International Journal of Art Therapy, December 2006; 11(2): 79–101

Routledge
Taylor & Francis Group

ORIGINAL ARTICLE

Examination of the changes that take place during an art therapy intervention

HILARY POUNSETT, KAREN PARKER, ALISON HAWTIN, & SUZANNE COLLINS

Abstract
Three Cambridge based art therapists, in collaboration with a clinical psychologist, designed this research to examine if change can be measured in art therapy with adults with moderate/severe learning disabilities. The aim was to gather objective information about changes in the client that correlate with the therapist's clinical opinion. The quantitative data was gathered by videoing the art therapy sessions every two months over the first year of therapy for three individual clients. The researchers created the POSER 2001, a measurement tool that allowed profiles of the client, therapist and their interactions to be generated from the videoed sessions. Psychologists independently rated these videos. Changes recorded by the POSER 2001 were then related to the three case studies written by each therapist, from the clients case notes, at the end of the data collection period. The results indicate that change can be measured within art therapy sessions without detriment to the therapeutic process and show the potential to collect qualitative and quantitative data, which together illustrate important aspects of the therapeutic process.

Keywords: *Research, consent, learning disability, quantitative/qualitative measures, video*

Introduction

The purpose of this research was to examine the changes that take place during an art therapy intervention, and establish whether these changes can be measured in ways that are objective and observable.

This research was undertaken in the context of three joint NHS/Social Services Community Teams for adults with learning disabilities. Each multi-disciplinary team has one part-time art therapist; all of whom were involved in the research within their normal working commitment. The study was based on individual case studies along with observational scales.

This research has taken seven years to complete, from initial thought to final data interpretation and publication.

In this research we have not pursued any specific analysis of the art product, although we make direct reference to clients' imagery and the art making process. We are aware of the compromise involved, but felt this to be a necessary omission at this stage of our experience as researchers, and the increasingly apparent enormity of the study. We wanted data that could be collected and analysed by non-art therapists.

Definitions

The Mental Health Act (1983) refers to learning disability as "mental impairment" that "means a state of arrested or incomplete development of mind...which includes significant impairment of intelligence and social functioning" (MHA, Part 1, p. 2), and must be present from childhood. The access criterion of our employing organisation is based on this definition. The World Health Organisation (1980) states that a disability is a restriction resulting from impairment, and a handicap is the disadvantage to an individual resulting from this impairment or disability. Valerie Sinason, psychotherapist, recalls how the language used to describe disability is in a constant state of flux as terms such as "retardation" and "subnormality" are replaced with phrases such as "special needs" and "learning disability". She suggests that this points to an evasion of the pain of handicap in our society,

Correspondence: Karen Parker, City Team LDP, Block 7, Ida Darwin, Fulbourn, Cambridge, CB1 5EE, UK. Tel: 01223 884076. Fax: 01223 884460. E-mail: karen.parker@cambsmh.nhs.uk

1745-4832 (print)/1745-4840 (online)
DOI: 10.1080/17454830600980325

where the emotional suffering associated with handicap is intrinsically linked with society's handicapping attitudes (1992).

Art therapy and psychotherapy research within the field of learning disability

Much of the small body of published literature about psychotherapy and art therapy with adults with learning disabilities has been written in case study form (Beail, 1989; Hughes, 1988; Sinason, 1992; Stott & Males, 1984; Symington, 1981; Tipple, 1993). Other research undertaken by art therapists in this field include Dubowski (1983), Males (1983, 1986) and Evans and Dubowski (2001). Professor Nigel Beail, a leading researcher of psychotherapy in learning disabilities, points out "the purpose of these case studies is to illustrate application" rather than address the question of outcome (Beail, 1995, p.188). Gilroy and Lee (1995, p. 6) echo this and identify "two areas of study – issues surrounding art therapy as a profession and case study-based research addressing clinical practice. . .The preference in both areas of art therapy research has been for qualitative methodologies, with outcome studies absent from the literature". However Pauline Mottram (1999) in her MA by Research Thesis identified four art therapy quantitative research studies by Russell-Lacy, Robinson, Benson and Cranage (1979), Luzzatto (1987), Perry (1991) and Gilroy (1995) and recently Professor Waller has conducted research, around dementia and art therapy, and this year gained funding with Dr Mike Crowford, reader in mental health services research, Imperial College London and colleagues regarding random control trials (RCT) on art therapy groups for people with schizophrenia.

Recently there has been an increase in interest in looking at the outcomes of psychotherapeutic interventions with people with learning disabilities (Allan & Lindsay, 2004; Balbernie, 1995; Beail, 1989, 1994; Frankish, 1989; Hollins & Sinason, 2000; Jahoda et al., 2004; Parkes et al., 2004; Taylor et al., 2004). However this literature is still in an early stage of development and uses small numbers of participants and may have some methodological difficulties. In addition many of these studies involved people with mild learning disabilities.

Art therapy is one of the few psychotherapeutic treatments that generally this client group has been able to access consistently. Some psychotherapy services maintain learning disabilities as an exclusion criterion. Banks and McGinnity (2004) in a Royal College of Psychiatry Survey found that there seemed to be a demand for psychotherapy services for clients with learning disabilities and that where they are offered they cover a range of models and that access is usually through learning disability services. Additionally lack of appropriate training and supervision impede access to services.

Although research paradigms from psychotherapy can be relevant, we were inspired to hear Dr. Andrea Gilroy (Gilroy, 1996), at an evidence based practice conference in Norwich, speak of our "need to develop our own kind of evidence".

In the last 10 years, arts therapists, like other health clinicians have come under pressure to meet the requirements of clinical effectiveness initiatives. This has resulted in several publications exploring research and evidence-based practice (Brooke, 1996; Edwards, 1993, 1999; Feder & Feder, 1998; Gilroy, 1996; Gilroy & Lee, 1995; McNiff, 1998; Rutten-Saris & Evans, 2000; Taylor, cited in Rees, 1998; Wadeson, 1992; Wigram, 1995; Wood, 1999).

More recent movements towards a more comprehensive art therapy research body include the establishment of the Art Therapy Practice Research Network, which includes a Learning Disabilities Special Interest Group. Research is now a component of the art therapy training and for State Registration with the Health Professions Council, we must "be aware of the principles and applications of scientific enquiry, including the evaluation of treatment efficacy and the research process" (Arts Therapists, Standards of Proficiency, 2003).

Holtom (1977) using surveys conducted a study of multi-disciplinary team member's perception of change attributable to art therapy. We also decided to undertake research looking at change. We wanted to look at the changes that take place during the art therapy sessions, and establish whether these changes can be measured in ways that are objective and observable. We also sought to respond to the point made by Beail (1998) that the reduction of problem behaviours tends to be recorded rather than evidence of the development of "pro-social" behaviours. Prouty (2002) speaks of "pre-therapy" work, many aspects of which we would consider therapeutic relationship building and integral to therapy. This was useful in assisting us in thinking about what to measure and why.

Hypothesis

- That it is possible to measure change in art therapy with this population.

Aims

1. To gather effective objective information about changes in the client that correlate with the therapist's clinical opinion.
2. To set clear goals following an initial interview and assessment, to see whether this would assist us in evaluating the effectiveness of the treatment, or whether this in fact hampered the development of the therapeutic process.

The use of video in art therapy with people with learning disabilities

The use of video with people with learning disabilities has been used in research as a way of monitoring change particularly with regard to challenging behaviour (McBrien, 1994).

Use of video in art therapy is not traditionally considered an appropriate way of gathering information about therapy sessions. However there are some examples of its use, Kathy Evans (2001) utilised video in her research with children with autism. As the purpose of our research was to gather data that was objective and observable, we felt that videoing the sessions was essential. This was not an easy decision, due to the fundamental wish to preserve the privacy of the client. Through lengthy discussion with our psychology colleagues, and as a result of submission to our local ethics committee for approval, we learnt a great deal about seeking consent of the client and maintaining their confidentiality. Not only were we worried about how the use of video might affect the client, but also whether we as therapists would feel inhibited and unable to work as we would normally.

Ethical considerations

The Cambridge Local Research and Ethics Committee (LREC) gave ethical approval for this study in 1997.

Consent

Factors in decision-making are multiple and complex; they are impacted by an individual's cognitive and emotional functioning, knowledge of what is being asked, the way the information is presented and the decision sought, and the nature of the relationship between the presenter and the decision-maker (Holland et al., 2004). By definition people with learning disabilities have impaired intellectual functioning and may have problems with memory. Low self-esteem and experiences of shame or guilt can affect compliance, suggestibility and vulnerability to exploitation. Expressing opinions or decisions effectively can be compounded by difficulties with communication. The Lord Chancellors Department (1997) in the report, "Who Decides? Making Decisions on Behalf of Mentally Handicapped Adults" suggested that legal decision-making involves at least three main stages: (a) understanding the nature of the choice to be made, (b) making the decision, and (c) conveying the decision to others.

We aimed to provide potential research participants enough meaningful information to enable them to make an informed decision about whether to participate in the research, this included seeking consent to be videoed. Consent forms and explanatory information about the research was produced in both written format and rhebus symbols. These were explained and given to the client and their carer at the initial meeting. During the assessment process, the therapist reiterated this information and a "video box" was left in the art therapy studio. Clients were shown the video camera and where it would be positioned in the video box in the room if they gave their consent. The client conveyed their decision regarding consent to their carer, who with them signed the consent forms and returned them to the therapist at the end of the assessment period. The authors deal with the issue of consent in more detail elsewhere (Parker et al., 2004) (see Appendix A, Consent Documents, parts 1 and 2).

Confidentiality

Data collected in this research was stored in a locked filing cabinet according to the guidelines in the Data Protection Act 1998.

All audio and videotapes were destroyed on completion of the research. Session notes are kept in the participants health care records as a standard record of therapeutic contact.

Methodology

Recruitment

Recruitment to the study was via general referrals to the Service for Adults with Learning Disabilities within a specified period of three months. All consecutive referrals within this timeframe were considered for recruitment into the research.

Inclusion criteria

Participants could be of any age, sex, ethnicity or disability, and they could be verbal or non-verbal. Each of the therapists involved in the research recruited one participant. All eventual participants had multiple disabilities.

Exclusion criteria

Potential participants were excluded at referral stage where the demands of being videoed were felt to be clinically detrimental, or where having to make the decision about whether to participate or not may have created anxiety that might have jeopardised assessment and treatment. Two individuals were excluded later; one became distressed when their care-worker was being interviewed about them. The second was excluded from the project when it became clear during the assessment that her commitment to therapy was poor.

Length of time in therapy

The interactions between the client and therapist were measured during the first year of therapy. Two clients continued in therapy beyond this.

Measures and their selection

For people with a learning disability and/or multiple disabilities, performance measures designed for the general population such as patient questionnaires or self-monitoring procedures are not always appropriate. Some measures are modified or designed specifically for this client group (Beail, 1998).

Measures were chosen for this study that were felt to be sensitive enough to show change over time for people with multiple disabilities in therapy. A number of measures were considered.

The Adaptive Behaviour Scale (ABS) (Payne, 1993) and Mini PAS-ADD (Prosser et al., 1996) were considered and rejected because of administration difficulties as well as concerns over their sensitivity levels in collecting meaningful information for the study. The Mini PAS-ADD (1998) is designed to give information about the mental health status of people with learning disabilities, and the ABS, their social behaviours. Both rely on others' reports. Two of our study's participants with mental health problems did not score on the trial with the Mini PAS-ADD or the ABS. This may have been due to poor information given by the "key informant", in both cases the main caregivers, who tended to give an overly positive view, perhaps because a negative view might be perceived as reflecting badly on their quality of care.

The CORE System (Evans et al., 1998) was not appropriate for this study, due to the necessary reading age of nine years and the ability to self-report. A Learning Disability version is now being created.

The Draw A Person (Machover, 1949) and the House-Tree-Person Test (Buck, 1977) were also rejected. Although they offer a tool that requires art making, as art therapists we were concerned about the possible detrimental effect that requesting a "product" and defining a task early on in the relationship might have. Also, particularly the DAP demands a developmental norm in representational drawing skills and cognitive processing that we could not presume of our clients.

After much searching we found The Play Observation and Emotional Rating System (POSER; Dieter Wolke, 1985, unpublished). We chose this scale because it focussed on interaction, which is integral to our work. The version we created, POSER 2001, was adapted from an amended version of the original scale, designed to measure mother/baby interactions. The language was made appropriate to adult interactions and three extra dimensions were added, to capture aspects of the adult therapy relationship. A complete list of the dimensions is shown here. This scale was then used to rate the videos of the therapy sessions (see Appendix B (The POSER Dimension sheet).

Video ratings

Therapy sessions were videoed approximately every two months. The POSER 2001 allowed a profile of the client, therapist and their interactions within therapy to be generated for each videoed session. Change recorded by the POSER 2001 could then be related to the three case studies, which were written by each art therapist on the conclusion of the data collection period. An independent observer rated all of the videos. A second independent observer rated 20% of the videos. Both were psychologists. Inter rater agreement about what was seen in each video was tested using intra-class correlations as seen in Table I. Spearman's rank correlation was used, as the data was not normally distributed. As can be seen, the degree of correlation between the two raters was good, with 14 correlations significant at the 0.01 level. This indicates that it was both possible to define behaviours and for independent observers working separately, to have high levels of agreement about what was happening in each video. Dimension 10

Table I. Intra-class correlations of each dimension on the Amended POSER (2001).

Dimension	Spearman's correlation (two-tailed)	*R* squared + + +
1	.484*	23.4%
2	.829**	68.7%
3	.604**	36.5%
4	.695**	48.3%
5	.705**	49.7%
6	.824**	67.8%
7	–	
8	.624**	38.9%
9	.941**	88.5%
10	.371	13.7%
11	.590**	34.8%
12	.881**	77.6%
13	.895**	80.1%
14	.756**	57.1%
15	.701**	49.1%
16	.868**	75.3%
17	–	
18	.873**	76.2%
19	–	

** Significant at 0.01 level.
* Significant at 0.05 level.
– = cannot compute as at least one variable is constant.
+ + + the percentage of one observers observations, which could explain the observations of the other.
For a full description of dimensions see Appendix B.

(intensity of client non-verbal interactions) appears to be a less reliable dimension at this stage.

Session notes

In the session notes, we used a triadic description of the central components of art therapy. We needed a format that was broad enough to reflect the individuality of each client and clinician-style, as well as general enough to support the other research methodologies.

Our format reflects that which is fundamental to Art Therapy (Dalley & Case, 1992; Dalley, 1984). We looked at the relationship the client had with each of these areas:

1. The art materials
   This defined the specific medium of the art in therapy. As well as the image/object we are interested in the way the art materials are used.
2. The therapist
   This included non-verbal and verbal interactions with the therapist including considerations of transference and counter-transference.
3. The space
   This included how clients access art materials and other objects and moves around the room. A familiarity with and developing capacity to independently use the room, table organisation, seating, spatial awareness, and awareness of others was part of this.

Procedure

Referrals to arts therapy were placed on a waiting list and prioritised according to clinical judgement, after discussion with the team.

Assessment

A six-session assessment phase was undertaken to ascertain the client's suitability for art therapy. Observations were made of the clients' strengths and difficulties in being in the room, making and accepting contact with the therapist, and the potential use of the art materials as a vehicle for communication and expression.

The art therapists drew up an initial hypothesis about the client (i.e. how the client came to be in their current position) and outlined treatment goals and aims.

Planned format of the analysis of data

1. Change recorded by each therapist in session notes (health records) to be written into a case study format.
2. Changes recorded by POSER 2001 dimensions from independent ratings of the videos depicted in graph form by the psychologist.
3. Comparison of the graphs and case studies.

Results

We found that the case study format remained close to the practice of each individual clinician and did not encroach on the client/therapist relationship. It allowed for the assessment of each client's development and the qualitative description of identified variables, through his or her change in the process of therapy.

Constructing the ratings for the video observations was labour intensive, challenging and a huge learning curve for us all. We defined specific aims and goals for the therapy. We hoped that the external raters/observers of the video could pick up changes in the therapeutic interaction that would reflect these aims and goals. The POSER 2001 achieved this by recording increase, decrease and no change, in the dimensions that measure affect, interpersonal communication and trends towards reciprocity between client and therapist.

Comparison of the graphs and case studies

Participant 1 (Art Therapist – Hilary Pounsett). The participant was an able bodied man of 28 years with a severe learning disability and autistic traits.

As a child he had lived with his parents, but due to his mother's poor health, he began to have regular stays in a residential hospital from the age of eight. He moved to a group home in a local town, in his mid-twenties, where he was permitted to go out unescorted. He had received little formal education. He had epilepsy that was difficult to control.

The participant was referred because staff felt concerned about his well-being; he had been observed to frequent areas used by male prostitutes. He returned home by himself and it was evident he had been sexually active.

The following goals were set:

1. To foster communication that might help gain an understanding of the participant's perspective on his lifestyle.
2. To support the staff in managing a difficult situation.

The therapy continued for three years.

The participant opted to bring objects into the studio ranging from photographs of himself, to large bunches of keys and pens. Any encouragement that he might explore the art materials evoked high anxiety in him. He opted to pack the paints away for example, apparently to safeguard them, revealing ideas about possible intrusive and damaging acts that might occur otherwise. I describe here how my interest in his objects and his energetic capacity to relate began to develop into some exchanges in which a more meaningful emotional dialogue could occur.

The first session at which video data was gathered shows a relatively high level of reciprocity and turn taking measured in Dimension 18 between the participant and myself. He had brought photographs of himself to the session and was naming himself repetitively as "me", "him", and saying his name in the second person, whilst pointing to his image in the photograph. I felt he was attempting to hold himself together under the pressure of considerable internal anxiety and using me to support him in this.

His energetic use of me to respond to him is accurately reflected in this dimension.

It had been this energetic capacity that I had noticed in the assessment and thought favourably disposed him to art therapy (see Figure 1).

The participant arrived after a three week break during which he had refused to attend. He surprised me by announcing his arrival in the third person and wishing to know if he had been missed.

He then set about taking charge of the room and was unable to sit down for more than a few moments. He switched lights on and off, becoming elated when he was able to "make things work". Due to his rapid movements, the data from the second videoed session in Dimension 13, Attentiveness/absorption in task, accurately record a loss of capacity to focus (see Figure 2). He is seen to be controlling of the session whereas my own direction of the session is low. I remained seated and said I thought he was excited and frightened, as he was having to get used to things all over again, and this

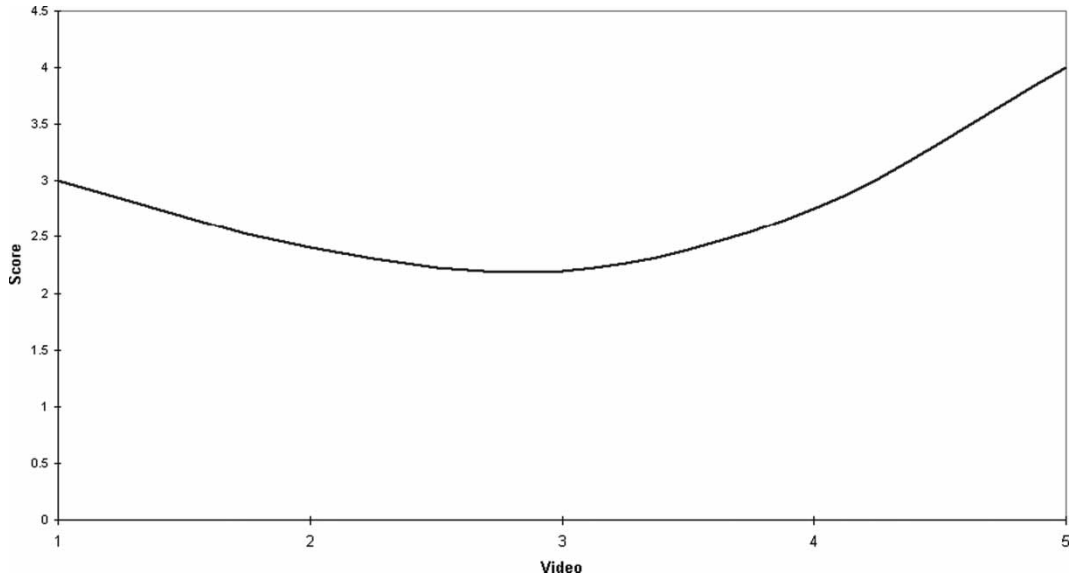

Figure 1. Dimension 18. Reciprocity, turn taking and mutual responsiveness (Participant 1).

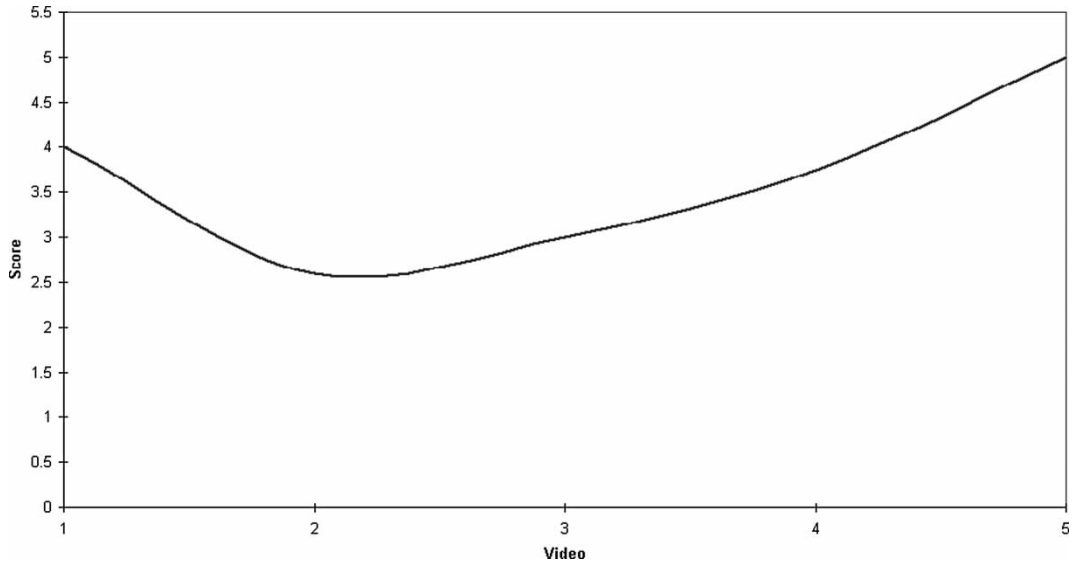

Figure 2. Dimension 13. Attentiveness/absorption in task (Participant 1).

was like before when he moved backwards and forwards from home to hospital.

The holding of the regular therapy time allowed the participant to painfully reveal his sense of broken attachments. This was not easy to maintain because he had often been up all night and would refuse to get in the car to be driven to the session. In an attempt to adapt to him staff tended to favour waiting until he was "in the right mood" before suggesting he do something. The regular appointment with me was a challenge for us all therefore but it allowed us to gradually understand that his chaotic, sexually promiscuous lifestyle was a defence against relating, rather than an example of successful normalisation of his adult sexual needs. This was a basic development of thinking in the supporting agencies.

The participant began to attend more regularly and some of the naming and repeating exchanges began to develop. Objects outside of the room began to be recalled in the interests of this. He began to allow his mind to associate more freely and more emotionally coherent exchanges took place. An example of this is when the participant brought a pen to a session and told me he had found it. I encouraged him to make some marks with it on a piece of paper. He did so and whilst looking at the marks said pensively, "red", then "traffic lights". He touched some old scar tissue on his arms and said "red blood", which led to the recollection of going to hospital following a self-inflicted injury. He looked at me and began to laugh rather hysterically, but paused and said "sad face", reading my expression intently, to which I nodded.

Such increases in meaningful exchanges are reflected in the figures that measure the participants "attention and absorption in task" I feel. This measure seems to allow the video raters to pick up

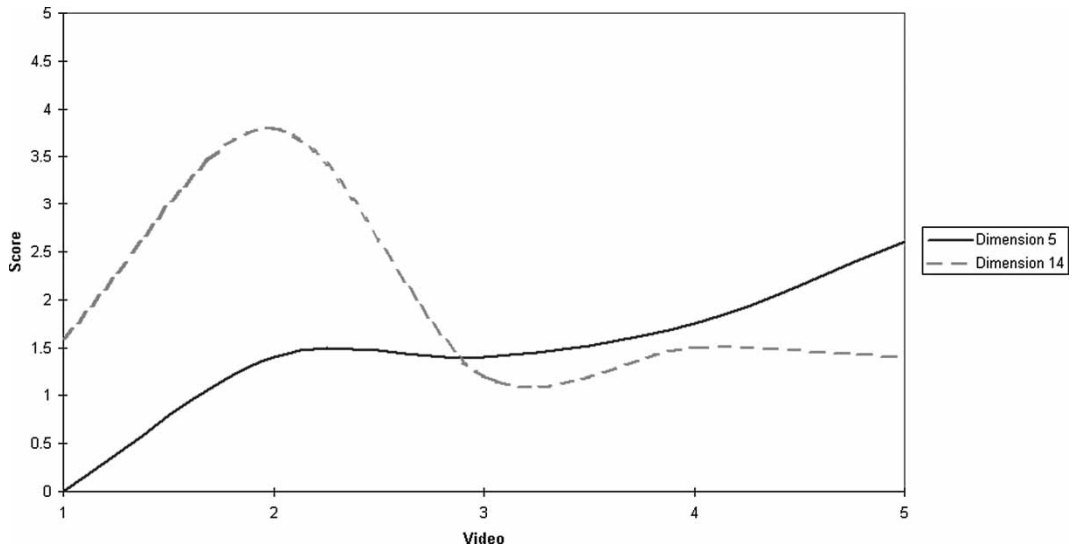

Figure 3. Dimension 5: Therapist, Behavioural direction of the session and Dimension 14: Client, behavioural direction of the session (Participant 1).

on the quality in the developing relationship, which gradually, incrementally increases, with the art materials providing a focus for a developing dialogue.

During this period the participant revealed to his key worker in his own language that he was being sexually exploited and he did not like it. It became clear that he was unable to protect himself and ideas of him being able to live independently were finally laid to rest, as support agencies were galvanised into providing alternative accommodation.

In the therapy he became overtly withdrawn. He attended but would remain motionless for long periods. The data from the video taken in this period (Figure 3) is able to record his decline in energy levels as the participant speaks less and gives up any attempt to "direct" the session. Alongside this my direction of the session can be seen to increase. My sense was that he could now risk resting in the session and allowed a depressed part to emerge, which had been concealed by a manic defence. The participant was able to communicate his wish not to leave the sexually abusive relationship. He seemed to understand why he had to move however.

The move proved to be reasonably successful. He was better attended to with a higher staff to client ratio and did not seek to re-establish the sexually "solicitous" behaviour in the new environment. Self-injurious behaviour increased however and his earlier voicing of attachment to his abusive, sexual partner (who was believed to be one of several), helped us understand that although he was safer he had "lost" a level of intense experience which had gratified him albeit perversely.

Discussion of goals. It became evident early on that attempting to question the participant about whether he was being hurt was not going to shed light on what was happening to him. He reacted as if he was being reprimanded and refused to speak.

There was agreement from the staff that the weekly therapy and our regular discussions helped "oxygenate" the support system to keep hope and thinking alive for this man. In this context, he was heard, when he voiced his fear and distress.

One practical outcome to share with the new group home was the participant's interest in time passing. After many weeks of turning a sink handle round and round, he had the idea that it was like the clock in the room, with hands that move round. He seemed very pleased to have "discovered" this. I thought it was of fundamental importance in terms of his development of self-awareness. The staff were able to use a clock to help the participant predict changes of various kinds. This was to take his mental capacities more seriously, whilst the changes of accommodation and staff support was to appreciate the extent of his vulnerability, such is the complexity of work with this client group.

Participant 2 (Art Therapist – Karen Parker). Participant 2 was a 28-year-old woman with a profound physical disability as a result of cerebral palsy, a moderate learning disability and epilepsy. She was totally dependent on others for all aspects of her care. She had a history of psychosis and depression. A psychiatrist was involved who prescribed anti-psychotic and epileptic medication. She had some control of her limbs, which requires much concentration and effort, as did speaking.

Staff at her group home referred her for therapy. They felt she was unhappy and would benefit from exploring her thoughts and feelings outside of the home and her family.

Participant 2 was familiar with art materials and showed a preference for paint. Her art-work was focussed and produced slowly in short bursts due to the physical effort required. Due to muscle atrophy her fingers curled into the palm of her hands, into which I placed the art medium she selected. Marks were made by whole arm movements and were largely uncontrolled. Colours and images had meaning for her; she used metaphor and titled her work. The goals of therapy were decided after the assessment:-

1. To enable expression of emotion.
2. To increase self-esteem and support a possible increase in autonomy and individual identification.
3. To explore her situation and her awareness of her disability.

Her first year in therapy was influenced by her sister's pregnancy—the birth paralleling her first steps towards acknowledging her individuality and womanhood. She was in therapy for four years.

The independent raters worked from transcripts of the videos for participant 2, which accounts for the consistently high score in Dimension 7: Clarity of communication. Her expressive and comprehensive language was good but her speech was difficult to understand. It felt prudent to work from transcripts if the data was to be reflective of her process through therapy.

Participant 2 quickly comprehended the nature of art therapy, saying she wanted to "express feelings and worries from the past". She was committed to attending and addressing issues.

Figure 4.

Her verbal defences were good but she had little control of her body. Initially she chose to focus on image making, delighting in the sticky qualities of finger paint in session 3 (Figure 4). She built up a thick impasto, pulling out large quantities of paint from the pot and dragging it across the paper with her hand. Gravity took its course. The layers of paint slowly slid down the paper towards her. Her amusement quickly turned to distress. She declared the image finished and requested I take it away. Her panic at her lack of control of the art materials and her request to dispose of the "mess", thereby denying its existence, paralleled her overwhelming emotions that she tried to keep suppressed. She was conscious of putting up a "smiling front" and internalising negative emotion, "I keep anger inside". Self-control was important; especially bearing in mind she had little control of her life or body. Her politeness, compliance and seeking of reassurance and clues to what she thought I wanted to hear were as necessary an adaptation for survival in the world she encountered as her "handicapped smile" (Sinason, 1992).

Participant 2 needed to feel safe to express and explore her feelings. The opportunity to discuss this arose the following week, which coincided with the first videoed session. She chose to return to the same image. She added delicate marks in blue/red/

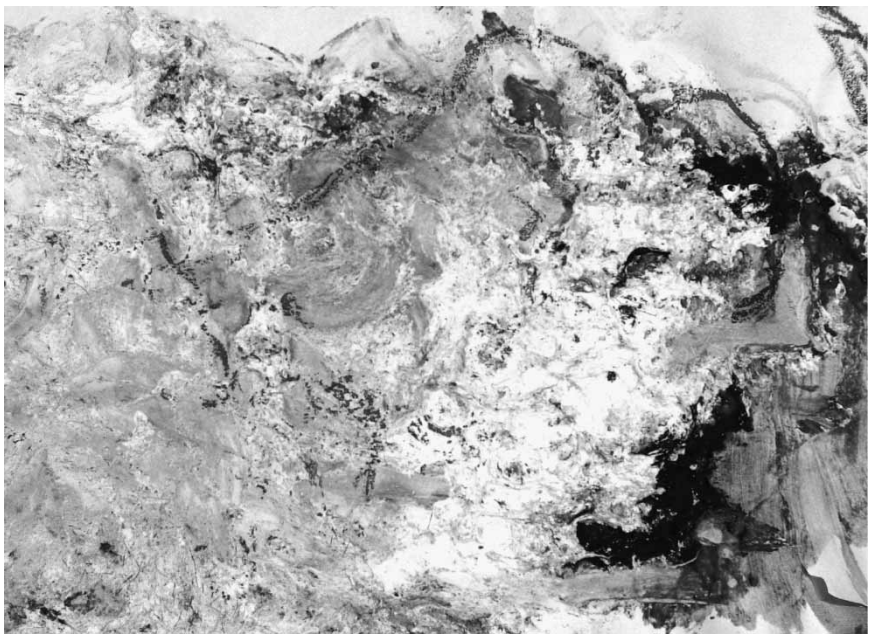

Figure 5.

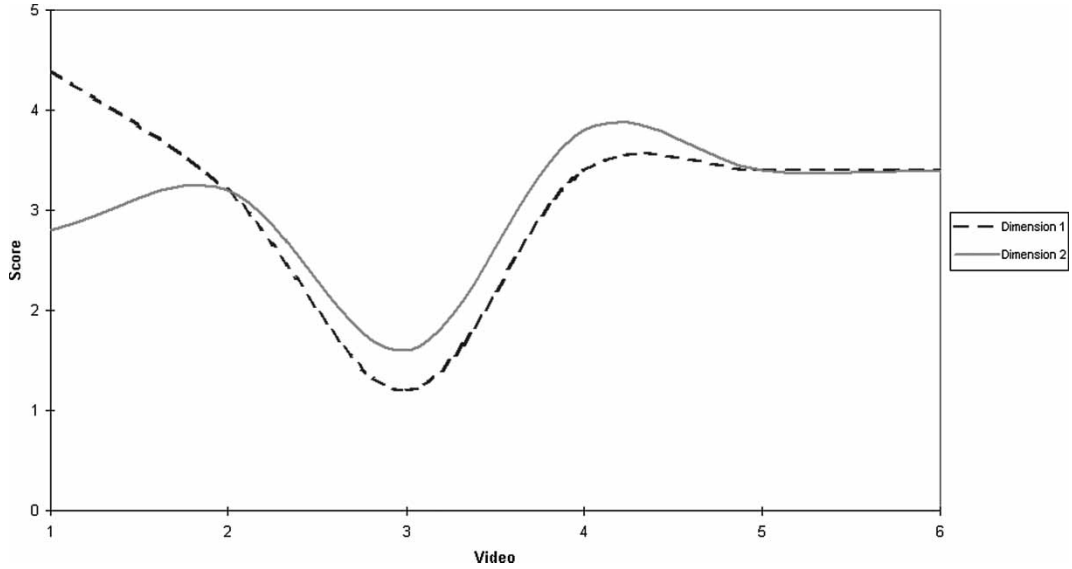

Figure 6. Dimension 1: Therapist, frequency of verbal involvement and Dimension 2: Therapist client centred speech. (Participant 2).

yellow oil pastel, these materials being easier to control and therefore less threatening to her. She drew over the previous week's "mess" (Figure 5, which is a close up of the top left-hand corner of Figure 4). She said the marks depicted a "Hungry Lion" and the "Red = Anger". We used this metaphor to explore her fear that her thoughts and fantasies would consume us. The case study states, "(she) seemed reassured after discussion, shared sad, helpless experiences and feelings directly in relation to self for the first time". She recorded her lowest score for positive affect during this session.

The therapist's session notes state that participant 2 was reflective in the third videoed session. It was an anxious time for her. She had just learnt about her sister's pregnancy. She admitted being "shocked" at the news and "jealous" of her sister for leading the life she herself craved. She painted for a short time in the session despite being "scared" of the strong feelings it evoked of "Envy" and "Anger", titles of which she gave to images she created. That this session was different is evident in the graphs depicting both therapist and client dimensions. The graphs of Dimensions 1: Frequency of verbal involvement and 2: Client centred speech, fall significantly showing a reduction in my speech (Figure 6). A similar pattern is evident in the client Dimensions 6: Frequency of vocalisation, she was quieter during this session; and in the client non-verbal dimentions, 10: Responsiveness to therapist initiation, 11: Activity level and 12: Intensity, indicating a much slower, less energetic manner (Figure 7). I feel the pattern in these graphs depicts the developing empathic relationship

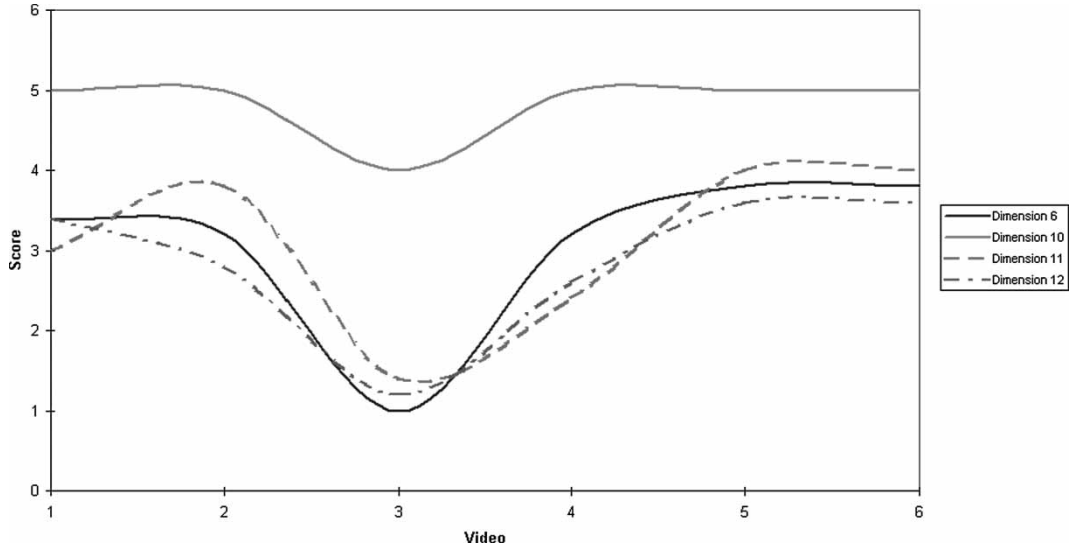

Figure 7. Client Dimension 6: Frequency of vocalisation; Dimension 10: Responsiveness to therapist initiation; Dimension 11: Activity level and Dimension 12: Intensity (Participant 2).

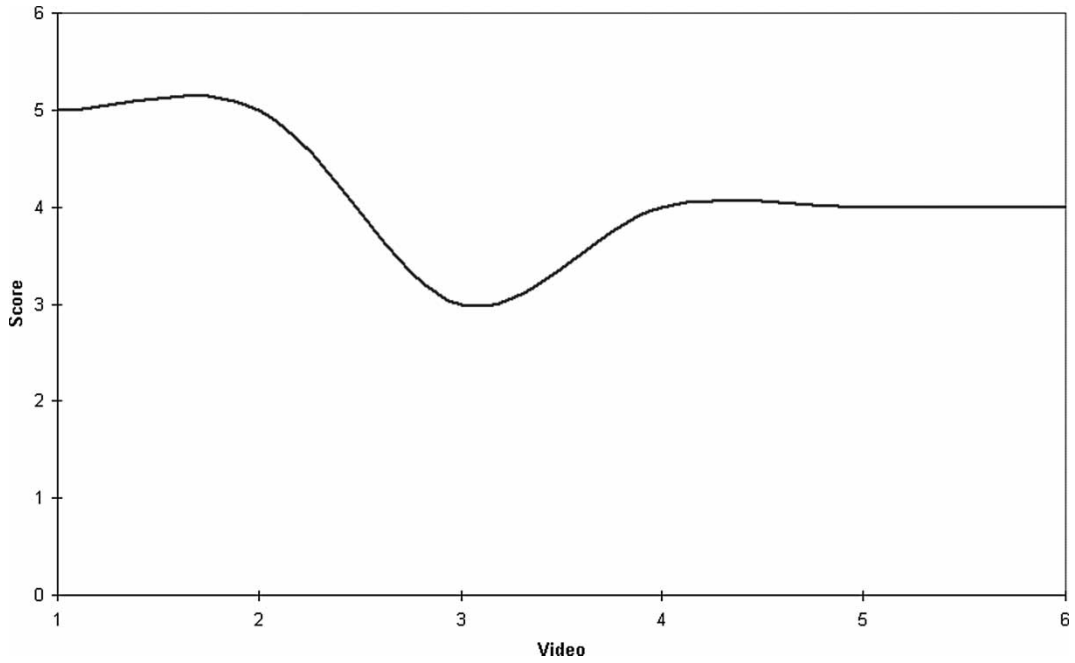

Figure 8. Dimension 18: Reciprocity, turn taking and mutual responsiveness (Participant 2).

between participant 2 and myself and is indicative of her growing capacity to reflect.

Her sister's pregnancy prompted memories of being "left out". Her realisation that it was unlikely she would have a child of her own was awful. The emotional and physical pain was tangible; she needed to grieve for her unborn children as much as the "normal" life that was lost to her.

Towards the end of the year participant 2 visibly strengthened. The birth of her sister's child evoked thoughts of her own birth, "Alone in a glass box (incubator) . . . frightened . . . lonely . . . untou- untouched". She was able to reflect on how frightened her parents must have been at the time of her birth. Recognising the opportunity for change in the family dynamics, she had the courage to assert she was no longer the baby. She became less compliant and eager to please me in the sessions, indicated by the 20% drop in her score in Dimension 18 (Figure 8). Her verbal complexity score increased indicating her growing capacity to think clearly and state her opinion. She began to attribute blame rather than take it all on herself. The house staff were giving positive feedback, as she seemed happier, was increasingly expressive and assertive, on one occasion requesting male staff no longer be involved in her personal care as she found it embarrassing. She was becoming increasingly aware of herself as a woman. Both staff and her family acknowledged her bravery in saying this.

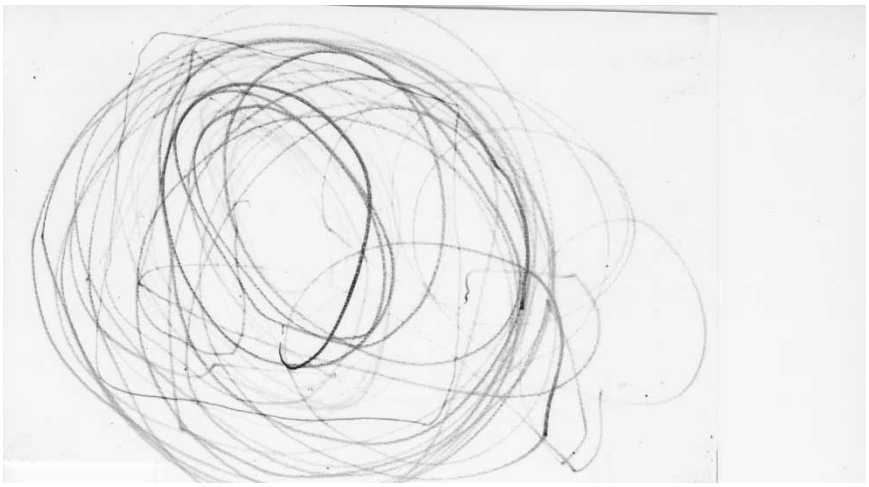

Figure 9.

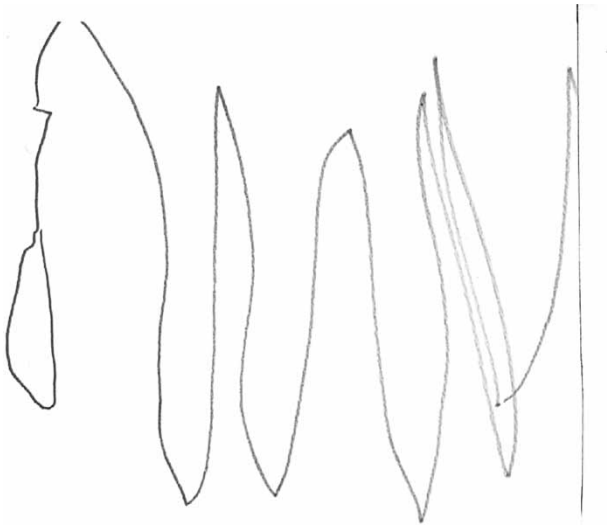

Figure 10. Client marks

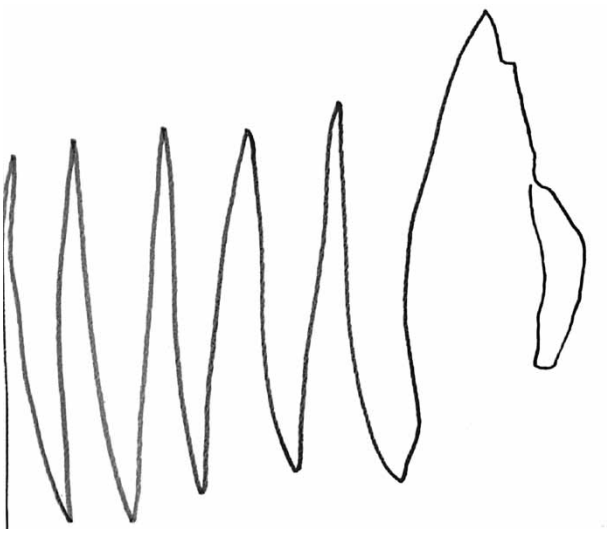

Figure 11. Therapist marks.

Participant 3 (Art Therapist – Alison Hawtin). Participant 3 was a 29-year-old man with a moderate learning disability. Most of his childhood was spent at an English residential school, and he travelled at times to visit his family in various countries.

Participant 3 had good receptive language skills though limited expressive language (average 1–3 word phrases). He also made various vocalisations/sounds and utilised non-verbal communication and gestures. Those around him responded to this and fulfilled his needs very quickly.

Participant 3 was referred to the Team due to the return of self-injurious challenging behaviour (severe head-banging/skin-picking) and other depressive symptoms, for which he had been removed from his regular day placement. He was prescribed an anti-depressant by his GP. The clinical psychologist referred him "to provide a therapeutic assessment of his emotional needs and to support his self-expression about the loss of his day placement and his future needs and wishes".

From the assessment, it seemed that participant 3 was almost paralysed by anxiety, experiencing an unclear awareness of his own Self and his presence and impact on his life and others. The overarching goal of his weekly, hour-long therapy over two years was to assist him in understanding this for himself, as well as:

1. To develop his expressive ability.
2. To increase his self-confidence and reduce his anxiety.
3. To improve his mood and increase his motivation.
4. To reduce his self-injurious behaviours.

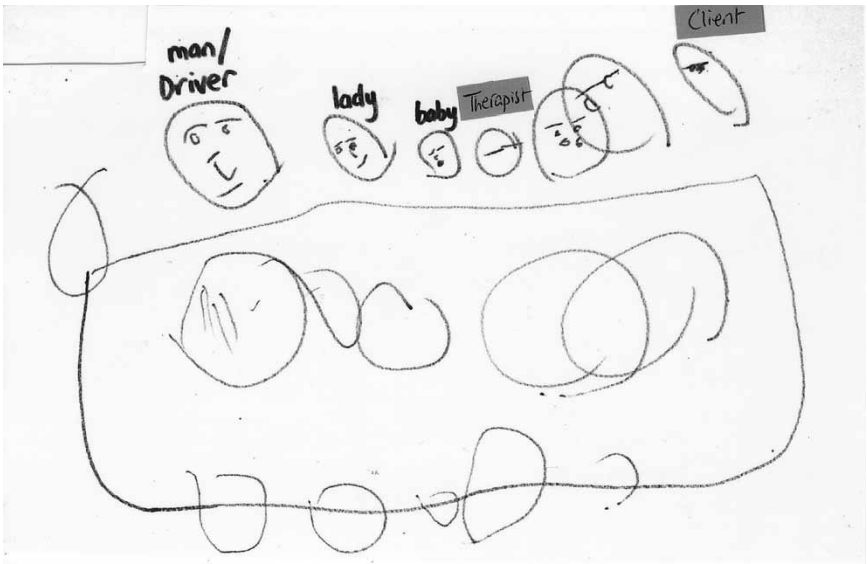

Figure 12.

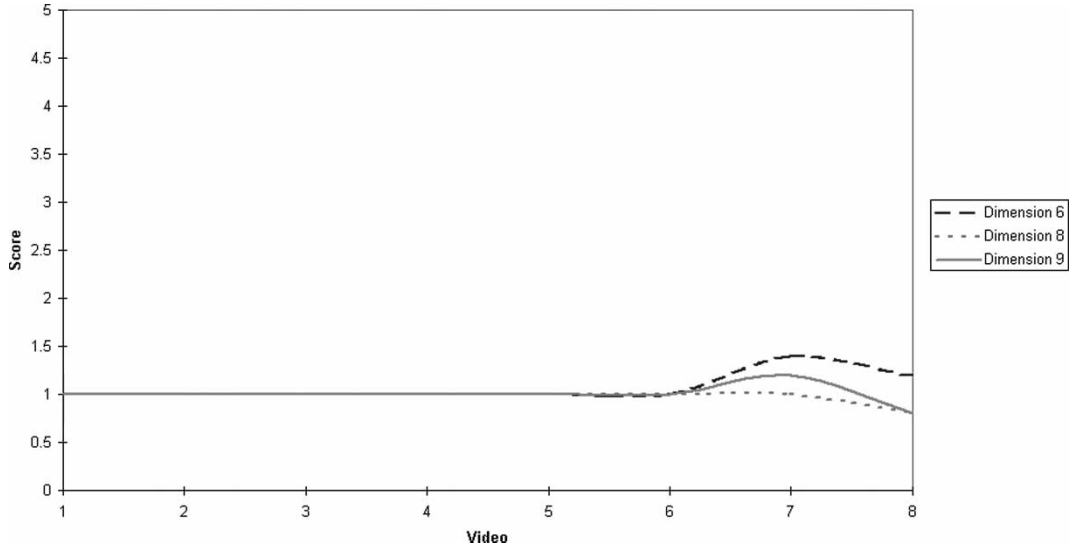

Figure 13. Client Dimension 6: Frequency of vocalisation; Dimension 8: Verbal direction and Dimension 9: Verbal complexity (Participant 3).

Participant 3's developing relationship with himself, the art materials and the therapist was particularly evident in the art-making process. Participant 3 moved, over time, from a self-stimulatory position, through one of exploration, to one of representation and self-expression. The case study states " . . . he appeared very sad and lost, whilst making unusually frequent touches to his mouth. I offered suggestions about sometimes things being hard to think and talk about. He drew a picture alone (Figure 9).

Then he invited me to draw too, and I mirrored his marks: a frequent and developing interaction between us (Figures 10 and 11).

This felt as if he was checking that I could reflect and understand him in the usual way. At these times of "successful reflection", he would seem to relax into the rest of the session. Participant 3 then drew alone again as I offered suggestions regarding his mood, life events and memories and he responded verbally, naming representations" (Figure 12).

This whole process was central to and paralleled the development of relationships with himself, the environment and others.

The verbal results shown in Figure 13 show a small increase in participant 3's verbal skills. This reflects a general characteristic of learning disability, where there is often little possibility of substantial cognitive change; although we know that mental health problems and emotional trauma can influence and mask cognitive capacity. I felt this was

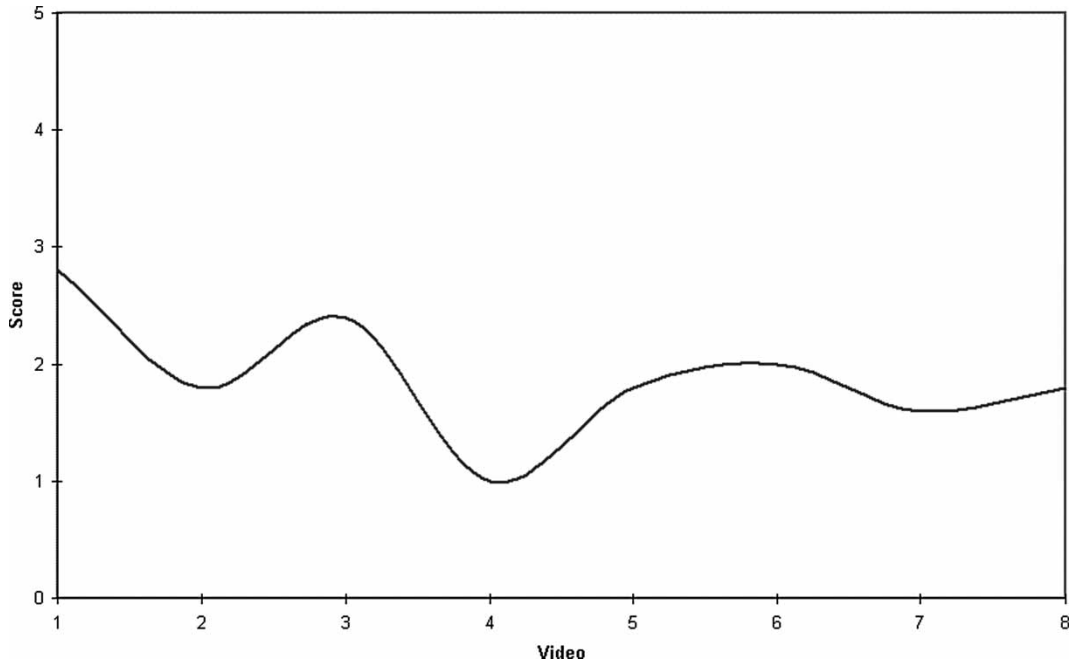

Figure 14. Dimension 10: Responsiveness to therapist initiation (Participant 3).

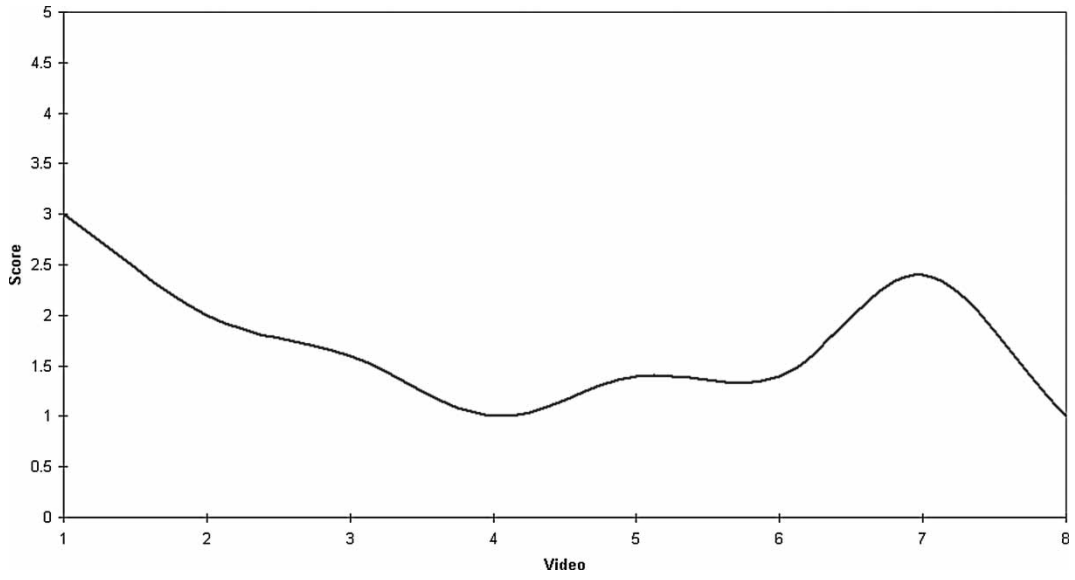

Figure 15. Dimension 11: Activity level (Participant 3).

the case with participant 3, and these apparently small changes were very significant for him and his progress.

The case study describes how "he was less responsive to my comments, questions, suggestions" and the data in Figure 14 shows that he was equally more clearly communicating this. He did not require therapist direction so much.

Figure 15 showing participant 3's activity level shows a significant decrease in his non-task activity that in fact, meant his idiosyncratic movements. The case study states that these "seemed to act as anxiety-reducers, and were somewhat ritualistic; but it became easier over time to determine and reflect what particular sounds and behaviours actually meant for him", and there was clarity developing in all his expressions and behaviours that could be responded to.

Participant 3's self-injurious behaviours were signs of anxiety and a very low toleration of frustration. Notably he did not resume these either during his re-integration into his previous day services, or after art therapy ending. The case study describes session 39 when participant 3 was hammering modelling clay on the table and then moved to the floor. It must be noted that participant 3 had a long-standing dislike of shiny floors, and he generally head-banged on floors and walls. The case study describes, "Participant 3 stroked the floor once and I sat beside him, verbally reflected his mood, action and past feelings about the floor. He seemed to be grounding himself and gaining

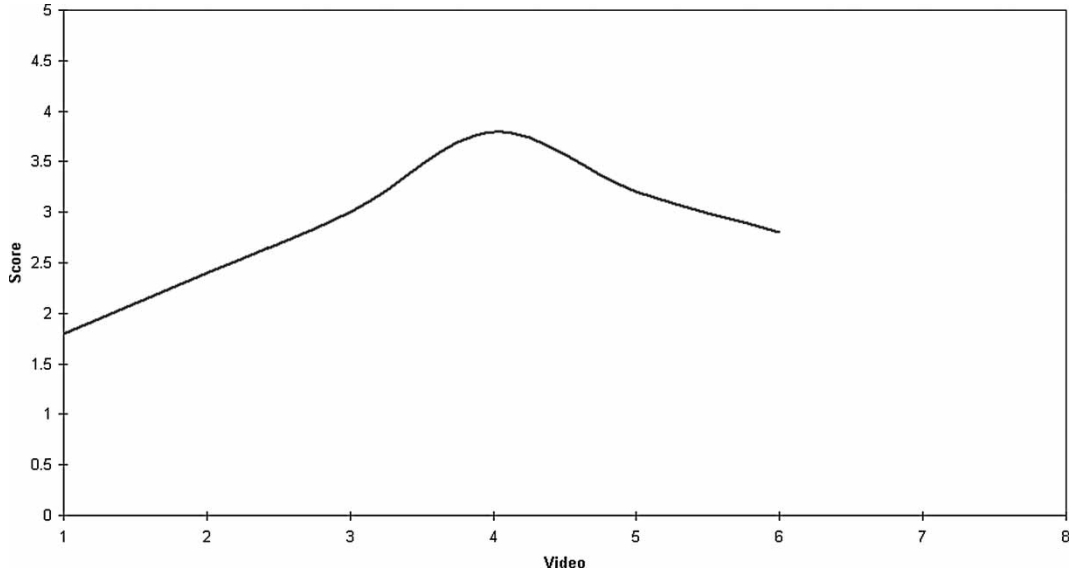

Figure 16. Dimension 13: Attentiveness/absorption in task (Participant 3).

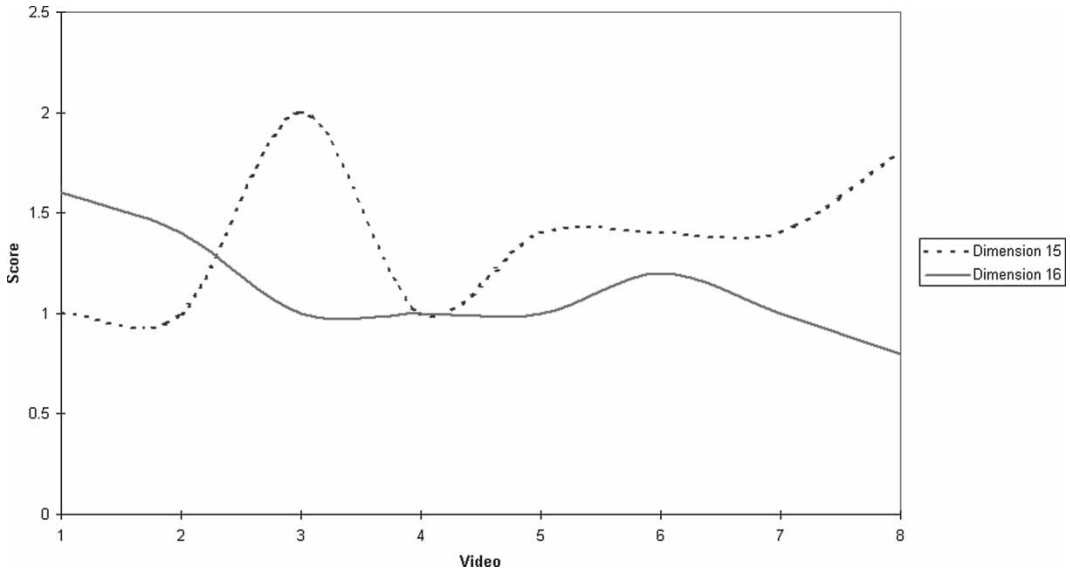

Figure 17. Dimension 15: Positive affect and Dimension 16: Negative affect.

confidence, as he did to the materials banging them on the floor, what he would previously have done to his own head. Participant 3 often looked toward a full-length mirror in the studio, which I then brought into his view and he would glance at it occasionally with a smile. In the next session, he continued with this work whilst I remained seated in my chair. He therefore had his back to me, but could see me in the mirror's reflection, which he again glanced at and smiled towards occasionally. He then came back and initiated a shared drawing activity before the session ended". I believe this indicates how he had moved through his self-injury into a different form of personal expression, understanding and relationship.

The graphs also show an increased absorption in task (Figure 16) alongside a decrease in activity level (Figure 15) and a decrease in responsiveness to therapist initiation (Figure 14). These show his successful movement towards an improved management of frustrations and challenges, as participant 3's anxieties are low, his absorption is high and his responsiveness to (or need for) the therapist is low (see video 4 results in all graphs). This can also be interpreted as an increase in confidence as he felt able to "ignore" the therapist and initiate his own actions/choices. The case study states "He progressed from requiring my active reading of his needs, to my physical support by hand-holding to move around the room and fetch things, to responding to "permissive" verbal support, to confidently moving around the room in a knowledgeable and varied way to access what he needed."

Figure 17, showing positive and negative affect, shows a clear reduction in negative and an increase

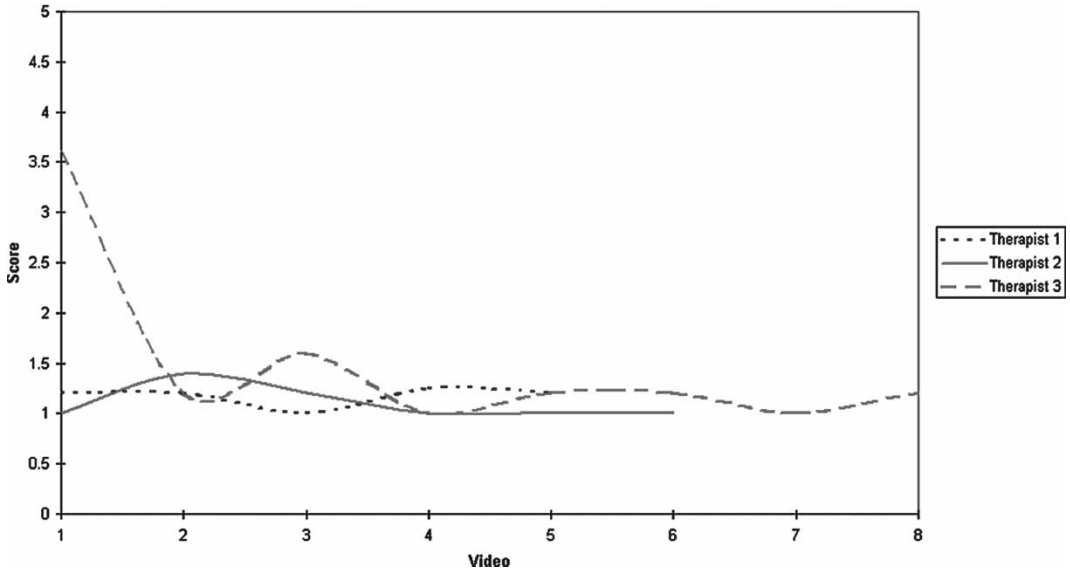

Figure 18. Direction 4: Verbal direction (All Therapists).

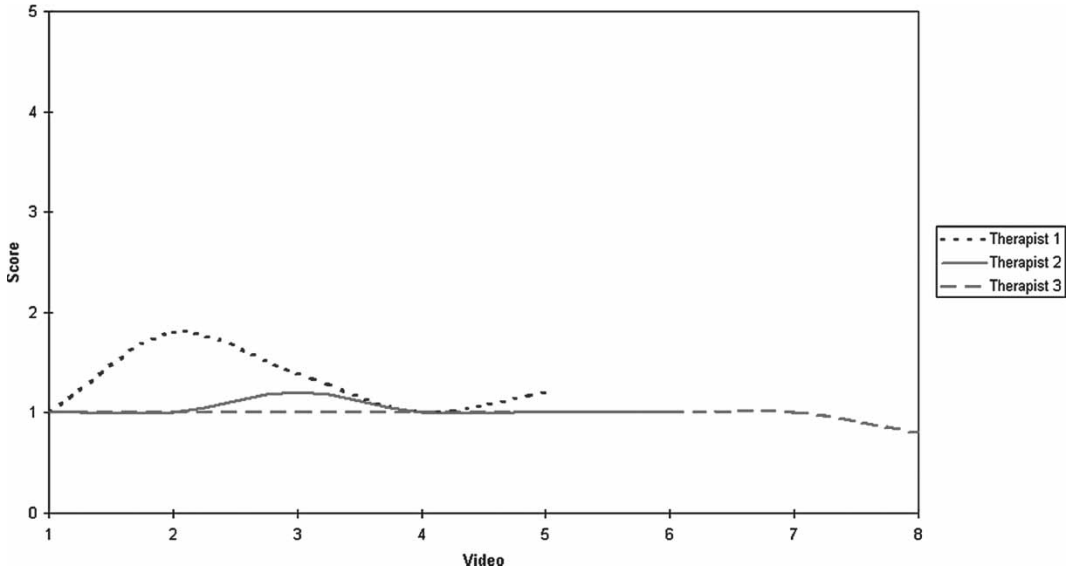

Figure 19. Dimension 3: Positive feedback (All Therapists).

in positive affect over the duration of the therapy. They meet in video 4; a probable flattened position of equilibrium prior to change.

In conclusion, from an observable measured position that correlates sympathetically with the content of the case study and the imagery, change has been visible, which is reflective of the initial goals.

Discussion

Aim Number 1 was "to gather effective objective information about changes in the client that correlate with the therapist's subjective view". The data analysis illustrates that we found this to be possible. The graphs are forms of data representation that are clinically significant as they show that art therapy sessions can be recorded, analysed and standardised, yet remain both person-centred and reflective of process as well as product.

The standardised session-note format has also been effective in enabling information to be found more readily for data comparison, and to illustrate fundamental areas of practice for all clinicians. The therapist's case studies did correlate with observed video data, which suggests that it was possible to gather meaningful information, which reflected the therapeutic interaction.

Aim Number 2 was "to set clear goals following an initial interview and assessment, and see whether this would assist us in evaluating the effectiveness of the treatment, or whether this in fact hampered the development of the therapeutic process".

We would acknowledge that the goals set for each participant are broad and corroboration of them relies on feedback from the external system i.e. carers, day placement staff, other clinicians as well as the therapist's clinical opinion. We felt the setting of goals did not hamper the therapeutic process or treatment.

We feel this study provides evidence of the development of Beails (1998) "pro-social behaviours", mentioned earlier in the paper. If "pro-social" is understood as behaviours encouraging and influencing meaningful reciprocal contact with others then, for example participant 1 became less repetitive in his speech and was able to enter into more meaningful exchanges with the therapist, as reflected in Dimension 18: Reciprocity; participant 2 became less compliant and increasingly confident in expressing her wishes as indicated in Dimension 18: Reciprocity and participant 3 began to initiate his own actions and communicate his choices as indicated in Dimension 10: Responsiveness to therapist's initiation.

In the case study format and POSER 2001, personal change is considered within the individual client's progress in therapy and not by comparison to a group norm. Therefore it is not relevant to compare individual participant's dimension results. This is not true of the therapist's dimensions however. An unexpected but interesting development of the overall measures was the inclusion of the therapist's dimensions, which have illuminated the therapeutic process. All three therapists score low, between 1.00 and 1.6 in Dimension 4, verbal direction (Figure 18), apart from the initial session, which we would predict to be higher due to the therapist needing to contain initial anxieties. In Dimension 3, positive feedback, all the therapist's scores were similarly low (Figure 19). This can be

interpreted as evidence of our non-directive, non-judgemental stance as therapists.

The POSER 2001 allowed for a close analysis of the therapist/client interaction, which is central to the therapeutic process. We required a measure that was sensitive to change over time and would be inclusive of clinically important effects. We hoped the POSER 2001, a formal level of research design, would show change and therefore the validity of the art therapy intervention, which is difficult to argue from the case study alone.

The POSER 2001 requires further work and piloting on a larger sample of people to ascertain a broader reliability and validity. The high correlations shown in terms of its inter-rater reliability, which give a good preliminary indication that its dimensions are relatively transparent. The POSER 2001 has the potential for measuring therapy with adults with multiple disabilities, but has a bias towards measuring broader behavioural changes. For example, participant 2 in Dimension 14: Client, behavioural direction of the session, scored a constant low due to the extent of her physical disability. The dimension was insensitive to tiny, observable signs of direction, understood by the therapist through eye movement, slight turning of the head. We found that some dimensions were not sensitive enough or were not relevant to these participants, for example Dimensions 7, 17 and 19, did not score effectively. The video camera, even with a wide-angle lens, could not capture whole body movements within the room, or fine motor movements or eye contact. It also had poor sound quality. For further research we would seek specialised advice in using audio-visual equipment. Videoing whole sessions every eight weeks collected too much data. Data could be collected less often, for example, from the beginning, middle and end of a specified period of therapy, without significant detriment to the information gathered.

Conclusion

Within the current climate of an ever-increasing need for a strong evidence-base to our practice, it is essential for all therapists to incorporate research into their practice. In our research for this paper we were reassured to find that research has been occurring over many years in various forms and in various settings. We should respect ourselves as clinicians with something to contribute in order to pursue robust routes to gaining the time, money and support required to be able to carry out research that reflects the nature of what we do. We have tried to offer here a true reflection of our working process describing the successes and the parts that did not work so well or were not anticipated and that we would endeavour to learn from and change in the future. For example we would seek a more active involvement from service users as researchers/co-researchers in the future.

Our initial idea was to create a small, feasible project fitting for infant researchers. It quickly became clear that it was in fact a massive project and that an apparently simple research question provokes many others. We now know to make the question we are researching ever more precise. This research project reminded us how important it is to co-work with research-experienced colleagues. It was also fruitful to work with other art therapists, as our own differing clinical perspectives helped us find clarity and fundamental shared truths about our work. Working as a team of four clinicians meant that the project stayed afloat regardless of individual fluctuations in morale and energy.

We believe that a successful outcome of this study has been in its progress toward finding a tool that measures the process of art therapy as well as the outcomes. Although the POSER 2001 needs further work, there are aspects that we particularly like. These include the way the tool focuses on the art therapy session, the relationship that develops between the client and therapist and that the data produced can be analysed by colleagues from other disciplines.

We paid close attention to the image-making process and use of objects as shown in the case studies and analyses, but we regret the absence of a research tool that could satisfactorily analyse the art product in this study. The limitations of the technology available to us prevented us from studying the image-making process directly from the videos, and therefore from recording it as a dimension. We focussed on utilising the measurement tool, to capture the interactions between client and therapist.

Change in therapy with people with a learning disability can be small and take time. Although it is possible that these results could be argued as insignificant in statistical terms, we know from our positions as therapists that such changes are not insignificant to the clients themselves or to those around them.

Acknowledgements

We would like to acknowledge with thanks the contributions of Diane Simcoe, art therapist who was involved in the initial stages of this research, and psychologists Kaaren Knight and Frances Marshall, who contributed their energy, time and expertise.

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Biographical details

Hilary Pounsett qualified as an art therapist from Sheffield in 1988. She has worked in mental health services and learning disability services since then and is engaged in further training at The Society of Analytical Psychology.

Karen Parker studied fine art and is a practicing artist. She ran a pottery in a day centre for adults with learning disabilities in Oxfordshire, before qualifying as an art therapist at St Albans in 1993. Since then she has worked within both hospital and community team settings. She has an interest in research and working with parents who have a learning disability.

Alison Hawtin gained her art degree at Dartington in Devon before qualifying at St Albans in 1994. Since, she has worked in Romanian and English health and education systems with people with learning disabilities and/or mental health problems, and is a visiting lecturer at the University of Hertfordshire. She continues to make her own art and undertake community art projects.

Suzanne Collins is Clinical Director of the Doctoral Programme in Clinical Psychology at the University of East Anglia, Norwich. She has attended the Universities of Surrey, Birmingham and East Anglia, and has been a practicing chartered clinical psychologist in the NHS since 1975.

Appendix A, part 1

ART THERAPY RESEARCH CONSENT FORM
LEARNING DISABILITY PARTNERSHIP

The Art Therapy Department, Learning Disability Partnership is undertaking research to: -

1. Record and measure changes that take place in Art Therapy.
2. To improve practice in focussing on the individual needs of clients.

The Art Therapy research will include some of the sessions being videoed and meeting with a Psychologist outside of the sessions.

All identities will be protected and all data gathered through this research would remain anonymous.

I note that I may withdraw my consent at any stage in the research and this will not jeopardise my continuing work with the Art Therapist.

Are you willing to be part of this research? **Yes** **No**

If yes fill in below: -

NAME . . . . . .

ADDRESS . . . . . .

. . . . . .

. . . . . .

. . . . . .

I understand what the Art Therapy research involves.

I agree to take part in the research.

Signed **Date**

Witness **Date**

Appendix A, part 1 (continued)

Compiled by the Art Therapy Department of the LDP

I ………………………………… , of (address)………………………………………………
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………………………………………………
………………………………………………
guardian/carer/parent/other of ……………………… have understood what the Art Therapy research involves.

I give my consent for ………………………… to take part in the research.
Signed Date
Signed Date

…………………………………………………………………………………

I…………………………………… Confirm that I have explained to the above what is involved in the research.

Signed Date
Designation

Appendix A, part 2

CAMBRIDGESHIRE
Learning Disability
LDP
Partnership


Video **Consent**

Name .....




I **consent** **to** **being** **videoed**




The **video** **will** **be** **kept** **in** **a** **locked** **cupboard**

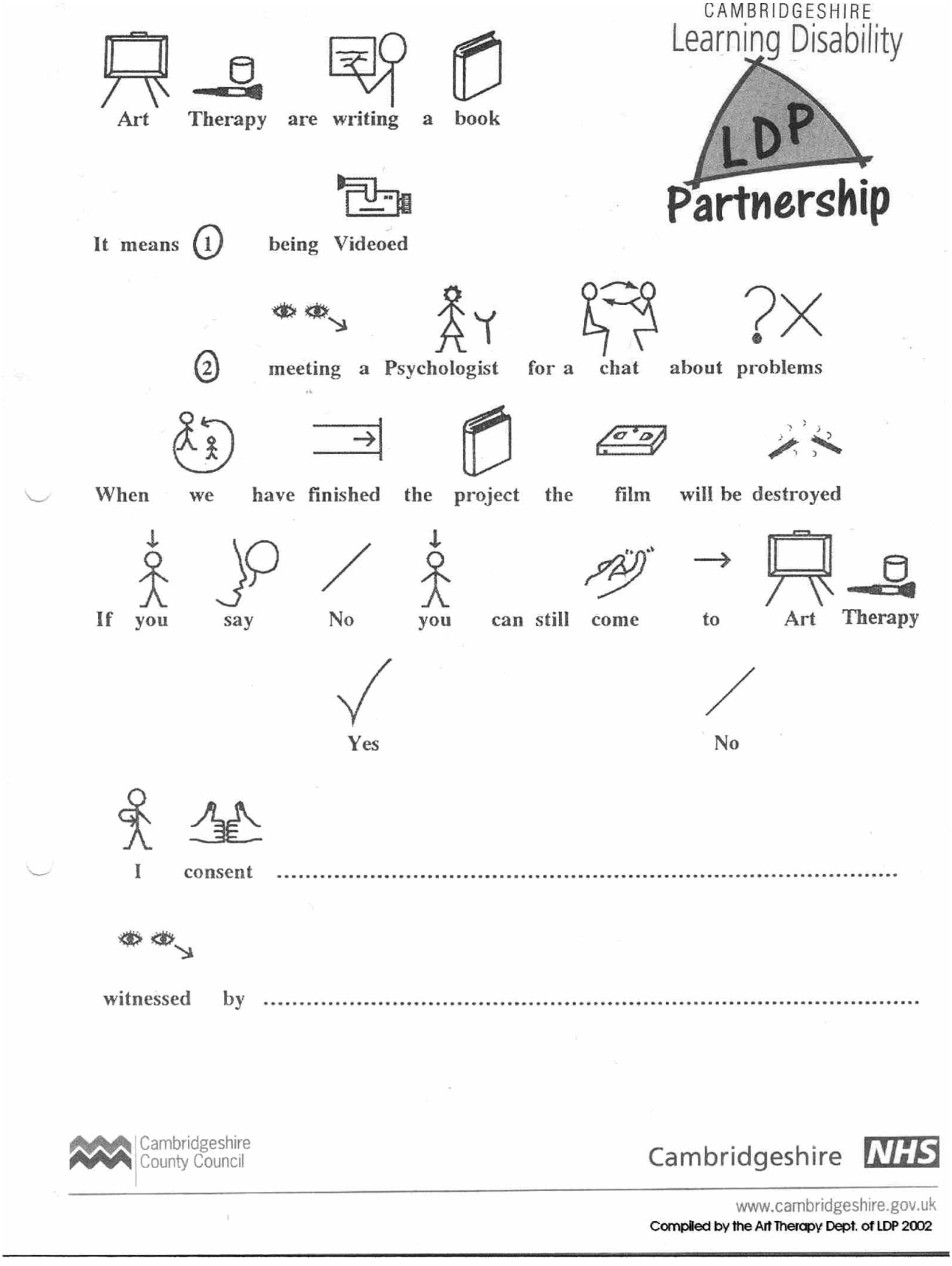
Compiled by the Art Therapy Dept. of LDP 2002

Cambridgeshire County Council

Cambridgeshire NHS

www.cambridgeshire.gov.uk

Appendix A, part 3



Appendix B

Dimensions used to rate therapist/client interactions in the adapted version of the POSER (Wolke, 1985, unpublished).

Therapist verbal:

1. Frequency of verbal involvement
2. Client centred speech
3. Positive feedback
4. Verbal direction

Therapist non-verbal:

5. Behavioural direction of the session

Client verbal:

6. Frequency of vocalisation
7. Clarity of communication
8. Verbal direction*
9. Verbal complexity*

Client non-verbal:

10. Responsiveness to therapist initiation
11. Activity level
12. Intensity
13. Attentiveness/absorption in task
14. Behavioural direction of the session*

Client affect:

15. Positive affect
16. Negative affect
17. Materials/problem solving

Therapist, client scores:

18. Reciprocity, turn taking and mutual responsiveness
19. Conflict

* Additional dimensions