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DEVELOPING PRINCIPLES OF BEST PRACTICE FOR ART THERAPISTS WORKING WITH CHILDREN AND FAMILIES

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Abstract

In 2010 the British Association of Art therapists asked art therapists working with specific client groups to produce clear guidelines about current views on best practice in the field. Using the Nominal Group Technique and a modified Delphi process, the special interest group Art Therapists working with Children Adolescents and Families (ATCAF) produced 18 Principles of Best Practice with a range of associated indicators. This paper presents the methods and the results of that process followed by a brief discussion.

Key Words: Art therapy**;** guidelines; child; adolescent; family; consensus

Introduction

Clarity about the nature, practice and process of health care interventions is an essential starting place for practice, training and research. Responding to this need, the British Association of Art therapists (BAAT), in 2010, asked art therapists working with specific client groups to produce clear guidelines about current views on best practice in the field. This article describes the process and outcome of the special interest group Art Therapists working with Children Adolescents and Families (ATCAF) production of the first stage of guidelines for working with this client group. It is a starting point for debate and further development.

Clinical guidelines. Clinical practice guidelines are used to inform the selection and delivery of particular interventions or procedures. Clinical guidelines are systematically developed statements used to assist practitioners' and patients' decision making, and their recommendations must be based on reliable evidence (DH, 1994). In an ideal world clinical guidelines would be based on evidence derived from rigorous empirical studies, however, in practice there may be insufficient research-based evidence (Murphy et al., 1998) and so increasingly consensus methods are used to develop clinical guidelines defining key aspects of health care and appropriate indications for interventions (Murphy et al., 1998).

In the UK, some art therapists working with specific client groups have already developed best practice guidelines and accounts of this process have been published (Springham, Dunne, Noyse, & Swearingen, 2012). Springham et al (2012) state that, 'Clinical guidelines are an important part of evidence-based practice. They operationalise research for practice and they define practice for research'.

Consensus methods. There is a range of consensus methods, but the three main approaches used in health services research are the Delphi method, the nominal group technique (NGT) and the consensus development conference (Murphy et al., 1998). These formal methods of sharing decision making within a group rather than leaving it to an individual have the following benefits: reducing the likelihood of arriving at a wrong decision; having more authority than a single individual's opinion;

creating a forum in which assumptions can be challenged and views must be justified; providing structure and a degree of protection to eliminate negative group processes; and having scientific credibility (Murphy et al., 1998).

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

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

Panel size. The size of a Delphi panel varies between published studies, with reported sample sizes varying from four to 3000 (Mullen, 2003). The RAND Appropriateness Methods (RAM) User's Manual presents a standardised modified Delphi method, and states that there is no magic number: 'panels can be of any size that permits sufficient diversity (a minimum of 7), while ensuring that all have the chance to participate (probably a maximum of 15)' (Fitch et al., 2001, p. 25).

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

***The Nominal Group Technique*.**The NGT was developed in the 1970s and aims to aid decision making by formally structuring group interactions. The key components of the method are: 'formulation and presentation of the nominal question; silent generation of ideas in writing; feedback from group members to record each idea in a succinct phrase; group discussion of each idea in turn for clarification and evaluation; individual voting on priority ideas; feedback of results; and further discussion and re-voting' (Telford, Boote, & Cooper, 2004) p. 210

Method

ATCAF decided to employed consensus methods to develop best practice guidelines

in two stages: an expert workshop using the nominal group technique (NGT), followed by a modified Delphi process. This decision was informed by the degree of expertise in art therapy with children and young people available in the SIG and the comparative lack of rigorous outcome-based studies in the field of art therapy with children and families.

The NGT was used at three meetings of ATCAF SIG over a period of five months. Following that a two round electronic Delphi process took place. The whole process took a year.

NGT. There were a number of stages to the process including: defining the nominal question; generating and recording principles; cross checking with HCPC competencies; voting on clarity and validity and recording the outcome; clarifying wording of principles and generating indicators for some of the principles; voting and recording the outcomes.

The NGT process began with the facilitator defining the nominal question, which in this instance was: *'What constitutes principles of good practice when offering art therapy to children, young people and families?'* The facilitator gave the expert group an example of a potential principle and then invited each participant to silently write down suggestions for further principles based on their own clinical knowledge and expertise. After forty-five minutes the suggestions were read aloud and recorded. Before the second NGT meeting the facilitator grouped the suggested principles into broad thematic clusters, combining similar principles, and expanding principles that had been given in note form.

At the second expert workshop, members were asked to consider the amended list principles and vote on each one for clarity and validity. The first task was to agree the facilitators clustering and combining of suggestions from the first round. Then the list of principles was cross checked with the HCPC Standards of Proficiency for Arts Therapists (HCPC, 2013) to avoid replication and to enable the group to focus on the specifics of working with children and families. Suggested principles that displayed a significant overlap with the HCPC Standards of Proficiency were removed. The group then voted on the validity and clarity of the remaining principles. Principles which received less than 80% of votes for both validity and clarity were rejected from the rest of the process. Principles that were seen as valid by more than 80% of the group were retained. However some of these were seen as poorly or unclearly expressed (with a vote of 80% less for clarity), and although these were retained a decision was taken to work on improving their wording.

Before the third expert workshop the principles that were voted as valid but not sufficiently clear were reworked by individual group members who were also tasked, between the second and third NGT meeting, with generating indicators for some principles.

At a final NGT meeting in February 2012 the reworked principles and newly formulated indicators were voted on for clarity and validity. Those which attained 80% or more for both clarity and validity were retained

Modified Delphi. Following the completion of the NGT, further consensus was sought from a different group of experts in the field using a two round modified Delphi process in which panel members were asked to rate the validity of the principles and indicators generated by the NGT expert workshops and to add to these drawing on their own clinical experience.

In March 2012 all the registered members of ATCAF were contacted by email to inviting them to participate in the Delphi process, however because there was a low response further members were sought at a joint meeting of ATCAF and the Learning Disability SIG and at a meeting of the Northern Art Therapy in Education SIG. A second invitation email was sent to all ATCAF members at the end of April 2012.

The art therapists who agreed to take part in the Delphi process were emailed the principles and indicators produced by the NGT in a questionnaire format. They were asked to rate each principle or indicator for validity on a scale of 1-9 where 1- 3 was not appropriate", 4-6 was "moderately appropriate"; and 7-9 was "appropriate". As discussed above, there is no definitive consensus level set for the Delphi method. We chose to define consensus on validity as the point at which 80% or more of the panel rated an item at 7 or above.

In round one panellist were asked to rate the NGT principles and indicators on the nine-point scale. They were also invited to add comments on any principle or indicator as they wished, either to explain why they had scored the PBPs as they had, or to add further comments. The panellist feedback from round one was incorporated into the second questionnaire leading to one new principle and twenty three new indicators which panellists were asked to rate in the same way as before.

Results

NGT Results. Twelve qualified art psychotherapists attended the first NGT meeting one of whom acted as facilitator as well as contributing to the generated principles. Fifty-six ideas for principle were recorded during the session, although not all were framed clearly as principles.

Twelve qualified art therapists attended the second NGT workshop, one of whom was again the facilitator. Each of the principles was voted on in an open show of hands for both clarity and validity. The process was lengthy and not all group members were able to stay to the end of the meeting. The group diminished over the period of the workshop from twelve to nine. Nine qualified art therapists attended the final NGT workshop at which voting took place on re-worded principles and newly generated indicators this process resulted in a list of 19 items with agreed indicators. These 19 items can be seen in Table 1. (Insert Table 1 here)

Delphi Results. Twelve people agreed to be on the Delphi panel. They were all qualified art psychotherapists from different geographical regions, with a wide range of experience of working with children and families. Five panel members had experience of predominantly working in NHS Child and Adolescent Mental Health Services, five had most of their experience working in schools, whereas two had mainly worked with women and children who had experience of domestic violence.

Several panel members had experience of more than one work setting including private practice. Two members of the group had significant experience of training other art therapists. One Delphi member had attended the first meeting only of the NGT group. As this was such an early stage of the development of the PBP it was felt appropriate for them to be part of the Delphi group. Apart from that the Delphi group members were completely different from the NGT group. In the first round twelve members completed the questionnaires. In the second round eleven questionnaires were completed.

Round one. The two coordinators of the Delphi survey analysed the results of round one during August and September 2012. Table 2 gives an example of a principle and indicator, the ratings in round one and the comments made by Delphi members. (Insert Table 2 here)

Fifteen of the nineteen Principles presented in the first round reached consensus in terms of being appropriate. Eleven of the fifteen principles that reached consensus in round one had amendments or additions to their indicators in round two as a result of comments made by Delphi members. Of the remaining four principles that did not reach consensus in round one two were transformed into indicators for other principles as a result of comments made by Delphi members and two were represented unchanged with new indicators. One completely new principle with two indicators was created for Round Two as a result of comments from round one. This left us with eighteen principles.

Round two: The round two mail-out included the results of round one, and also presented panellists with the slightly modified set of principles and twenty three new indicators. They were not invited to make comments in the second round but an anonymised list of all the comments made by members in round one was included. All the principles and indicators presented in round two were rated by 80% or more of the panel as 7 or above and therefore reached the agreed consensus. These principles and indicators are shown in Table 3. Italicised text indicates sections that had been amended or added for round two in the light of panellists' comments in round one. (Insert Table 3 here)

Discussion

Strengths. These Principles, and a brief description of the methodology, scope, strengths and limitations of the process were approved by BAAT Council in March 2013. The guidelines draw on the experience of practicing art therapists with many years of working with this client group in a range of settings and highlight key aspects of this work, particularly how it might differ from work with other client groups.

Since March 2013 the ATCAF PBP have been available to all BAAT members on the BAAT website to be used in conjunction with local policies and practices and with consideration of the wide range of settings that art therapists work in with children and families. It has been used as a reference for considering how art therapists working in schools may be guided by them in relation to linking with the family (Hill, 2014), and they are used for training purposes by ATCAF members training on the Art Therapy Northern Programme in Sheffield.

For the members of ATCAF involved in the process of developing the PBP the informal feedback from the NGT group was that the collaborative nature of the experience was very affirming. It was a rewarding process that stimulated the group to share what they are best at, working as art therapists with children and their families. Members of the Delphi expert group were invited to feedback comments about their experience for the Newsbriefing article. Two Delphi members did so and said: 'I'm now more able to articulate what art therapists actually do in schools, in language that makes sense to anyone. I also feel more confident about how I am working, knowing that it follows the shared principles of best practice'; and from another 'new ideas and insights bubbled up enriched in connection with reading the responses of other people participating. I felt pleased that I was able to contribute to this communal process of thought and debate.'

Since publication of the methodology used we have had inquiries from other groups of art therapists to help in the development of other guidelines. As a result we facilitated the NGT process conducted by the art therapists working with brain injuries and neurological conditions clinical guidelines group. At their final meeting in September 2015 we invited the five members of the group attending to complete a brief survey about both the NGT process itself and the effects of having an external facilitator at each meeting of their NGT. The following comments were made about the NGT process:

- It was democratic
- It was inclusive and fair
- It gave everyone in the group a voice
- It tapped into many years' experience
- It was hard getting enough people from across Britain together
- It took a long time but was worth it
- It was very frustrating at times but rewarding and valuable
- A structure and framework was needed to get the task completed
- It was a useful reflective process
- It was a good learning experience
- It helped clarify the art therapist's role
- It was rewarding passing on knowledge and experience
- Working on the 'clarity' of each principle and indicator was really helpful
- The process overcame any potential difficulty of power relationships and established dynamics in the group
- It made it easier for everyone in the group to contribute.
- It was valuable having the reflective time that actively addressed the challenges of the work

The group were unanimous in their view that it helped their process having an external facilitator. Their reasons were:

- It was invaluable having the external facilitator. The process might not have been completed without this help
- It would have been too easy to get distracted into lengthy discussions.
- Group members could participate fully without having to structure the meetings

- Participants were more able to think creatively
- The external facilitator held and contained the process
- They helped the group stay on task
- It was helpful having someone external to the group who had experience of the process and could be firm but flexible.

Limitations. We did not attempt to link the principles with outcome-based research into art therapy with children and families as we felt that there was insufficient evidence available at the time to help draft the guidelines. A recent systematic review of art therapy for non-psychotic disorders confirmed there is limited available evidence to draw on (Uttley et al., 2015).

Another limitation is the lack of service user involvement in the development of the principles. Following the approval of the guidelines, BAAT Council initiated the process of service user involvement by asking Research-Net to look at the PBP. Research-Net is a group of service users, practitioners and carers who have come together to do research. Two parents from Research-Net, both of whom had children who have used CAMHS services extensively and one of whom had received services from CAMHS herself some years ago, examined the PBP. Their comments about each Principle with its indicators were audio recorded and given to ATCAF. The interventions they had experienced did not include art therapy so they were not able to comment on the PBP that very specifically relate to art therapy practice but they felt able to comment on most of our Principles. They liked them and particularly welcomed the emphasis on keeping parents involved and informed. They noted that we had no principles relating to endings in therapy and felt this was an omission. One of the interviewees said when her son's therapy ended it was really helpful to be sign posted to a group he could access in the community. ATCAF have since discussed the possibility of further service user feedback on the PBP however this would involve checking for ethics approval and designing a formal piece of research which ATCAF as a SIG have not currently got the resources to do.

This was a pragmatic piece of guideline development and is part of a developing process. We began in an impromptu way with the NGT and some aspects of how this was conducted could have been improved. For example a literature search could have been conducted first, and it would have been useful to have had the HPCP Standards of Proficiency available at the first workshop to prevent duplication and save the time that we spent cross-checking to rule them out later. Also, an external facilitator would have offered more impartiality.

Findings in the context of other research

There were few published clinical guidelines for art therapists prior to BAAT's initiative in 2010 requesting special interests groups to give their attention to this. Waller and Sheppard (2006) developed guidelines for working with older people living with the later stages of dementia. This has been followed up more recently by the Art Therapy Outlooks on Later Life (ATOLL) special interest group's development of Art Therapy guidelines for mild to moderate Dementia (ATOLL, 2015). These guidelines were developed by fourteen art therapists with experience of work with

this client group, and included consultation with both trainees on some courses and an arts therapy service user group. The context and scope of these guidelines included how they fit with current NICE guidelines and the National Dementia Strategy. Brooker et al (2007) describe an evidence-based clinical practice guideline for the use of art work in art psychotherapy with people who are prone to psychotic states. This includes information about: the aims of the work with those prone to psychotic states; the context and setting; the role of the art work; referrals; assessments; formats; and therapeutic approaches. The authors describe the guidelines as based on the best available evidence pertaining to art psychotherapy with people prone to psychotic states. The personality disorder special interest group published their account of their process and outcome of developing guidelines for art therapy with service users who have the condition of personality disorder (Springham, Dunne, Noyse and Swearingen 2012). Guidelines such as these provide a good starting point defining practice with specific conditions or client groups.

Implications for learning and for practice

The principles developed through the process described have been used on training courses to provide important additional guidance for art therapists about to enter the profession. They emphasise what is different when working as an art therapist with children and highlight the importance of communicating with the child's parents or caregivers and the system around the child. Art therapists work in a wide variety of settings with children including schools, CAMHS, social care, fostering and adoption services, and voluntary sector organisations, and the PBP provide an additional framework to HCPC standards of proficiency for art therapists working with children in all these settings. The development of the guidelines was a significant shared and learning experience for those that took part. It drew on the years of expertise within the group and BAAT's recognition of this has been a consolidating experience for SIG

Conclusion

This description of the process and outcome of developing guidelines for art therapists working with children and families resulted in a set of PBP which have proved to be useful in the field. The method used has created interest from art therapists in other special interest groups. Our hope is that by explicating our methods other people might be able to build and improve on them in the future.

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Tables

Table 1

Principle	Indicators
A. Throughout therapy (i.e. assessment and treatment) the art therapist supports the child to understand why he or she is coming to art therapy	**A.1** The therapist pays attention to the child's understanding of attending art therapy and uses child centred ways to explore this.
B. The boundaries and the structure of sessions are clearly explained in ways that are appropriate for the child, carers and wider system.	**B.1** The therapist explains the structures and boundaries of therapy in the first meeting with the child and the parents/carers. **B.2** When appropriate the art therapist explains the boundaries and structure of therapy to the wider system.
C. The art therapist is familiar with child development and has an understanding of the impact of early childhood experiences on the child's development	**C.1** The art therapist has a working knowledge and understanding of child development and the impact of early trauma through study and training.
D. The environment and materials are adapted to be as age appropriate and developmentally appropriate as possible	None
E. The art therapist interacts with the child at the appropriate level of emotional functioning and recognises that the level may fluctuate over time.	None
F. The therapist recognises that art therapy with a child is different from adult art therapy	**F.1.** Therapeutic responses, language and setting are age appropriate **F.2.** The therapist reflects on the process as well as the product of the sessions **F.3** The child's ability to tolerate anxiety is monitored and managed
G. The art therapist may participate in the child's play or activities when appropriate whilst at all times maintaining the therapeutic frame.	**G.1** The art therapist is sensitive to shifting boundaries within the session and ensures containment of the child's emotional state
H. The art therapist aims to foster reflective function or mentalization in the child, family and the wider system	**H.1.** The therapist focuses on the meaning underlying behaviour **H.2** The therapist encourages parents/carers to reflect on the child's inner world **H.3** The therapist encourages an understanding of other peoples thoughts and feelings
I. The art therapist will make an agreement about confidentiality at the start of the assessment/therapy. This will vary depending on the model of therapy being offered and the client group.	None
J. The extent to which the art therapist	None

communicates with the wider system will be explained to the child and carers	
K. Informed consent is sought from the child and parents/carers on issues of treatment and, where appropriate, liaison with the wider system.	**K.1** The art therapist gives a clear explanation of the basic principles of how Art Therapy works before seeking consent **K.2** The art therapist gives a clear explanation of the structure of Art Therapy assessment, treatment and the review process before seeking consent.
L. The art therapist has a working knowledge of safeguarding procedures and is aware of their responsibilities.	**L.1** The art therapist maintains up to date knowledge and awareness of safeguarding through regular training **L.2** The art therapist has knowledge of safeguarding procedures within their organisation and how and when to communicate with other agencies
M. The child is seen as part of a wider system and work is planned to reflect this	**M.1** The art therapist recognises that the child is affected by the systems around them e.g. family, school, social relationships. **M.2** The therapist uses appropriate interventions to engage and work with the systems around the child
N. The art therapist is mindful of the complex feelings of parents/carers while their child is in therapy	**N.1** The art therapist identifies when a parent/carer may benefit from additional support so they are able to provide greater containment for the child.
O. The art therapist is aware that the child may be holding or acting out unresolved issues from family, past and present	**O.1** The art therapist is mindful that family work or support for the parents/carers may need to be carried out alongside the art therapy. **O.2** The art therapist is as aware as possible of the family's history and, in the case of a child in the care of Local Authority, the child's history of coming into care. **O.3** The art therapist is familiar with the impact of impaired infant mother relationships through relevant study and training.
P. The art therapist understands that the child has limited autonomy in terms of their ability to choose the parameters of art therapy.	**P.1** The art therapist is mindful of the adult/child power dynamic within the therapeutic relationship.
Q. The art therapist reflects on, and supports the child to reflect on, the emotional content and significance of the art making process as well as the final image.	**Q.1** The art therapist actively wonders about the meaning of both process and image. **Q.2** Through modelling the art therapist encourages the child to reflect on the

	meaning of the process and image. **Q.3** The art therapist promotes interest in the emotional content of the work above aesthetic considerations
R. The art therapist assesses and evaluates the suitability of art therapy for the child. Throughout treatment the art therapist continues to assess the suitability and the child's engagement.	**R.1** The art therapist organises regular review sessions which may involve parents/carers and/or appropriate professionals.
S. The art therapist will consider and negotiate the most appropriate approach for each individual child	**S.1** Options considered may involve Individual Art Therapy, Family Art Therapy, Dyadic Art Therapy and Group Art Therapy **S.2.** The chosen approach will be reviewed regularly and re negotiated if appropriate

Table 1

Principle and Indicator in Round 1	Ratings	Comments
A. Throughout therapy (i.e. assessment and treatment) the art therapist supports the child to understand why he or she is coming to art therapy	Rating 1 2 3 4 5 6 7 8 9 1 3 2 6 (The numbers under individual ratings show how many panel members rated the item at each level. A blank box indicates no panel members rated the item at that level)	"The reasons for referral can differ from how the child uses or benefits from therapy, for me this self determination is important too – sometimes only becomes apparent as therapy progresses – although the pressure may come from the wider system to focus on' "I think this is very important because the clarity of communication between the child, and the family, build up trust necessary for the therapy to be effective. The child may think they are coming to art therapy sessions because they are 'naughty' and this and other understandings need to be looked at. "Necessitates working with parents (eg if a child attends AT due to bereavement the parents/cares need to know that the A Therapist is being explicit). "I feel it helps a child to understand why they are in therapy, and to see if they agree." "The therapist should also ask the child to give their view of why they are coming and contract aims with them – this could imply that the therapist 'knows' more that the child."
Indicator for A The therapist pays attention to the child's understanding of attending art therapy and uses child-centred ways to explore this.	Rating 1 2 3 4 5 6 7 8 9 4 8	"This seems to be an appropriate way of expressing the principle, recognising that using language relevant to the child's cognitive level is necessary." "Somehow the indicator makes more sense to me than the principle."

Table 2

Principle A Throughout therapy (i.e. assessment and treatment) the art therapist supports the child to understand why he or she is coming to art therapy	Indicators for Principle A A.1 *The therapist pays attention to the child's understanding of attending art therapy and uses child-centred and developmentally appropriate ways to explore this.* A.2 *The art therapist notices if the reasons for referral of the child differ from how the child uses or benefits from therapy and these differences are acknowledged and thought about.* A.3 If the child is attending art therapy due to a particular issue, e.g. bereavement, the parents/carers need to know that the art therapist is being explicit about this with the child or if not why not.
Principle B The boundaries and the structure of sessions are clearly explained in ways that are appropriate for the child, carers and wider system.	Indicators for B *B.1 The art therapist explains the structure and boundaries of therapy at the start to the parents/carers and to the child and revisits and explores these whenever appropriate* B.2 When appropriate the art therapist explains the boundaries and structure of therapy to the wider system.
Principle C The art therapist is familiar with child development and has an understanding of the impact of early childhood experiences on the child's development	Indicators for C *C.1 The art therapist has a working knowledge of and keeps up to date with current understanding of child development and the impact of early trauma through study and training.* *C.2 the art therapist keeps up to date with the understanding of the impact of early trauma on emotional development eg developments in neuroscience*
Principle D : The environment and materials are adapted to be as age appropriate and developmentally appropriate as possible	Indicators for Principle D *D.1 The art therapist will be aware of the need for safety but will provide as varied a range of materials as is possible.* *D.2 The art therapist will be familiar with the value of tactile materials i.e. clay, sand, water, paint and be aware that if for good reasons these are not available a vital aspect of therapeutic work with children will be missing.*
Principle E The art therapist Interacts with the child at the	Indicator for Principle E E.1.The art therapist will pay attention to the fact that the way a child relates to them

appropriate level of emotional functioning and recognises that this level may	developmentally and emotionally may fluctuate within a session as well as overtime.
Principle F The therapist recognizes that art therapy with a child is different from adult art therapy	Indicators for F *F.1.The art therapist's therapeutic responses, language and setting take account of the child's cognitive abilities, developmental stage and emotional situation* F.2. The therapist reflects on the process as well as the product of the sessions *F.3.The art therapist monitors the child's ability to tolerate anxieties and supports them in trying to manage these* *F.4. The art therapist recognises that communications with and work with the child's family, carers, school system and other systems in their lives are likely to play an important role in the helpfulness of the therapy.* *F.5 The art therapist is mindful of the adult/child power dynamic within the therapeutic relationship*
Principle G The art therapist may participate in the child's play or activities when appropriate whilst at all times maintaining the therapeutic frame.	Indicator for G G.1 *The art therapist is sensitive to their role fluctuating in response to the needs of the child but they at all times ensure containment of the child's emotional state.*
Principle H *The art therapist aims to foster reflective function or mentalization in the child, and where possible in the family and the wider system*	Indicators for H H.1. The therapist focuses on the meaning underlying behaviour *H.2. The art therapist, or other colleagues, encourage parents/carers to reflect on the child's inner world* H.3. The art therapist facilitates an understanding of other peoples thoughts and feelings
Principle I The art therapist will make an agreement about confidentiality at the start of the assessment/therapy. This will vary depending on the model of therapy being offered and the client group.	Indicators for I *I*. 1 *The art therapist will revisit issues of confidentiality with the child and their parents/carers as occasions arise.* *I.2 The art therapist needs to be clear with the child the limits of confidentiality in relation to safeguarding*
Principle J	Indicators for J

Informed consent is sought from the child and parents/carers on issues of treatment and, where appropriate, liaison with the wider system.	J.1 The art therapist gives a clear explanation of the basic principles of how Art Therapy works before seeking J.2 The art therapist gives a clear explanation of the structure of Art Therapy assessment, treatment and the review process before seeking consent *J.3 The art therapist will gain consent from the person with parental responsibility face to face and not through a third party*
<u>Principle K</u> The art therapist has a working knowledge of safeguarding procedures and is aware of their responsibilities	<u>Indicators for K</u> K.1 The art therapist maintains up to date knowledge and awareness of safeguarding through regular training K.2 The art therapist has knowledge of safeguarding procedures within their organisation and how and when to communicate with other agencies *K.3 The art therapist will seek guidance, and supervision, when necessary on safe guarding issues* *K. 4 The art therapist must be prepared to communicate/discuss with the child what may happen in response to a safeguarding concern.*
<u>Principle L</u> The child is seen as part of a wider system and work is planned to reflect this	<u>Indicators for L</u> L.1 The art therapist recognises that the child is affected by the systems around them e.g. family, school, social relationships. L.2. The therapist uses appropriate interventions to engage and work with the systems around the child *L.3 The extent to which the art therapist communicates directly with the wider system will be explained to the child and carers*
<u>Principle M</u> The art therapist is mindful of the complex feelings of parents/carers while their child is in therapy	<u>Indicators for M</u> M.1 The art therapist identifies when a parent/carer may benefit from additional support so they are able to provide greater containment for the child.
<u>Principle N</u> The art therapist is aware that the child may be holding and acting out unresolved issues from family, past and present.	<u>Indicators for N</u> N.1 The art therapist is mindful that family work or support for the parents/carers may need to be carried out alongside the art therapy. N.2 The art therapist is as aware as possible of the family's history and, in the case of a child in the care of Local Authority, the child's history of coming into care. N.3 The art therapist is familiar with the impact of impaired infant-mother relationships through

	relevant study and training
Principle O *The art therapist reflects on, and supports the child to reflect on, the emotional content and significance of the art making process as well as the final image.*	Indicators for O *O.1 The art therapist actively wonders about the meaning of both process and image.* *O.2 Through modelling the art therapist encourages the child to reflect on the meaning of the process and image.* *O3.The art therapist promotes interest in the emotional content of the work, and will focus on aesthetic qualities when these further illuminate the emotional content.*
Principle P The art therapist assesses and evaluates the suitability of art therapy for the child. Throughout treatment the art therapist continues to assess the suitability and the child's engagement.	Indicator for P P.1 The art therapist organises regular review sessions which may involve parents/carers and/or appropriate professionals
Principle Q The art therapist will consider and negotiate the most appropriate approach for each individual child	Indicators for Q *1 Options considered may involve Individual Art Therapy, Family Art Therapy, Dyadic Art Therapy, sibling art therapy and Group Art Therapy* Q.2 The chosen approach will be reviewed regularly and re-negotiated if appropriate.
Principle R *The art therapist recognises that children and young people are significantly influenced by socio – cultural dynamics and context, and will actively consider issues of cultural diversity in their work*	Indicators for R *R.1 The art therapist may be working with a broad range of diversity issues, and may need to acquire specialist knowledge and training in order to maximise the efficacy of a therapeutic intervention with a particular child.* *R.2 The art therapist will be alert not only to the more obvious issues of difference such as race, religion and ability, but to subtle and hidden ones, e.g. conception by donor insemination – and take into account the degree to which a particular child or young person is aware of and effected by feelings of difference.*

Table 3