunities to engage and play with (mother), with (her mother) mirroring her actions... (Mother) feels that she is becoming more confident in setting boundaries and is aware that structure helps (child) feel safe".</li> </ul>
Enhanced ability of child to express emotions to parent	52%	<ul style="list-style-type: none"> <li>"(Child) was highly motivated by sensation, and this exploration aided in the process of creating connection and communication... (Child) and (mother) were able to experience some very special moments together often involving laughter, when engaged in sensory experiences".</li> <li>"(Mother) struggled at first to accept her son's aggressive expressions within the therapy space. However, once the importance of a non-judgmental response was explained, (mother) was able to allow her child this freedom, and (child) was able to show these negative emotions to his mother without being judged. (child's) aggression within the family home dramatically reduced".</li> </ul>
Increased child confidence/self-esteem	52%	<ul style="list-style-type: none"> <li>"(Child) showed fear towards a plastic spider in the room each week. After a few weeks this fear began to reduce and (child) asked to touch the spider, eventually becoming fond of the spider, asking to play with it regularly".</li> <li>"(Child) has never been to childcare; always staying inside the house. The only time he left the house was when he was allowed to go the shops with his father... (Child) was very fearful of leaving the house... (Child) was nervous about being with the therapist at first, but then able to enjoy and explore the therapy room once there".</li> <li>"(Child) has witnessed domestic violence as well as family separation. The mother reports that he is very clingy and anxious and will not leave her side... Over the course of individual therapy (child) became more calm and collaborative in most sessions and often enjoyed co-creating alongside the therapist... (Child) will now depart comfortably from his mother".</li> </ul>
Improved capacity to parent	45%	<ul style="list-style-type: none"> <li>"(Mother) took some of the activities she learnt from the sessions home; reporting that she had incorporated baby massage into her daily routine, and was now surrounding (baby) with new stimuli for her to explore".</li> <li>"(Child) sometimes hit his mother and sister and expects that they will do (activities) for him. Reflection with (mother) after each therapy session has helped her to be more aware of (child's) over-dependence on his female elders. (Mother) is now practicing using encouraging words with her son, and learning how to step back, have patience and allow (child) to try things for himself".</li> </ul>
Increased parenting confidence	33%	<ul style="list-style-type: none"> <li>"During the final session it was clear that (mother) had taken, understood, and retained all of (the therapist's) advice... Ultimately (the mother) was creative, fun and everything (her son) needed within the room... He appeared content and happily responded to his mother with excited facial, bodily and vocal expressions".</li> <li>"(Child) remains full of energy and continues to attempt to push the boundaries... the difference is that (mother) now views this defiance differently and no longer feels guilty when putting limits in place".</li> </ul>

Qualitative outcome examined*	Proportion of reports noting outcome**	Examples of therapists' comments reflecting this outcome
Evidence of trauma processing	27%	<ul style="list-style-type: none"> <li>"(Child) has witnessed a lot of domestic violence inflicted on his mother by his father throughout his life... On one occasion, (the child) placed (the therapist) in jail and expressed great anger – hitting a doll repeatedly. (The therapist) was aware that she had been placed in a position of witness to the violence – a position (child) may have often experienced".</li> <li>"(Child) then began to role-play talking to her father on a toy mobile phone. She asked her father questions about where he was living and working, and wondered aloud about whether he was alone... (The therapist) discovered that (mother) had not spoken with her daughter about the reasons for leaving her father. (Mother) was also rejecting (child's) questions about this topic which (the therapist) discovered she was frequently asking".</li> </ul>

\* Note that end-of-therapy reports do not prompt therapists to report on any of these outcomes, nor will all outcomes be relevant to each child or relevant for commenting on in a report specifically focussing on the child's progress, not the parent's.

\*\* Proportions based on sample size of 33.

## Discussion

### 4.1 Assessment of intervention effectiveness

Various data sources were drawn upon to make assessments about whether or not BoysTown's Expressive Therapies Intervention, embedded within holistic case-managed support programs for vulnerable families, is effective in enhancing the social and emotional wellbeing of young children with complex needs as a result of their traumatic life and family experiences. The analysis of these data sources suggests unequivocally that participation in this integrated model of expressive therapies is associated with a range of positive impacts on children's social and emotional wellbeing and functioning.

- *Analysis of CBCL data* indicates that for those pre-school children for whom pre/post assessments were available, statistically significant improvements were observed in relation to internalising problems, externalising problems and total problems including improvements in six of the seven behaviour subscales (in order of treatment effect size: aggressive behaviour, emotional reactivity, attention problems, withdrawn behaviour, anxious/depressed behaviour and sleep problems). Not only were these improvements found to be statistically significant and to reach the threshold for a "large" treatment effect, but they were also found to have clinical significance. A substantial majority of preschool children entered therapy in the clinical or borderline clinical symptom ranges for internalising (67%) and externalising problems (70%) and at exit from therapy, just 13% remained in the clinical or borderline clinical ranges on either of these measures.
- *Analysis of parent survey data* indicated that at least four out of every five respondents observed improvements in their child's emotional wellbeing, their child's emotional regulation, their child's ability to express emotions to the parent, their child's behavioural adjustment, the quality of their relationship with their child, and their confidence and capacity to parent their child. In addition, more than half indicated improvements in their child's ability to express emotions to others, their social interactions and their confidence and self-esteem.
- *Analysis of therapists' end-of-therapy reports* revealed that at least four out of five therapist reports noted improvements in the child's emotional regulation and wellbeing, social interactions, ability to express emotions to others, and behavioural adjustment. In addition, more than half the reports indicated improvements in the quality of the parent-child relationship, enhanced ability on the part of the child to communicate emotions to the parent, and improvements in the child's self-confidence and self-esteem.

It is important in considering this evidence, however, to bear in mind that the preschool-aged children for whom outcome data were available were enrolled in expressive



therapies for longer on average than all expressive therapy clients in this age group (i.e. between 17 and 23 weeks on average (means) compared with a mean of 9 weeks for all preschool-aged expressive therapy participants). Treatment effectiveness is likely to be related to length of time in therapy so caution should be applied in generalising these findings to all expressive therapy participants.

## **4.2 Attribution of effectiveness**

### **4.2.1 Attributing treatment effects to expressive therapies**

As noted in the methodology section, a range of practical and ethical constraints have prevented BoysTown from employing an experimental or quasi-experimental research design for this evaluation. Without a comparison or control group, it is not possible to attribute the treatment effects observed in the CBCL analysis specifically to the Expressive Therapies Intervention. Improvements may conceivably have occurred with no intervention at all or they may have occurred due to, or due in part to, other program elements.

Therapists' and parents'/carers' observations of changes in children, however, frequently include the making of intelligible connections between specific therapeutic elements or techniques and changes occurring in children's wellbeing and functioning (see Tables 8 and 10). The impacts of particular therapeutic activities noted by therapists and parents/carers can be seen to closely align with the kinds of impacts these therapeutic activities and techniques are attributed to have in the therapeutic and research literature, as outlined in section 1.2.3 at the start of this report. For example, parents/carers frequently attribute improvements in the emotional quality of their relationships with their children to the parenting education and mentoring they have received from therapists (a part of filial therapy). Similarly, therapists often note the critical role of somatosensory processes in the initial phase of therapy for lowering a child's fear and stress arousal and enhancing self-regulation prior to being able to successfully engage the child in other higher order therapeutic work. These qualitative insights from parents/carers and therapists therefore help to strengthen the likelihood that the observed changes in children are not accidental or inevitable or due solely to other program elements, but are genuinely the result of the application of a theoretically-coherent research-evidenced therapeutic framework.

### **4.2.2 The likely impact of broader program elements**

At the same time, it is entirely plausible and indeed likely that broader program elements impact on the outcomes of expressive therapies for children. This is, after all, one of the reasons that BoysTown originally chose to deliver the Expressive Therapies Intervention in the context of holistic case-managed family support programs, rather than as a standalone intervention. It believed these programs would support the achievement of therapeutic objectives. Some of the data reported in the findings section indirectly point to the influence of programmatic context on therapeutic outcomes achieved. The data presented in Figure 12 comparing changes in CBCL symptom range classification for preschool-aged children according to the site where therapy was provided suggest children achieve equivalently dramatic improvements in their symptom range classification from intake to exit regardless of where they attend therapy. However, children in the Deception Bay CBCL/1.5-5 sample ( $n = 13$ ) were enrolled in expressive therapies for a mean of 41 weeks and participated in a mean of 19 therapy sessions while children in the refuge CBCL/1.5-5 sample ( $n = 17$ ) were enrolled for an average of 9 weeks and participated in a mean of 10 therapy sessions. Given that both sites employ the same therapeutic framework and processes, these observed differences suggest that the refuge program and service delivery context, compared with the Deception Bay programs and service delivery context, more powerfully enhances the efficacy of the Expressive Therapies Intervention.

This makes good sense, according to expressive therapists from both sites who were interviewed by the research team in the preparation of this report. The refuge endeavours to cultivate around resident families a "total environment" characterised

foremost by safety. Case management provided to resident families is particularly intensive given the time-limited nature of the refuge program and the fact that it is provided onsite and where families are residing. Engaging families in a range of integrated parenting, child and family support services is greatly facilitated by the resident nature of the service population and the intensity of the support relationships established. Parents receive counselling adjacent to their children's to help them process and integrate their trauma-related experiences. Moreover, there is the potential for families at the refuge to provide a community of support for individual women and children in relation to shared experiences of domestic and family violence and the journey of recovering from the impacts of these experiences. Accordingly, this service delivery context provides unique additional opportunities for therapeutic group work across family groups.

At Deception Bay, by contrast, many of the children who participate in expressive therapies have no relationship with other children at the centre; nor do their parents/carers. The parents/carers may be participating in case management but the intensity of that support will depend substantially on the motivation and engagement of the parent/carer. The comparative difficulty of maintaining the engagement of families in the Deception Bay context is apparent in the fact that over the average 41 weeks of enrolment in expressive therapies, children in the CBCL/1.5-5 sample only participated in an average of 19 sessions, while at the refuge over an average of 9 weeks children were engaged in an average of 10 sessions – that is, less than one session per fortnight at Deception Bay compared with more than one per week at the refuge.

Also, there is no site-based counselling available for parents/carers at Deception Bay in the way that there is at the refuge. Accordingly, many parents/carers who need counselling have to seek outside assistance and then face a range of common but significant barriers to accessing such counselling – time, motivation, financial capacity, transport difficulties and knowledge about how to access services. Therapists interviewed in the process of developing this report noted that therapeutic outcomes for children can be seriously undermined or delayed by the failure to address the underlying therapeutic needs of parents/carers. As one therapist interviewed by the research team stated: "the parent cannot give full attention to their child until they are prepared and enabled to give full attention to themselves".

Finally, and most importantly, children participating in therapy at Deception Bay will frequently return home between therapy sessions to care environments that remain chaotic, stressful and also sometimes fearful and unsafe. There is no "total environment" of safety and support surrounding these children. In light of this fact, and in view of the other issues outlined above, it makes sense that the therapeutic process is on average more protracted for children in the Deception Bay context than for those at the refuge. This also makes sense in light of Perry's neurosequential model for therapeutic work with maltreated children which emphasises that until a traumatised child feels safe, negligible therapeutic or developmental work will be achievable (Perry, 2006; Perry & Szalavitz, 2006). Therapists at Deception Bay may have to build this sense of safety slowly through the only mechanism that may be available to them – their relationship with the child.

## **4.3 Significance of the findings**

### **4.3.1 Addressing a gap in existing knowledge**

One of the objectives of this evaluation was to contribute to the evidence base regarding effective therapeutic interventions with traumatised and attachment-disturbed preschool-aged children. This objective arises from the fact that very few creative arts or play therapy interventions with preschool-aged children have been formally evaluated. While the evidence base for such interventions with school-aged children is more considerable (see for example, Baggerly, Ray & Bratton, 2012), relatively little is known about their effectiveness with very young children.

The findings noted above in relation to preschool-aged children suggest very compellingly that a trauma/attachment informed creative arts and play therapy intervention in the

context of holistic family support programs can achieve significant positive impacts for young children. While it was not the intention of this study to investigate the comparative treatment effectiveness of the intervention on the preschool and school-age cohorts, the CBCL analysis does provide some comparative data for the two age groups. Figure 11 provided a comparison between the age groups in relation to changes in symptom range classification from intake into therapy to exit from therapy. This figure shows that while improvements in symptom range classification are evident for both groups from intake to exit, the magnitude of improvement on all three main problem scales is greater in the younger age group.

These observations are possibly not surprising from a neurodevelopmental perspective as children in this age group are in a period of rapid brain development and undertaking core developmental steps like learning to regulate their stress arousal and emotional states and relate socially. Accordingly, early intervention focusing on emotional regulation and social development is likely to be assimilated more easily than after the conclusion of this period of rapid brain development. Notwithstanding this point, the findings of the evaluation in relation to the impacts of the Expressive Therapies Intervention on preschool-aged children are noteworthy in light of the substantial absence of other evidence in the research literature about the effectiveness of expressive therapies interventions with young children.

#### **4.3.2 Contributing to recovery from developmental trauma and insecure attachment**

The findings of this evaluation are more generally significant in light of the wealth of research regarding the long term impacts of developmental trauma and insecure attachment on children. As noted earlier, chronic childhood trauma has been found to compromise potentially every aspect of brain development associated with normal child development. This is because chronic fear and stress prevent the regulation of the brainstem and therefore interfere with the development of all higher order regions of the brain and the integration of brain systems (Perry, 2006; Perry *et al.* 1995). Pervasive impacts of chronic childhood trauma include “chronic affect dysregulation, sleep problems, exaggerated startle response, destructive behaviour against self and others, learning disabilities, hypervigilance, dissociative problems, somatisation, generalised anxiety, and distortion in concepts of self and others” (Klorer, 2004: 12).

Insecure, and especially disorganised, attachment can have similarly devastating long term impacts on children’s social and emotional functioning and wellbeing. As noted earlier, secure attachment with a caregiver facilitates many critically important steps in early child development. If children are prevented from undertaking these steps because of relational trauma or insecure attachment in early childhood, they are at high risk of developing complex emotional and behavioural problems stemming from difficulties with emotional self-regulation, impulse control, learning delays, low self-esteem and shame, poorly developed and negative sense of self and others, and/or difficulty understanding, trusting, and relating to others (Cairns, 2002; Schofield & Beek, 2006; Stien & Kendall, 2004). Without effective intervention, these problems can persist and deepen through adolescence and undermine social and emotional wellbeing throughout the life course (Stien & Kendall, 2004).

In light of the long term negative impacts of developmental trauma and insecure attachment on children, the findings of the current study are particularly poignant in so far as they suggest that the therapeutic intervention has positive impacts on children’s development of secure attachment relationships and healing from developmental trauma. As outlined at the start of the report, key therapeutic tasks in working with children who have experienced attachment difficulties and/or developmental trauma include:

- lowering fear/stress arousal and regulating lower-brain functions
- enhancing the child’s capacity for emotional self-regulation
- building capacity for secure attachment and for relating effectively to others
- facilitating trauma processing and integration, and
- enhancing the child’s sense of self-worth and self-efficacy.

The first two of these tasks are regarded as the most fundamental, without which further developmental or higher-order therapeutic progress will be impeded or precluded (Perry, 2006; Foderaro & Ryan, 2000). The findings of the pre/post CBCL analysis indicate widespread and significant improvements in behaviours of children associated with elevated stress arousal and poor brainstem regulation, like attention difficulties, emotional reactivity, and aggression. They also show improvements in another set of behaviours commonly associated with post-traumatic fear states – internalising behaviours. Chronic internalising of feelings can result in difficulties sleeping, somatic complaints, and anxious or depressed behaviour (Perry, 2006; Streeck-Fischer & van de Kolk, 2000). The pre/post CBCL analysis indicates that children who participated in the Expressive Therapies Intervention achieved statistically and clinically significant reductions in internalising behaviours, including significant reductions in withdrawn behaviour, anxious/depressed behaviour, and sleep problems. A moderate effect size was also seen in relation to a reduction in somatic complaints although the reduction itself was not statistically significant.

Analysis of the parent feedback survey and therapists' end-of-therapy reports corroborates these CBCL findings and in addition speaks to widespread improvements in children's emotional self-regulation – such as enhanced ability to express emotions in words rather than actions, self-soothe, recover from upsets, reduce internalising and/or externalising behaviours, and draw on carers to co-regulate emotional states. Parents/carers and therapists also widely observed improvements in the quality of children's relationships with their parent/carer, children's ability to relate socially to others, children's sense of self-esteem and self-confidence, and their willingness to explore the world. About a quarter of both parent surveys and therapists' reports also reported evidence of children's trauma processing and integration.

The findings of the current study therefore strongly suggest that the therapeutic intervention in the context of family support programs has positive impacts on both children's development of secure attachment relationships and healing from developmental trauma. To this extent they suggest that due to participation in the intervention, children may have increased opportunities to circumvent the entrenchment of complex emotional and behavioural problems, to achieve normal developmental milestones and to experience greater emotional and social wellbeing into the future.

The current study, however, does not establish that the observed changes in children are sustained over time or that they have long term positive benefits. Further research is required to support that claim. However, given the timeliness of the intervention in terms of children's developmental stages and the fact that the intervention very often involves not only important developmental and intrapersonal transformations but also fundamental transformations in family and parent-child relationships, it would be reasonable to hypothesise that the positive impacts observed on children will have valuable repercussions well into the future.

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