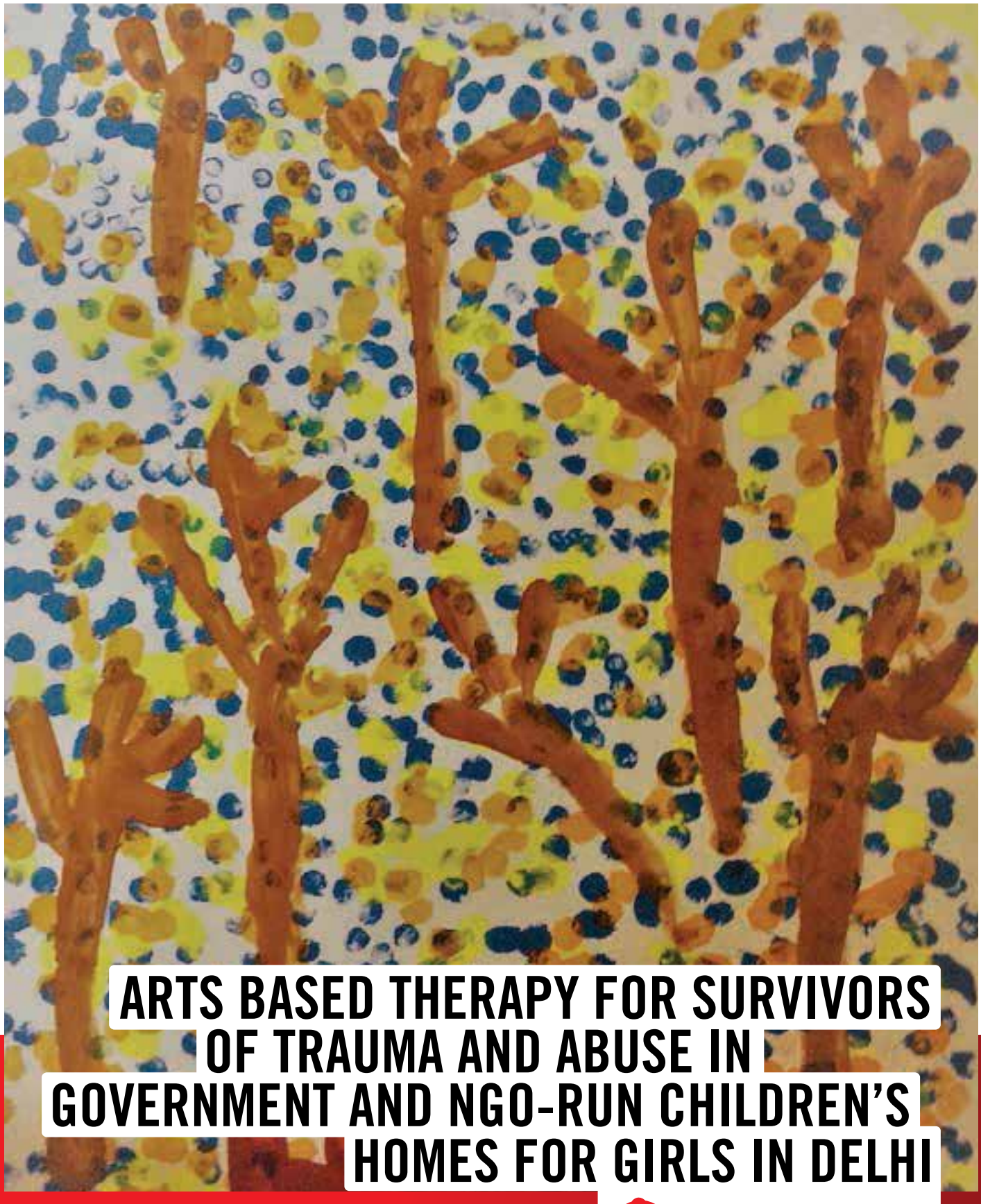

ARTS BASED THERAPY FOR SURVIVORS OF TRAUMA AND ABUSE IN GOVERNMENT AND NGO-RUN CHILDREN'S HOMES FOR GIRLS IN DELHI

Save the Children®

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Save the Children works for children's rights. We deliver immediate and lasting improvement to children's lives worldwide.

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ABBREVIATIONS

ABT	Arts Based Therapy
ADHD	Attention Deficit Hyperactivity Disorder
CBCL	Child Behaviour Checklist
CCL	Children in Conflict with Law
CNCP	Children in Need of Care and Protection
DMT	Dance Movement Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
DWCD	Department of Women and Child Development, Government of NCT of Delhi
HFD	Human Figure Drawing
ICPS	Integrated Child Protection Scheme
IHBAS	Institute of Human Behaviour and Allied Sciences
JJA	Juvenile Justice Act
NIPCCD	National Institute of Public Cooperation and Child Development
NISD	National Institute of Social Defense
VIMHANS	Vidyasagar Institute of Mental Health and Neuro Sciences
WISC	Wechsler Intelligence Scale for Children

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“It took me four years to paint like Raphael, but a lifetime to paint like a child.”

-Pablo Picasso

EXECUTIVE SUMMARY

Institutional Care and Psychosocial Needs: An Overview

More than 7 billion people are living in the world, including 2.2 billion children (aged 0-18) – amongst them millions of children and young people are without parental care or at risk of losing it. They are the most vulnerable and marginalized group throughout society.

There are millions of children living in institutions worldwide.[1] Overall, UNICEF estimates that the total number of children in institutional care globally is 2.2 million, but they point out that under-reporting and a lack of regulation in some countries indicates that this figure is an underestimate. Target beneficiaries for institutional care varies as per country norms. In India, Juvenile Justice (Care and Protection of Children) Act 2015 governs institutional and non-institutional mechanism for children in need of care and protection (CNCP) and children in conflict with law (CCL). The law defines CNCP as an umbrella term for all those below 18 years of age who are homeless, found to be begging, living on the street, subjected to any form of abuse or exploitation, children with special needs and inappropriate family care, missing, runaway or without a caregiver. CCL is defined as a child alleged or found to have committed an offense and who has not completed 18 years of age on the date of commission of offense.

While institutional care is considered to be the last resort for all children, it is often resorted for short and long term rehabilitation as most of the at-risk children, survivors of abuse or exploitation and children in conflict with law often have inappropriate family conditions. Numerous civil society organizations across the country provide institutional care to either or both categories of children. There is an alarming number of children who are under institutional care in India. (Browne, 2009) However, there is no official record of the total number of children in institutional care in India. Different government and civil society reports mention numbers varying from a few thousands to millions of children. US State Department's Trafficking in Persons 2016 report shared information received from central government in 2009 on 19,742 children to have been rescued including survivors of trafficking. The National Crime Record Bureau's seminal report, Crime in India 2015 recorded 41,000 juveniles (CCLs) apprehended in 2015 and around 7000 cases of human trafficking registered.

Children in institutions have often been through grave life experiences – loss, abandonment, death of loved ones, violence, betrayal and neglect. While policy makers, civil society, and practitioners working within institutions recognize the seriousness of the traumas many of these children have experienced, the importance of guaranteeing *positive mental health conditions* for them, as children and as future adult citizens, is yet to be clearly stated. Children growing up without a family and in the very particular environment of institutions face psychological challenges that need to be addressed in a systemic way.

Gaps in Mental Health in India

DASRA's report on mental health, Mind the Gap, 2016 illustrates the mental health continuum of Wellness → Distress → Disorder → Disability in which each of us are alleged to lie and at some point move along in one direction or the other. It further goes on to explain the gaps in existing mental health infrastructure and human resources. *"According to estimates, even if all ~4000 psychiatrists available in India are involved in face-to-face patient contact for eight hours a day, five days a week, and see a single patient for a total of 15-30 minutes over a 12-month period, they would together be able to care for only 10-20% of the mental health patients in India."*

Further, while there are at least 3.5 million people who need hospitalization on account of mental health, there are only 40 institutions with a bed capacity of 26,000 for mental health patients. And of these 40, only 9 are equipped to treat children.

The report acknowledges the neglect to alternative therapies in the service delivery approach and emphasizes on the need for sector expansion including training and capacity building of relevant stakeholders.

[1] https://wearelumos.org/sites/default/files/1.Global%20Numbers_2_0.pdf

Besides taking care of specific traumatic instances, to realize children's full potential and inherent abilities, and ensure that their permanence in the institution is serene and positive. There need to be a holistic approach to mental health, considering every child as a unique individual, with his/her own needs, fears, background, abilities, interests and problems.

Save the Children's Intervention on Art Based Therapy in Child Care Institutions

In this context, Save the Children initiated the Creative Arts based therapy as a child-friendly psycho-social alternative intervention for child survivors of trauma and abuse living in child care institutions for girls. It started as a pilot project and was implemented in two children's home in Delhi: Children's Home – Girls I, Nirmal Chaya Complex, a government home for girls and Udaan, an NGO run children's home for girls operating under Salaam Balaak Trust, an NGO working with street children and child laborers. The objective of the intervention was to pilot test the efficacy of Creative Arts Based Therapy on the psycho-social health of children in institutions with the larger objective of developing a safe and enabling rehabilitation of children in need of care and protection in India.

This report documents the impact of Creative Arts Based Therapy on children in institutions undertaken as part of Save the Children's intervention. The report uses the term Creative Arts Based Therapy interchangeably with Arts Based Therapy. There are two sections of the project: Firstly, Arts Based Therapy intervention for children at the age group of 6 to 14 years. 50 children in need of care and protection were selected for group therapy from the two Children's Homes. After few dropouts owing to administrative reasons, a final sample of 21 children in the control group and 23 children in the interventional group was considered. Secondly, Dance Movement Therapy intervention for adolescents at the age group of 15-17 years. For the adolescent group, seven children were selected from Nirmal Chaya. Out of the seven adolescents, four discontinued after a few initial sessions as they were restored and four new adolescents joined the sessions.

Save the Children understands Arts Based Therapy (ABT) as an evidence-based use of art forms (music, drama and visual arts) to accomplish individualized goals within a therapeutic relationship. ABT is a term that was coined by World Center for Creative Learning Foundation (WCCLF) to represent the use of multiple art forms and their combinations in therapy.

Dance Movement Therapy (DMT) is the therapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual, based on the empirically supported premise that the body, mind and spirit are interconnected (Dance Movement Therapy Association of Australia). DMT is known to help develop strengths such as healthy self-image, anger management, creativity and playfulness, positive problem solving, effective communication skills, relationship building and emotional stability.

Therapeutic goals identified for the children aged 6-14 years were: Self-expression, cognitive abilities (memory, sustained attention and abstract thinking), behavioural difficulties and group interactions. Therapeutic goals identified for adolescent groups were self-expression, cognitive skills (understanding body and sexuality, problem solving and anger management) and group interactions (group goals and sense of belongingness). These goals for the two groups were addressed using ABT and DMT approach respectively.

Assessment Tools

The impact of the therapy was studied using quantitative and qualitative methods. The quantitative measures included Child Behaviour Checklist, CBCL (Achenbach 2001), Human Figure Drawing, HFD (Elizebeth Koppitz, 1968) and Arts Based Therapy Checklist for Children At-risk (WCCLF). The qualitative measure included case study method.

Key Findings

The findings of the study revealed significant effect of ABT and DMT as an intervention to address the social, emotional, and cognitive needs of children and adolescents with a history of trauma and abuse. The children showed improvement particularly in:

- Children's Profile: The mean age of children in the control and intervention group was 12 and 10 years respectively. Since Save the Children was given permission to work in a girl's home by the Department (DWCD), the target children – in intervention as well as control group were all girls.
- Parents' Profile: Maximum number of parents of children in the control group as well as intervention group were deceased (single or both, 20), daily wage earners (9-10), or beggars (9).
- Classification of children under children in need of care and protection: Maximum number of children

were children with inappropriate and/or unsafe family environment (24), children of single parents (14), missing children (8) and children of beggars (8).

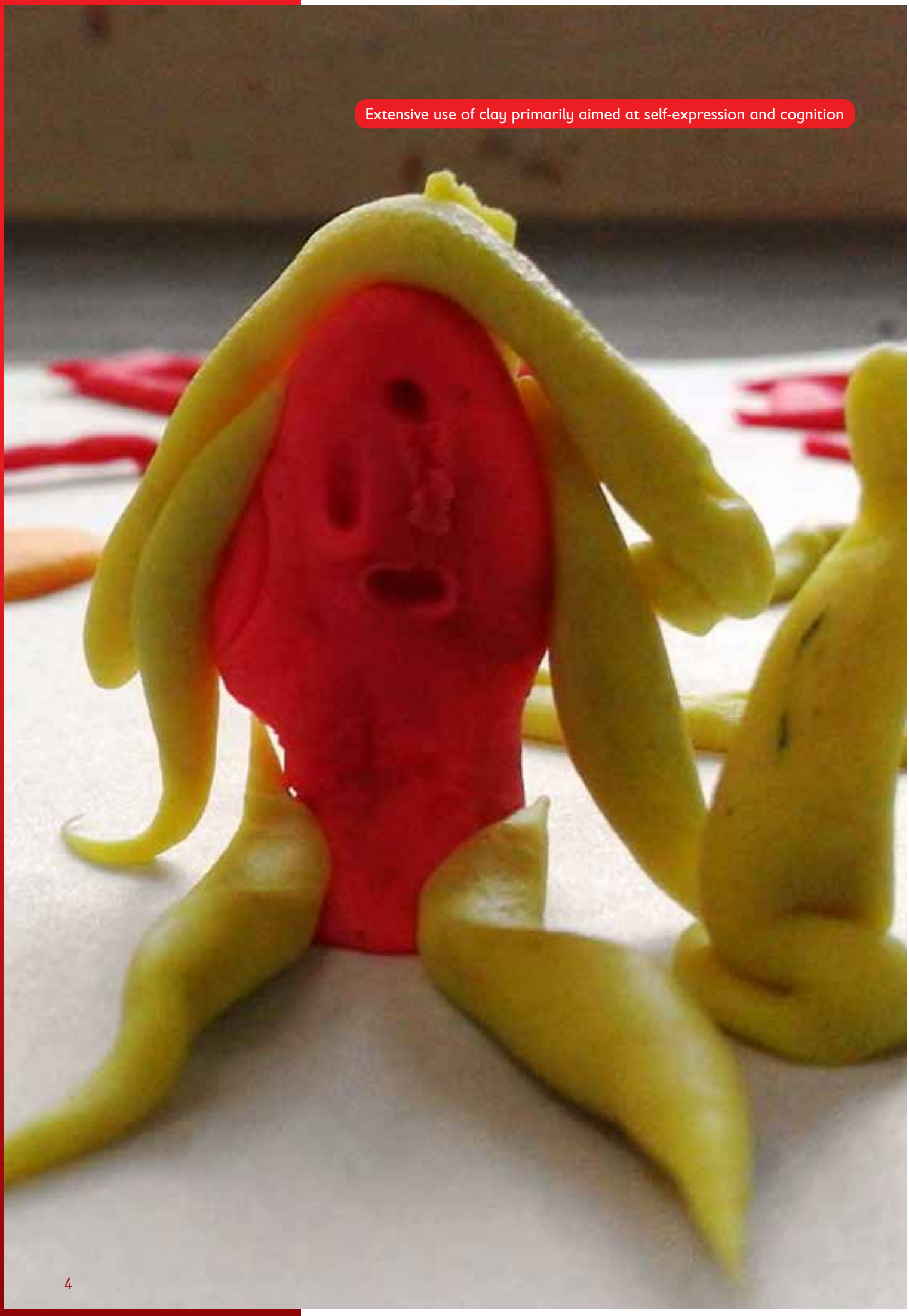
- Status of Education: In the intervention group, there were equal number of children who were out of school and enrolled in primary school (7 each). In the control group, maximum number of children were enrolled in school - secondary (11), primary (6) and high school (1).
- Increased participation in extracurricular activities as well as social activities
- Reduced hyperactive behaviour and conduct problems and improvement in depression and somatic complaints
- Improvement in other behavioural problems such as aggression, rule breaking behaviour and social problems.
- The adolescent group also showed improvement particularly in self-expression, developing self-esteem and positive attitude towards self and others.
- Results of the differences between the pre and post scores were observed not to be statistically significant in the variables of DSM anxiety, syndromic behavior, expression of somatization, oppositional defiance and internalizing behavior problem
- It was found that the tendency to externalize emotions was more prominent
- Interpretation of Human Figure Drawing on mental maturity and emotional expression showed that the quality of the figures improved before and after the intervention. However, there was no significant improvement in emotional expression of the figures while significant improvement was seen in the mental maturity through pre and post analysis
- Differences in the scores on ABT checklist indicated significant differences in the pre and post scores reporting improvement in cognition, communication, group interaction and mindfulness.

Limitations of the Study

- **Small sample size:** A limitation of the study was the relatively small sample size. For this reason, these findings cannot be generalized to the broader community based on this study alone.
- **Frequent changes in the homes:** There were some changes in the groups, both intervention and control group. During the course of the intervention there where children who were rehabilitated into their families or sent to another home, which decreased the sample size of the project and affected the outcomes as well.
- **Short-term study:** Considering that the study was a short-term project (8 months), a longer study (2-3 years) would have yield more perceptible changes.

Implications for Future Research and Intervention

- **Continuation:** As already mentioned, children in residential institutions do not have access to services to address their psycho-social needs, considering the lack of adequate human resource and skilled professionals. The pilot project reflected that alternative approaches such as ABT and DMT are beneficial and have helped children develop a positive-self attitude. Thereby, continuation of such projects is a necessity for children enabling them to live a productive life.
- **Larger study:** The present study was an attempt to understand the efficacy of ABT intervention on child survivors of trauma and abuse in institutions. The findings of the study have reflected on the positive impact of ABT. Thereby, extensive research and work on ABT is crucial to firstly strengthen the literature, and secondly to reach out to as many children in institutions who are in critical need of such interventions.
- **Human resource:** The present project had limited human resources. To extend the ABT intervention to other residential homes for children, there is a requirement of professionals and skilled individuals who can use ABT as an intervention for children and adolescents.
- **Awareness:** Awareness on mental health problems among children in institutions at all levels, especially professionals and care takers related to the facilities, would help in the interventional process. Therefore, there is a need to work on addressing the existing gap in awareness and sensitization amongst key stakeholders through workshops, skill enhancement and exposure to better service delivery frameworks.
- **Collaboration:** To expand the scale of a future study and intervention, collaborations with technical institutes such as NIPCCD, NISD, IHBAS, VIMHANS needs to be explored.
- **Mainstreaming ABT:** In order to best utilize the skills, artistic space and artistic tools offered by ABT, there is a need to mainstream the approach by integrating it with mainstream psychosocial, psychotherapeutic and psychiatric intervention for at-risk and special needs target groups.
- **Diversification of target group:** The present study was undertaken with a focused target group under children in need of care and protection as those children who have a history of abuse and trauma. To widen the scale of the future intervention in a similar setting of a child care institution, the target group can be diversified to bring in a larger number of children who are broadly categorized under a child care institution as children in need of care and protection, CNCP.


Extensive use of clay primarily aimed at self-expression and cognition

CHAPTER 1

INTRODUCTION

India is home to the largest number of children in the world. More than one-third of the country's population, around 440 million, is below 18 years.[2] According to one assumption 40 percent of these children are in need of care and protection, which indicates the extent of the problem.[3] In a country like India with its multicultural, multi-ethnic and multi-religious population, the problems of socially marginalized and economically backward groups are immense. The challenge is to reach out to the most vulnerable and socially excluded children in the country and create an environment wherein, not only is every child protected, but s/he also has access to opportunities and education for her/his all round growth and development.

Children at risk present a complex milieu of causes and conditions that influence their state of being. The causes could range from poverty, being abandoned by family, domestic violence, unaffordable housing, conflict with law, physical and sexual abuse, exposure to alcoholism and drug abuse, broken homes, etc. Many children opt to live on the streets because they feel it is safer than their homes and many land up in institutions. Institutions have played a major role in supporting and taking care of these children by providing the basics – food, clothing, shelter and education. But, socio-emotional development has a larger impact on what determines their adaptation, adjustment, values and success. Children growing up without a family and in the environment of institutions *face psychological challenges that need to be addressed in a systemic way*.

The damaging psychological consequences of institutional care have been written about for over 50 years. The publications of Goldfarb (1944; 1945) and Bowlby (1951) were particularly influential and highlighted a number of emotional, behavioural and intellectual impairments that characterized children who had been raised in residential care. Children living in institutions without parents are reported to perform poorly on intelligence tests and to be slow learners with specific difficulties in language and social development, in comparison to children with foster parents. In addition, they had problems concentrating and forming emotional relationships, and were often described as attention-seeking. The lack of an emotional attachment to a mother figure during early childhood was attributed as the cause of these problems, which were considered to be long-lasting.

Of the 27 studies scientifically investigated by Johnson et al. (2006) concerning the development of children who have been raised in institutions, 17 studies measured social and behavioural problems that were more prevalent in residential care children compared with other children. Evidence of negative social or behavioural consequences for children raised in institutional care was reported by 16 (94%) of the studies, highlighting problems with anti-social conduct. In addition, one in ten children who spent their early lives in poor conditions, often deprived of interaction with others, were found to show 'quasi-autistic' behaviours such as face guarding and/or stereotypical 'self-stimulation/comfort' behaviours, such as body rocking or head banging (Beckett et al., 2002; Rutter et al., 1999, 2007b; Sweeny and Bascom 1995).

Reports from many countries around the world stated that children and adolescents living in institutions are more prone to violence than those living in families.[4] Some studies have found that violence in residential institutions is six times higher than violence in foster care, and that children in group care are almost four times more likely to experience sexual abuse than children in family-based care. Additionally, self-harm, especially by children in detention or those who have gone through particular traumas, is another form of violence that can occur frequently in residential care and should not be underestimated.

[2] According to the World Population Prospects: 2008 Revision population database, the child population in the age-group 0-4 for India in 2010 is estimated to be (medium variant) 126 million against 88 million in China. The population of children in the age group 0-14 for the same year for India is estimated as 374 million as compared to 269 million in China.

[3] Child Abuse and Neglect: Challenges and Opportunities, By R.N. Srivastava, Rajeev Seth, Joan van Niekerk

[4] World Report on Violence Against Children, p. 183.

International research has indicated that children in long-term residential care are at risk of impaired cognitive, social and emotional development. Studies have also indicated that institutionalized upbringing is associated with increased rates of emotional disturbance in childhood. Common emotional issues related to these children were reported to be insecure attachment style, lack of sympathy, exhibiting poor sense of self, aggressiveness and being prone to non-compliance. Children exposed to neglect and abuse, were also reported to have problems with internalizing (anxiety, depression) and externalizing (aggression, impulsivity) behaviour problems.

The children in the institutions are often in need of services that address the psychological and emotional problems leading to severe developmental delays. Most of these institutions provide counseling services to children. However, factors such as low staff-to-child ratios/interaction and low levels of staff experience impacts the effectiveness of such services.

Considering the above discussion, it can be concluded that children in institutions require interventions to support them to deal with their psychological, emotional and behavioural difficulties. Children's psychological well-being affects every aspect of their lives, from their ability to learn, to be healthy, to play, to be productive and relate to other people as they grow (Atwine et al., 2005; Cluver et al., 2008; Killian and Durrheim, 2008). Thus, interventions to promote the psychological wellbeing of the children should focus on areas such as addressing psychological problems, advancing socialization skills, organizing extracurricular activities and improving coping strategies.

Arts Based Therapy

Arts Based Therapy is recognized as a successful alternative medium to promote psychological well-being in children. It is usually a very effective way of working with children who may be going through a difficult time. Creative arts allow children the opportunity to grow and develop self-awareness through self-expression. This has been shown to reduce stress and accelerate psychological and physical healing.

"Art is a unique way for people to communicate and gain understanding, as well as heal and express themselves" (Wadeson 1980). Art helps one tap into the unconscious. This can help problems, wishes, fears or conflicts to surface and be exposed so that an individual can heal and come to terms with his or her problems. "The creative process in art therapy allows people to access the imaginative part of themselves to bring inner guidance and self-healing to a conscious level" (Feldman, 1999).

Arts based therapy (ABT) is defined as the clinical and evidence based use of art forms i.e. music, drama, visual arts, to accomplish individualized goals within a therapeutic relationship. ABT is a term that was coined by World Centre for Creative Learning Foundation to represent the use of multiple art forms and their combinations in therapy. ABT uses different media: painting, singing, drumming, dance, playing, storytelling and drama in creating a therapeutic relationship between the child and the therapist.

The basic principle of creative arts therapy is that the process of creating art is immensely healing, which counters stress, trauma and improves cognitive skills. It enables catharsis of angry, hostile feelings through a non-intrusive, self-initiated process. Creative Arts therapy involves a holistic approach in that it not only addresses emotional and cognitive issues but also enhances social, physical and developmental growth (Carolan, 2001; Snyder, 1997). Creative Art therapy appears to help with the immediate discharge of tension and simultaneously minimize anxiety levels (Dwivedi, 1993; Naitove, 1986). The act of external expression provides a means for dealing with difficult and negative life experiences (Dwivedi, 1993; Snyder, 1997).

Arts based therapy is effective with children because they may experience difficulties integrating their experience of abuse and processing it emotionally and cognitively due to their developmental immaturity (Ryan, 1996). Difficulties associated with the treatment of abused children relate to their inability to verbalize their emotions and thoughts generated by the abuse (Zinni, 1997). Children also tend to feel overwhelmed and intimidated by the verbal expression of their experience (Killian & Brakarsh, 2004; Pifalo, 2002). Creative Arts therapy is consequently perceived as a successful alternative to conventional psychotherapy for this population group (Bissonnet, 2001; Case & Dalley, 1990; Murphy, 2001).

Dance Movement Therapy

Dance movement therapy is another alternative medium for children and adolescents, to further the emotional, cognitive, physical and social integration of an individual, based on the empirically supported premise that the body, mind and spirit are interconnected.

Dance movement therapy combines the creative process and the study of human movement into a holistic approach that draws upon the elements inherent in dance. Programs are designed to meet specific goals and bring about therapeutic change.

Adolescence starts around the onset of puberty which can range from about 11 to 18 years of age (Hair, Jager, & Garrett, 2002). Adolescents are also on the verge of changes in personality, cognitive development, hormonal levels, emotion, spirituality, and physical appearance (Hair, Jager & Garrett, 2002). Typical personality characteristics of adolescence are that they challenge authority, are argumentative, indecisive, hypocritical, self-conscious, self-centered, spontaneous, and energetic (Papalia & Olds, 1996). Adolescents may exhibit behaviours such as boredom, anxiety, fear of self-disclosure, fear of being left out, resistance to authority, partial or no participation in activities (Payne, 1992).

Adolescents in institutions experience a lot of emotional and behavioural problems. In institutions there is a decrease in the amount of safe, appropriate space and opportunities for adolescents to authentically express themselves. Adolescents face difficulties to deal with their physical and emotional changes in a constructive way. Most of the adolescents in institutions feel trapped and they do not see any hopes for their future. It is very important for institutions to deal with the adolescents issues and provide them with the space to explore themselves in a constructive manner.

Dance movement therapy is one of the therapeutic mediums to help adolescents develop an understanding about their changing bodies, emotions and to develop future aspirations. It provides a sense of freedom for them to express themselves without any fear of judgment.

Conclusion

Considering the delicate emotional, cognitive and social condition of these children living in the institutions, it was hypothesized that Creative Arts Based Therapy intervention and Dance Movement Therapy would address these deficits amongst the children and adolescents living in these homes in terms of human resources, their skills and infrastructure required to practice creative arts based therapy. With this hypothesis in mind, the present pilot study was planned with the aim of exploring the efficacy of creative arts based therapy on the cognitive, social and emotional problems of child survivors of trauma and abuse in government and NGO run Children's Homes in Delhi.

Games and exercises played a critical role in conflict resolution, conduct issues and enhancing group interactions

CHAPTER 2

LITERATURE REVIEW

International research has shown that children in long-term residential care are at risk of impaired cognitive, social and emotional development (UNICEF, 2012). Institutional care may affect a child's ability to make smooth transitions from one developmental stage to another throughout his/her life. Children brought up in institutions may suffer from severe behaviour and emotional problems, such as aggressive or antisocial behaviour, have less knowledge and understanding of the world, and become adults with psychiatric impairments. Also, children raised in institutions are at risk for learning problems-such as poor reading ability and have more difficulty with critical thinking, establishing cause-and-effect, and impulsivity (Dr.Victor Groza, 2010).

However, the effects of institutionalization are not uniform and are dependent on other factors. The extent of suffering is not the same for every child who is institutionalized. The differential effects are due to child characteristics (genetic predisposition, basic personality, attractiveness and prenatal risk factors), caregiver characteristics (training, motivation and attitude), institutional characteristics (child-to-caregiver ratio, quality and degree of programming), and the child's history (the age of the child when he/she entered the institution and the length of time in the institution) (Dr.Victor Groza, 2010).

In a research study on adolescent children (12-17 years) in orphanages, **Ms. Sujata and Ms. Subin Mariya Jacob** (2014) found that children in institutions are at risk of hyperactivity disorder and peer problems and abnormal pro-social behaviour. The study concluded that there is a need for cultivating positive emotions to optimize health and well-being in children in institutions.

Children in institutional care were found to have greater emotional problems (Ford et al. 2007; Erol, et al. 2010).They tend to be emotionally withdrawn (Zeanah, et al. 2005) and experience emotional loneliness (Han and Choi 2006; Ptacek et al. 2011). Studies comparing the institutionalized and non-institutionalized children found differences in the level of depression with institutionalized children displaying higher levels (Dell'aglio and Hutz 2004; Wathier and Dell'aglio 2007). They are also known to have more social problems than other children according to Palacios et al. (2013) who compared 40 internationally adopted, 50 institutionalized children and 58 community based children.

On the other hand, different results were seen in a study consisting of 1357 institution-living and 1480 community-living children across five developing countries including India. In this study Whetten et al. (2009) found that children in institutions had fewer emotional difficulties as they could focus on their needs rather than their families'. Children from poor communities where their caregivers may not be able to provide them with appropriate care may be better off when in institutional care in some scenarios as these children would often have to forego their emotional needs for their families'.

In a study on psychosocial problems and well being in institutionalized and non-institutionalized children, G. Padmaja, B. Sushma and Swati Agarwal (2014) found that internalizing and externalizing problems were both found in high levels among institutionalized children. Aguilar-Vafaie et al. (2011) in their study on orphan adolescent boys (n=71) and girls (n=69) looked at the various factors that put the children at risk for developing internalizing and externalizing problems. The risk factors for internalizing problems included neighbourhood poverty and peers who show deviant behaviour and for externalizing problems it was gender. Besides risk factors, the protective factors that resulted in better outcomes for children include perceived feelings of intimacy and connectedness and positive attitudes towards school in female adolescents.

One important factor that can be noted from the above study is that social connections play a crucial role in developing or reducing psychological problems. Social support and positive social interactions with others decrease the vulnerability of children to negative outcomes. So enhancing the quality of relationships and promoting stable, secure attachment with peers and caregivers can bring about positive outcomes among these children.

It is important to examine the range of problems and challenges those children in institutions poses to treatment providers and systems of care. It is well established that the high level of victimization and traumatic exposure for youth in residential treatment programs is often underreported and, thus, underestimated (Singer 2007). Consequently, careful assessment and detailed clinical information gathering is crucial to understanding the unique symptom presentation of these youth and implementing appropriate and effective interventions.

However, there is not much research on intervention programmes in institutions for psycho-social well-being of children and adolescents living in institutions. Some of the research studies have indicated that a concentrated effort has to be made to teach appropriate social skills (Fisher, Masia-Warner & Klein, 2004) to children, particularly those who are under institutional care. A psychosocial intervention with a multipronged approach involving multiple stakeholders would be beneficial for institutionalized children. Counseling for children with social interaction anxiety is also required. At the same time, social skills development programme for institutionalized children have to be implemented. Programs targeting creation of awareness in the caretakers/supervisors in the institutions in this area, and programs aimed at improving the interactional skills of institutionalized children appear to be essential.

Arts Based Therapy

The advancement of studies in neuroscience has established the linkages of the practice of art and its positive effects on the brain. It has been established that different neural networks are involved in various forms of arts such as music, visual arts, dance, drama (Ashbury and Rich 2008).

In 2008, the Dana Arts and Cognition Consortium report's findings allow for a deeper understanding of how to define and evaluate the possible causal relationships between arts training and the ability of the brain to learn in other cognitive domains. Various studies of using the arts for children and adults have shown higher motivation linked to sustained attention, positive outcomes in the level of expression, readiness to explore artistic mediums, thereby improving the quality of life. The challenge is to integrate these findings from the fields of neuroscience with practice in the field with special needs populations.

It is a challenge for the institution to provide for physical, psychosocial, emotional and developmental needs of all children. Institutional care needs to provide for significant and serious delays in the 'development of both their intellectual capacity (for example, language skills and the ability to concentrate on learning) and in their ability to interact socially with others (temper tantrums and behavioural problems are common)' (Every Child 2005). What a holistic intervention really aims at is the crucial development of resilience – a concept that aims to 'support the social and cultural expressions' which enable and develop 'resilience and coping in ways that effectively support children's wellbeing' (Boyden & Mann 2005). It is critical that besides interventions that provide and support the developmental aspects for children at risk, attention is given to creating individual and community spaces which allow articulation and development of personal views on critical issues, and awareness training (Mindfulness). There are few but significant interventions which are using 'mindfulness and emotional intelligence exercises to equip disadvantaged and underserved youth with the tools to make better decisions and to consider more skillful options than violence, self-harm, drugs, and crime' (Sharkey 2010). ABT follows somewhat similar trajectory, in that it creates the space for interaction, expression, play combined with possibility of exploring crucial concepts with Mindful self-awareness and contemplation, leading to better understanding and action.

Creative arts have long been used with children to promote psychological health and social support. They offer children "a way to express their feelings, perceptions, thoughts, and memories in ways that words cannot" (Malchiodi, 2005, p. 9). Studies indicate that expressive arts assist healing from childhood trauma and aid in overall mental health "by providing opportunities to share experiences in an empathic environment through symbolically expressing emotions in a concrete way" (Smilen, 2009, p. 381).

Creative arts assist in the healing process by altering a child's physiology. When children engage in expressive arts, it alerts the parasympathetic system in their brain (Lane, 2005). Their breathing slows, their blood pressure lowers, and the body becomes more relaxed. This helps reduce the physiological hyper arousal, or fight-or-flight response, associated with stress. Creative expression modifies our biochemistry and improves our physical well-being. When children participate in the arts, it actually changes their bodies.

The creative process causes specific areas of the brain to release endorphins and other neurotransmitters that affect brain cells and the cells of the immune system, relieving pain and triggering the immune system to function more efficiently. Endorphins are like opiates, creating an experience of expansion, connection, and relaxation. In conjunction with these physiologic changes, art can regularly change people's attitudes, emotional states, and perception of pain. (Lane, 2005, p. 122)

A child's spiritual awareness and development can also be improved by the use of expressive arts. The use of dance deepens "children's spiritual awareness and provides a context for the development of a kinesthetic intelligence, which allows children to embody and give expression to abstract concepts and ideas" (Bhagwan, 2009, p. 229). Creative arts also "engage children in learning that is intimately related to spiritual development, involving self-understanding, understanding relationships, wider environmental connectedness, and connection with the divine" (Coholic, Lougheed, & Lebreton, 2009, p. 31). The arts engage the senses in a way that transcends the ordinary and mundane aspects of life. As children connect to their poems, songs, dances, or paintings, they become more aware of their thoughts, emotions, and core beliefs. This assists in self-discovery and self-understanding and helps them find meaning.

Dance Movement Therapy

According to the American Dance Therapy Association website (2009), dance movement therapy is defined as "the psychotherapeutic use of movement as a process which furthers the emotional, cognitive, physical, and social integration of the individual." Levy (1988) described Dance Movement Therapy as "the use of dance and movement that allows the body movement to reflect inner emotional states and changes in movement behaviour can lead to changes in the psyche, thus promoting health and growth." Dance movement therapy (DMT) is a specialty discipline similar to other creative therapies such as art, music, drama, and poetry (Goodill, 2005).

Cohen and Walco (1999) published an article arguing the effectiveness of DMT for children and adolescent boys and girls with cancer. Their results confirm that DMT helped children adapt to the demands of their situations as well as learn how to moderate and control emotions of their related behaviours by recognizing the extremes. Wennerstand (2008) reported that DMT is especially helpful to clients who struggle with communication skills and low self-esteem. The client leads the movements and the therapist empathically mirrors and senses allowing the client to take control and trust themselves. DMT has also been effective when treating young Black Americans from urban settings who struggle with homicides, suicides, drug abuse, delinquency, and teen pregnancy (Farr, 1997).

Research has stated consistently that Dance Movement Therapy has been noted to be an incredibly effective alternative counseling technique that combines body movement with expressing internal feelings (Wennerstrand 2008; Payne 2000).

Low self-esteem and poor body image are major problems consuming adolescent lives, especially ladies who come from middle to high socioeconomic classes. These negative thoughts interfere with a person's academic and social lives; there is little to no information on overcoming these negative thoughts. Parker, Low, Walker, and Gamm (2005) suggest that friendships can often lead to jealous situations. Jealous situations are especially threatening to individuals with low self-esteem. It is very likely that adolescents with chronically low self-esteem struggle to form trusting relationships with their peers (Parker et al. 2005). Carlyle (2006) once said "nothing builds self-esteem or self-confidence like accomplishment". Due to the age and the onset of these feelings, it is crucial that young women have a safe place where mentors are present where they can build their confidence and feel self-worth.

Mackeen and Herman (1974) suggest that it's possible to change one's self concept. Through interventions presented by professionals, new self-attitudes can be learned. DMT groups can offer opportunities for bringing the mind and the body together as one, helping to alleviate low self esteem (Torre, 2008), allowing them to feel universality and altruism with other girls, and supply installment of hope (Yalom, 2005).

DMT offers the opportunity for exploration, containment and expression of emotions through the movement metaphor (Meekums, 2002). Previously, there have been numerous studies stating the effectiveness of DMT with adolescent participants who struggle with mental health issues placed in mental health facilities (Cohen & Walco, 1999; Goodill, 2005; Krantz, 1999; Wennerstand, 2008). There are very minimal studies regarding DMT's use in residential setting for adolescents. According to a research young adults enjoy DMT because it provides a different means for self-expression without requiring conversation as well as their growth through vulnerability (Wennerstand, 2008).

CHAPTER 3

METHODOLOGY

The project: *'Creative Arts based Therapy (CABT) for Child Survivors of Trauma and Abuse in Government and NGO run Children's Homes in Delhi'* was initiated with the goal of establishing child-friendly psychosocial intervention for child survivors of trauma and abuse in government and NGO run children's homes in Delhi. This section describes the aims and objectives, study design, sample description, tools, process as well as the intervention process of the present study.

Aims and Objectives

Expanding on the pressing need as well as the findings of the empirical research, the present pilot study aimed to explore the efficacy of Arts Based Therapy and Dance Movement Therapy on the cognitive, social and emotional problems of child survivors of trauma and abuse in government and NGO run Children's Homes in Delhi. The objective of the study was to scientifically explore scope, strengths and adaptability of these methods of treatment on children with a sensitive past. Based on the aims and objects of the study, certain hypotheses were formulated. The main hypotheses of the present study were:

1. There will be a statistically significant improvement in the therapeutic goals of self expression, behaviour, cognition and group interaction in the post test scores among the interventional group as compared to the control group.
2. There will be a statistically significant increase in the post test score among the interventional group on CBCL competence scale as compared to the control group.
3. There will be a statistically significant increase in the post test score among the interventional group on CBCL DSM scale as compared to the control group.
4. There will be a statistically significant increase in the post test score among the interventional group on CBCL syndromic scale as compared to the control group.
5. There will be a statistically significant improvement in the quality of drawings on post test scores among the interventional group on Human Figure Drawing Test as compared to the control group.
6. There will be a statistically significant decrease in the emotional indicators in the post test scores among the interventional group measured on the Human Figure Drawing Test as compared to the control group.
7. There will be a statistically significant increase in the post test score among the interventional group on ABT checklist as compared to the control group.

Sample

The project was implemented in two children's homes[5] in Delhi: ***Children's Home – Girls I & II,*** Nirmal Chaya Complex, a government children's home for girls and ***Udaan***, an NGO run children's home for girls operating under Salaam Baalak Trust, an NGO working with street children and child labourers. The project started its on-ground preparation for implementation in October 2015 after the approval from Department of Women and Child Development, Government of NCT of Delhi and started practice in mid-November 2015.

Sample Group Profile

Arts Based Therapy Intervention

Nirmal Chaya: A sample of 25 children was selected for the study (9-14 years). The target group in Nirmal Chaya comprised of missing children; children whose parents are in Tihar jail (prison complex in Delhi and one of the largest complex of prisons in South Asia run by the Department of Delhi Prisons, Government of NCT of Delhi), and have single parent or are orphans.

Udaan: A sample of 24 children was selected for the study (9-12 years). The target group in Udaan comprised of missing children, children whose parents are into begging or children who have faced physical and sexual abuse and thereby parents have kept them in Udaan for security reasons.

[5] As per amended **Juvenile Justice Act, 2015**, the State Government may establish and maintain, in every district or group of districts, either by itself or through voluntary or non-governmental organizations, "Children's Homes", registered for the placement of children in need of care and protection for their care, treatment, education, training, development and rehabilitation, specialized services for children with special needs.

Dance Movement Therapy (DMT) Intervention

Nirmal Chaya: For the DMT intervention 7 children (15-17 years) were selected from Nirmal Chaya. Out of the seven adolescents, four discontinued after a few initial sessions as they were restored and four new adolescents joined the sessions. The target group comprised of children with family in dispute, orphans and single parent.

The project was implemented under the name of Creative Arts Based Therapy. The term creative arts based therapy was used for the purpose of the present study as two forms of creative therapies were used in the course of this pilot project. *Arts Based Therapy* was used as an intervention on the group of children ranging between the ages of 6-15; and *Dance Movement Therapy* was used as an intervention for the adolescent group. For the arts based therapy group, 50 children in need of care and protections were selected for group therapy from the two children homes. However, during the course of the study, few children dropped out due to administrative reasons. The final sample consisted of 21 children in the control group and 23 children in the interventional group. For the adolescent group, 7 children were selected from Nirmal Chaya. Out of the 7 adolescents, only 3 remained till the final stage of the project due to administrative reasons. Due to its transient nature between childhood and adulthood, adolescence is assumed to be a period of emotional confusion and a change in emotional expression is usually observed. Keeping this factor in mind as well as the small sample size, the observations of the adolescents are discussed in a case study format.

For the purpose of the study, certain inclusion and exclusion criteria were decided. Children with physical and mental disability, short-term stay in the institution and non-familiarity with Hindi and English language were included in the exclusion criteria. Long duration of stay in the institution, good physical/ mental health and ages between 6- 15 years were included as inclusion criteria. Figure 3.1 depicts the sample distribution in the groups from the 2 homes.

Tools (Arts Based Therapy Intervention)

Keeping the aim and objective in mind, certain assessment tools were selected for the study. Tools used in the present study were Child Behaviour Checklist (CBCL), Human Figure Drawing (HFD) and Arts Based Therapy Checklist (ABT). A brief description of the tools is given below. CBCL and ABT Checklist and Koppitz's list of 30 indicators for emotional expression are appended as annexures on Page 32-40.

Child Behaviour Checklist

The Child Behaviour Checklist (CBCL) is a widely used caregiver paper-pencil report form identifying problem behaviour in children. It is one of the most widely used tools in both research and clinical practice with youths. The school-age version of the CBCL (CBCL/6-18) instructs a respondent who is familiar with the child (usually a parent or other close caregiver) to report on the child's problems. Alternative measures are available for teachers (the Teacher's Report Form) and the child (the Youth Self Report, for youth's age 11 to 18 years). The school-age checklist contains 118 problem behaviour questions. The main scoring for the CBCL is based on statistical groupings of sets of behaviours that typically occur together. The original scale used principal components analysis to group the items, and more recent research has used confirmatory factor analysis to test the structure. Scoring of the checklist is split in three segments, namely, Competence scale, DSM scale and Syndromic scale.

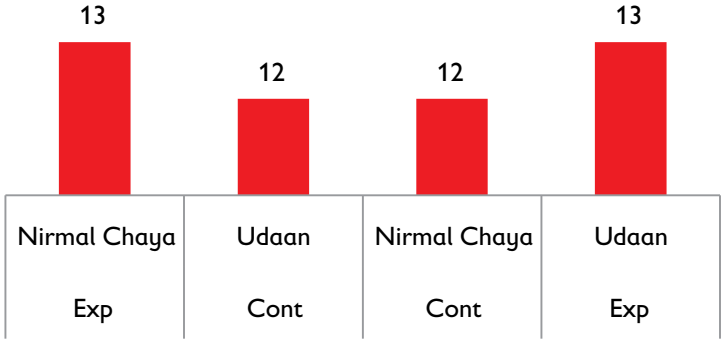


Figure 3.1: Sample Distribution

Competence scale measures the current activity level of the individual in the domains of co-curricular activities, social interaction and school.The DSM 5 scale measures behaviour in the domains of depression, anxiety, somatic, ADHD, oppositional and conduct problems. Similar questions are grouped into a number of syndrome scale scores. The eight empirically-based syndrome scales are: Aggressive Behaviour, Anxious/Depressed, Attention Problems, Rule-Breaking Behaviour, Somatic Complaints, Social Problems, Thought Problems and Withdrawn/Depressed.

There are two "broad band" scales that combine several of the syndrome scales: *Internalizing problems sums the Anxious/depressed, Withdrawn-depressed, and Somatic complaints* scores; *Externalizing problems combines Rule-breaking and Aggressive behaviour*. In addition there is a total problems score, which is the sum of the scores of all the problem items. The CBCL uses a normative sample to create standard scores. The standard scores are scaled so that 50 is average for the youth's age and gender, with a standard deviation of 10 points. Higher scores indicate greater problems.

For each syndrome (Internalizing and Externalizing problem scales, and the total score) scores can be interpreted as falling in the *normal, borderline*, or *clinical behaviour*. Any score that falls below the 93rd percentile is considered normal, scores between the 93-97th percentile are borderline clinical, and any score above the 97th percentile are in the clinical range. Norms take into account both age (6-11 & 12-18 years) and gender (girls and boys). Test retests; inter rater and internal consistency reliability for the checklist was reported to be adequate and good.

Human Figure Drawing Test

The study of children's representational drawings was one of the first areas of child psychology to become established as a field of research. The sequential nature of children's drawing development was established early on, with Luquet's model becoming the accepted and popular version. An understanding of the normal development of the HFD can shed light on the processes and the problems that are involved in constructing a recognizable representation. The Human Figure Drawing (HFD) test, The Draw-a-Person test (DAP), or Goodenough–Harris Draw-a-Person test is a popular instrument for the assessment of children's cognitive functioning (Piotrowski et al., 1985), it is a psychological projective or cognitive test used to evaluate children and adolescents. Koppitz (1968) developed a drawing test as a measurement of intellectual maturity.

This test can be used both as a developmental test and as a projective test. HDF reflects primarily a child's level of development and his interpersonal relationships, i.e. – his attitudes towards himself and towards the significant others in his life. It also reveals a child's attitude towards life's stress and strains and his way of meeting them. Drawings also reflect strong fears and anxieties which may concern the child. It is believed that HFD reflects the child's current stage of mental development and his attitudes and concerns of the given moment, all of which would change in time due to maturation and experience. It is regarded as a portrait of the inner child of the moment. The structure of a drawing is determined by his age and level of maturity reflects his attitude and those concerns which are most important to him at that time.

Koppitz (1968) developed a procedure for assessing the presence or absence of various items in human figure drawing that could be expected to appear in HFDs of 5- to 12-year-old children. She developed a scoring system for the HFD as a test of mental maturity as well as 30 items for measuring emotional indicators. Reliability studies (Koppitz, 1968; Snyder & Gaston, 1970; Fabry & Bertinetti, 1990; van de Vijfeijken, 1994; Abell et al., 1996) indicate that the inter-rater reliability commonly exceeds 0.90. Several studies showed low to high correlations between children's HFD score and their intelligence score. Gayton et al. (1974) used the Wechsler Intelligence Scale for Children (WISC) and found a correlation of 0.68. Abell et al. (1996) compared the scores between HFD, the WISC and the Stanford–Binet test. Between the HFD and the other measures the correlations were maximally 0.29.

The study of children's drawings have shown conclusively significant relation between the drawing development and the intellectual maturity. Owing to this, an Indian adaptation of the Goodenough DAP test was done in 1959 by Dr. Pramila Phatak measuring the mental maturity.

For the administration, each child receives a blank sheet of A4 paper and a pencil with an eraser. The instruction is: 'On this piece of paper, I would like you to draw a whole person. It can be any kind of a person you want to draw, just make sure that it is a whole person. For scoring for mental maturity, Indian adaptation of DAP by Dr. Pramila Phatak was used. For scoring for emotional indicator, the children's drawings were categorized according to the 30 original Koppitz indicators present in their drawing. Interpretations of the scores were based on the cut off as indicated by the Koppitz scoring. Two or more emotional indicators

on a HFD were considered to be highly suggestive of emotional problems and unsatisfactory interpersonal relationship.

Arts Based Therapy Checklist

Arts Based Therapy Checklist is developed by 'World Centre for Creative Learning Foundation, Pune' for identifying a child's cognitive ability, mindfulness and body awareness, communications and group interaction. The checklist covers the following domains: body, sensory, mindfulness, cognitive domain, expression, communication and group interaction.

Process

Initial Processes for On-Ground Preparation in Selected Two Homes

Permission was sought from Department of Women and Child Development, Government of NCT of Delhi to carry out the project in the government home. The Department assigned Children's Home – Girls 1, Nirmal Chaya Complex (West Delhi District) run by SBT for intervention. Similarly, Salaam Baalak Trust (SBT), an existing partner NGO of Save the Children for implementing child domestic workers intervention, was selected for intervention in an NGO run home. Udaan, a children's home for girls in West Delhi District was assigned by Salaam Baalak Trust considering the requirement of psychosocial needs of the children in their institutions.

Refurbishment of Creative Arts Based Therapy was done in the government home only as the NGO run home has an existing room for counseling services. The refurbishment included painting of the room, installation of display boards and curtains. Art supplies and music instruments (Djembe, Tambourine, *Ghungru* (musical anklets), and percussion instruments) were procured for both homes.

Identification Process of Sample Group

Discussions were held with different stakeholders in the two homes, Superintendent of two children's homes, existing counseling staff and child welfare officers. The meetings helped to understand the context of the homes, sort out permissions, decide on the group for art based therapy and dance movement therapy, and fix the schedule. In the government home, counseling services were already being managed by an NGO called Manas Foundation. In NGO run home, a team of counselors provided already being to the children. Since in both the homes, the counselors were over-worked as the number of children were far more than the capacity of the counseling team, those groups of children were selected who were being left out from the counseling service. In Nirmal Chaya (Government run home), it was the children who were staying in the home on a long term basis (commonly known as commit children in 9-12 year age group school going children). In Udaan Home as well, children in the age group of 9-12 year were selected. The target group was finalized by end of November and initial assessment of children started in December 2015. This assessment was to guide the therapist in determining the therapeutic goals for intervention.

The CABT intervention began in December 2015 with 30 children in Nirmal Chaya and Udaan. The CABT intervention included both individual and group sessions. The sessions were being conducted thrice a week in both the children homes.

Creative Arts based therapy is use of various art forms for the assessment and accomplishment of individualized objectives. The ABT intervention in this project was implemented in 3 phases:

- **Assessment phase** *(December 2015 to January 2016):* In ABT, assessment of the target group was the initial step, where the therapist used various psychological assessment tools such as Child Behaviour Checklist, Human Figure Drawing and Art Based Therapy Checklist and art forms to identify the needs of the clients. In this process, various psychological aspects of the clients were explored, such as their self-perception, cognitive abilities, perception about relationships, etc, under various therapeutic domains. The sample was divided into two groups: interventional group who underwent arts based therapy and DMT intervention and the control group on who did not undergo intervention.
- **Planning phase** *(February 2016):* Based on the assessment conducted in the previous phase, a report was prepared and therapeutic goals were set for the clients. This was followed by development of objective to tap the progress made by clients in the sessions during the intervention phase.
- **Intervention phase** *(March to July 2016)*: In the intervention phase, the sessions were designed with the objective of addressing the identified needs of the target group. The progress of the groups was recorded as pre and post test scores. The scores of the interventional and control groups were analyzed statistically.

Modalities at the Children's Home (Intervention Group)

Nirmal Chaya: In Nirmal Chaya the CABT intervention took place in a separate room which was dedicated for the therapy sessions. The CABT room was a space in the institution, where a child could come and explore their creativity. Thereby, there was a floating group of children along with a fix group. The clients could use any art form, i.e. art, dance, music or play.

The sessions started with establishing rapport with the children, making the CABT room a creative space for children to express themselves with no instructions on how to do, but to do what they like to do. Gradually the sessions structured shape with children maintaining the time schedule, indulging themselves into planned and group activities and more sharing among each other.

Udaan: The CABT sessions were conducted with a fixed group of 12 children. Since there was no fixed space for the sessions, sessions were designed in a way that suited the context.

The CABT sessions in Udaan were structured. The children established close bond with the therapist and showed gradual progression in their level of participation in the sessions.

Assessment Report

The assessment of children was done based on the psychological tools. The assessment forms were selected considering the target group with the history of abuse and trauma. The pilot study was planned on children who had a history of trauma and abuse, hence to have a more focused intervention plan, four therapeutic domains: Body, Perception of self, Self-expression and group interaction were selected for the study.

Therapeutic Goals for the Target Group

Brief Context

The therapeutic goals below were framed, considering the background of the children, the children's behaviour patterns and participation in the sessions, ability to express and relate to others.

	Therapeutic Domain	Therapeutic Goals for Children Group
1.	Self Expression	The ability to introspect of themselves through use of the artistic work.
2.	Cognition	Enhancing attention span, problem solving skills and abstract thinking
3.	Behaviour	To address the behavioural issues of fighting, abusing each other, stealing and lying
4.	Group interactions	Ability to speak appropriately in the group and accept challenges in the spirit of teamwork

	Therapeutic Domain	Therapeutic Goals for Adolescent Group
1.	Perception of self and others	To support them to develop a positive self attitude and feel motivated and develop self acceptance
2.	Behaviour	To address the issue of depression, aggression and behavioural issues

Data Analysis

Analysis of results (statistical methods): Results were analyzed using the paired and unpaired t-test by SPSS 20. Demographic and baseline data for the control and interventional group (Table 3.1) showed normal distribution. Results of Arts Based Therapy on the pre- and post-intervention scores for both the groups (interventional group and control group) on CBCL, HFD as well as ABT checklist and their components are analyzed and discussed.

Analysis of results (qualitative method): Qualitative analysis of the results was done in the form of case study discussion for the Dance Movement Therapy intervention for adolescents. Due to the small sample size as well as complexity of the issue, results of the adolescent group are discussed in the form of case study.

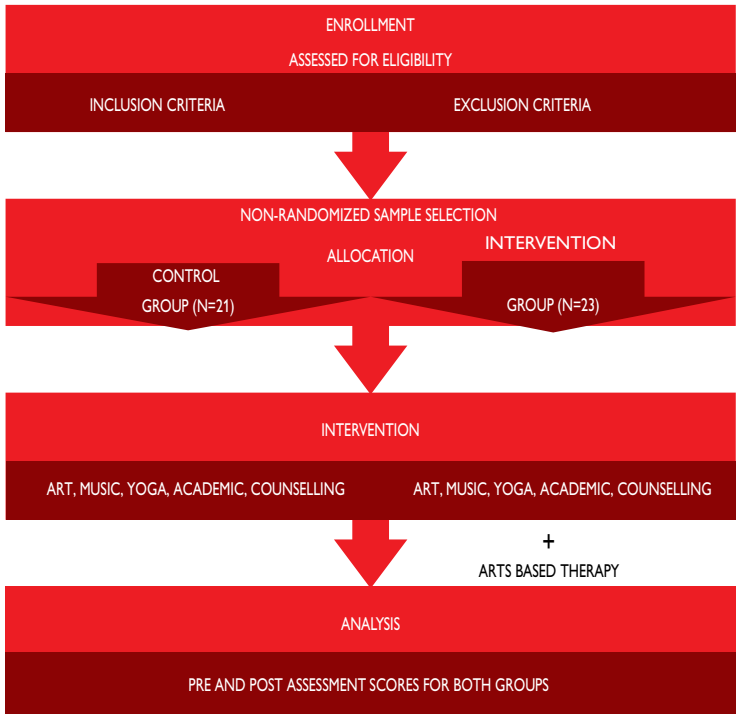


Figure 3.2: Study flow of the project

Table 3.1: Demographic and baseline data for the control and interventional group

	Control Group	Intervention Group		Control Group	Intervention Group
Age (Mean)	11.72	9.98	**School**		
Home			Out of school	3	7
			Primary	6	7
Nirmal Chaya	9	11	Secondary	11	5
Udaan	12	12	High	1	4
Father			**Mother**		
Deceased	5	4	Deceased	0	7
Begging	3	3	Begging	3	0
Daily Wage	7	3	Daily wage	7	2
Disabled	2	2	Disabled	1	0
Terminally ill	1	1	Terminally ill	1	3
Other data					
Parent convict	2	3	Sexual abuse	0	3
Single Parent	6	9	Parent terminal	0	2
Runaway child	0	2	Begging	4	4
Inappropriate and/or unsafe family environment	12	13	Orphan	1	4

CHAPTER 4

RESULTS AND DISCUSSION

The objective of the present study was to develop safe and enabling rehabilitation of children in need of care and protection in India, with a specific objective to study the efficacy of Arts Based Therapy on the psycho-social health of children in institutions. The results of the study were analyzed using SPSS 2.0 software. Analyses of results were done by quantitative as well as the qualitative method. In the quantitative method, difference in the mean scores of pre and post scores were compared among the interventional and control groups by using unpaired t test. Range scores were also compared among the pre and most measurement for the intervention and control groups to study the improvement in problem behaviours among children. No statistical tool was used for this analysis as the sample size was small; results are discussed based on the numerical scores. In the quantitative analysis, few case study descriptions are discussed in the ABT study. Analysis of the DMT study is discussed in the form of case study.

Demographic Data

The mean age of the children in the control and intervention group was 12 and 10 years respectively. Figure 4.1 shows the school background of the sample population. Maximum number of children in the Intervention Group (IG) were either enrolled in primary school or out of school. Maximum number of children in the Control Group (CG) were attending secondary school. Maximum number of parents of children in the control group as well as intervention group were either deceased (single or both, 20), daily wage earners (9-10), or beggars (9) (Figure 4.2 and Table 3.1).

Figure 4.3 breakdowns the broad category of children in need of care and protection in reference to the children in the control as well as intervention group. Majority of the children in the intervention and control group were those who had inappropriate or unsafe family environment (IG: 13, CG: 11) and children of single parents (IG: 8, CG: 6). Missing children and children of beggars were also found common in both the groups (4 each in each of the groups).

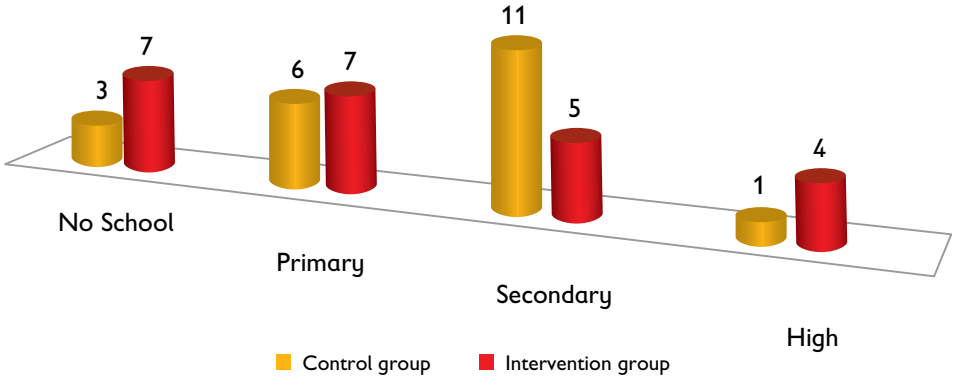


Figure 4.1: School Background

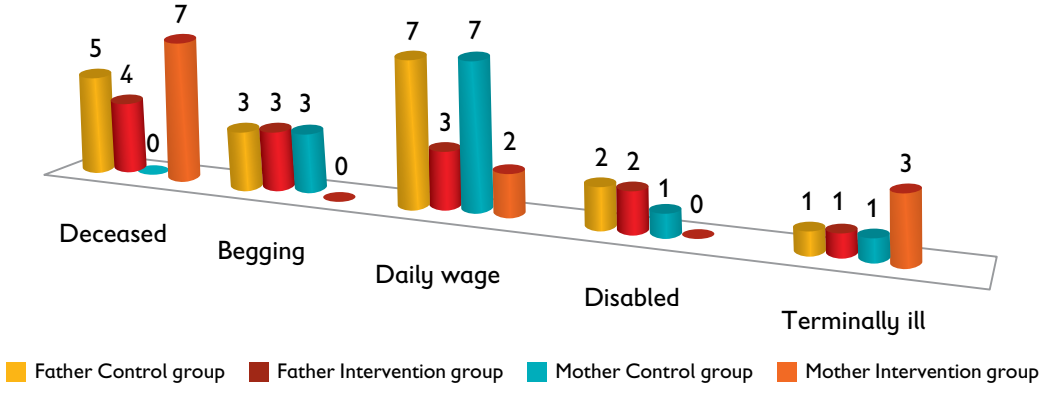


Figure 4.2: Parent Background

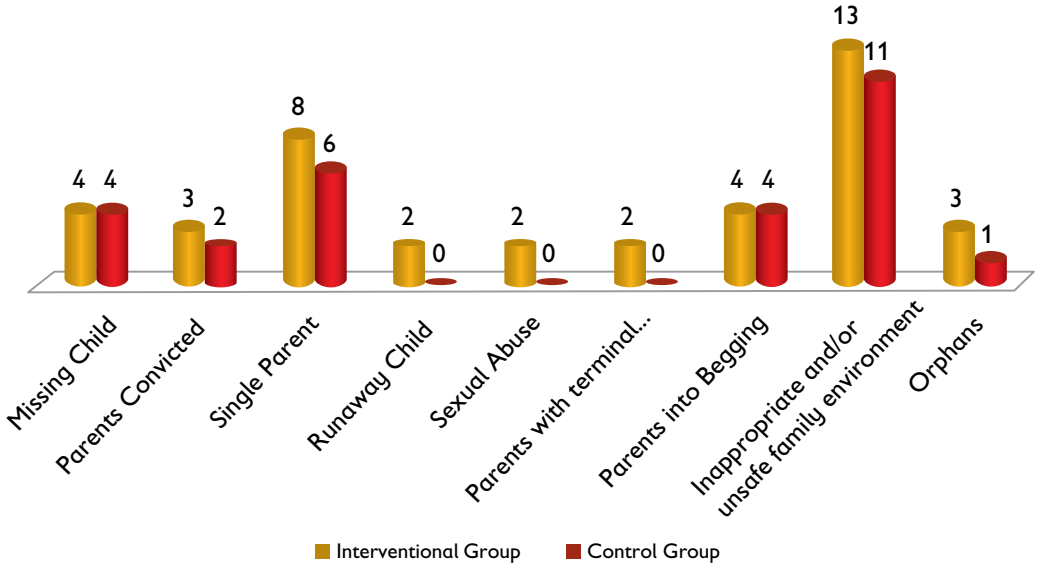


Figure 4.3: Background of the child

Quantitative Analysis – Arts Based Therapy Intervention

The objective of the study was to see the efficacy of Arts Based Therapy on the intervention group. After scoring and calculation of mean scores, difference in the pre and post mean scores were calculated. Independent sample t test was used to compare the pre and post scores of the control and intervention groups. Results of statistically significant outcomes are depicted in the graphs and discussed in this section. (Table depicting all the domains of the assessment scales can be referred in the Appendix).

Child Behaviour Checklist

Figure 4.4 shows mean difference score among the groups on CBCL competence scale. Results indicated statistically significant improvement in overall as well as in the domains of activities and socialization among the intervention group as compared to the control group. Intervention group showed increased participation in extracurricular activities as well as social activities, no difference was observed in school participation among the groups. Results indicated that in the intervention group, children were participating in social and sports activities more; they were interacting socially indicating an improvement in self expression and group interaction. Though subjective observation indicated improvement in school performance, no statistically significant difference was observed which could be attributed to the duration and timeline of the project.

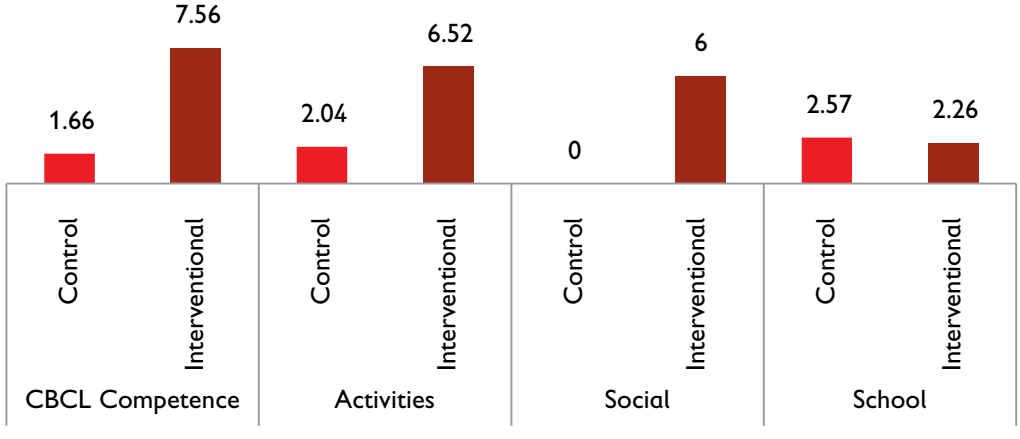


Figure 4.4: Pre and Post Mean Difference CBCL Competence Scores

Hence, the hypothesis that there will be a statistically significant increase in the post test score among the interventional group on CBCL competence scale as compared to the control group is accepted.

Figure 4.5 indicates the DSM 5 scale scores on CBCL. Statistically significant improvement was observed in the interventional group in the domains of depression, somatization, ADHD and conduct disorder.

Hence, the hypothesis that there will be a statistically significant increase in the post test score among the interventional group on CBCL DSM scale as compared to the control group is accepted.

Figure 4.6 shows the syndromic scale scores on CBCL. Statistically significant improvements were observed in the interventional group in the domains of improvement observed in anxiety/depression, aggression; rule breaking, social Problems, thought and attention problems. Improvement in externalizing problematic behaviour (Rule breaking behaviour and Aggression) was also observed in the post test assessment indicating that the children in this group were making an effort to control impulsive behaviour and channelize aggression into socially appropriate behaviours.

Hence, the hypothesis that there will be a statistically significant increase in the post test score among the interventional group on CBCL syndromic scale as compared to the control group is accepted.

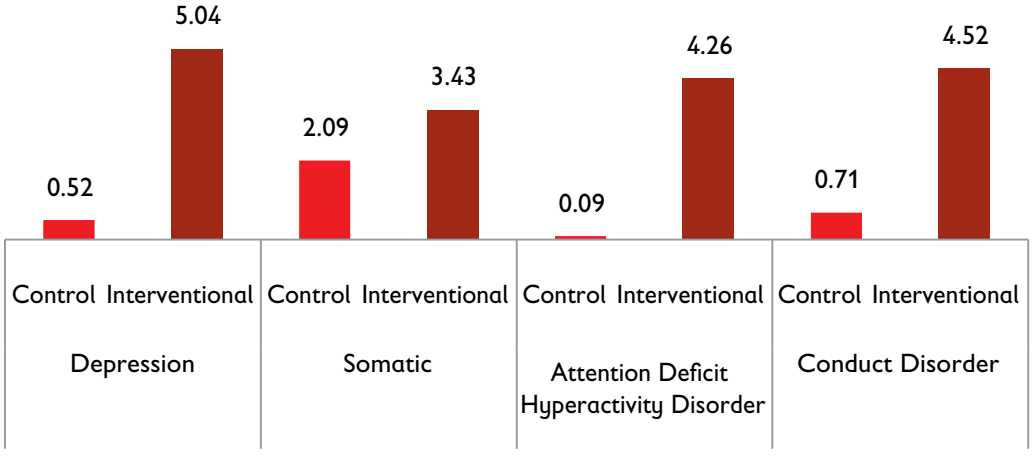


Figure 4.5: Pre and Post Mean Difference CBCL DSM Scores

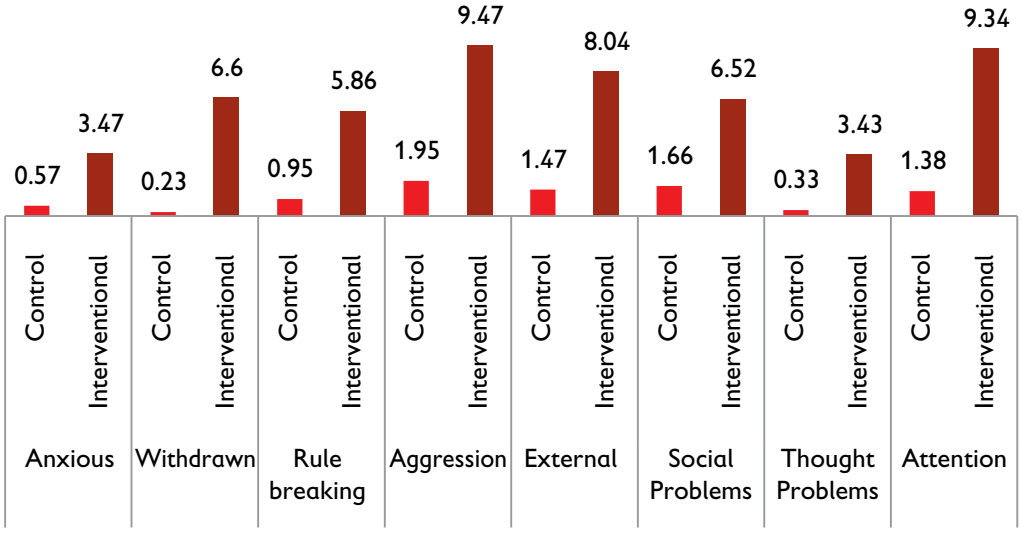


Figure 4.6: Pre and Post Mean Difference CBCL Syndromic Scores

Human Figure Drawing

Figure 4.7 shows the difference in the pre and post mean scores on the mental maturity scale of HFD. Results indicated statistically significant difference in the post test scores among the intervention group indicating that post ABT intervention, children in the intervention group had improved fine motor skills, improved self expression through art and improved cognitive skills.

Hence the hypothesis that there will be a statistically significant improvement in the quality of drawings on post test scores among the interventional group on Human Figure Drawing Test as compared to the control group is accepted.

No statistically significant difference in the emotional response was observed on HFD.

Hence, the hypothesis that there will be a statistically significant decrease in the emotional indicators in the post test scores among the interventional group measured on the Human Figure Drawing Test as compared to the control group is not accepted.

Arts Based Therapy

Figure 4.8 indicates the mean difference scores on ABT checklist. Results indicated statistically significant improvement in scores in the post assessment intervention group, especially cognition, communication, group interaction and mindfulness.

Hence, the hypothesis that there will be a statistically significant increase in the post test score among the interventional group on ABT checklist as compared to the control group is accepted.

Figure 4.7: HFD Mean difference of Pre and Post Scores between groups on HFD Mental Maturity scores

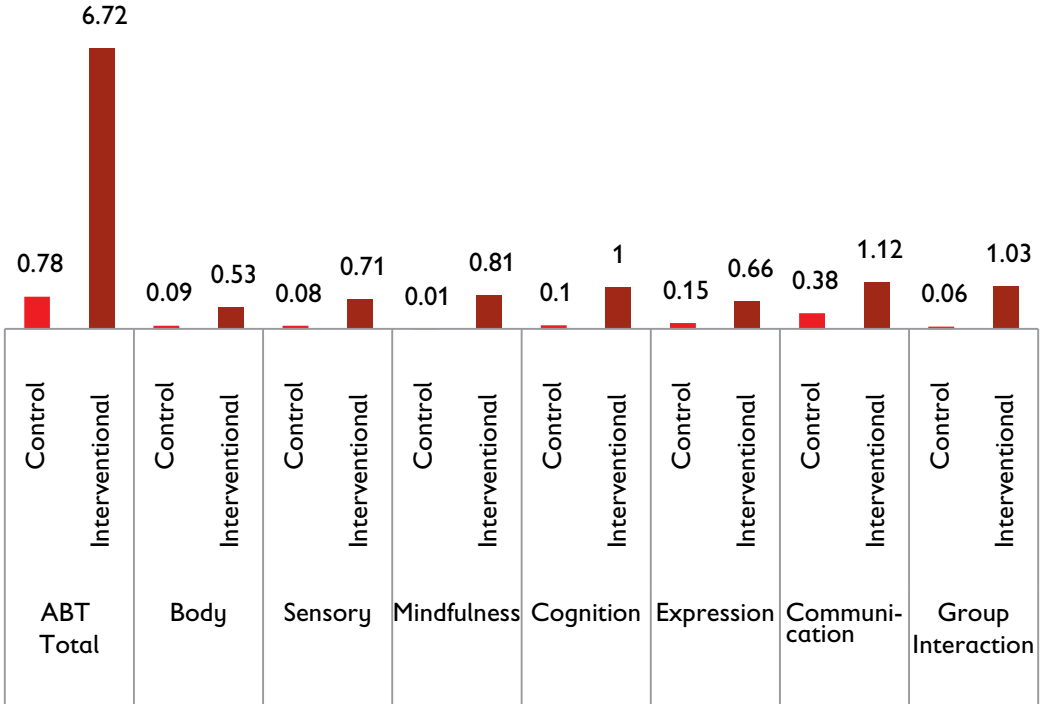


Figure 4.8: Pre and Post Mean Difference ABT Scores

Quantitative Analysis – Normative Score Comparison of Improved and not Improved Scores

After finding the significance levels in the mean differences of the before and after scores, further analysis was done to find out the number of children who improved in their performance in the post assessment session. For this, a numerical calculation was done on the number of children who shifted from either the clinical range to borderline or from borderline to normal. Children who came in the range from clinical to borderline and those who came from borderline to normal were placed in the improved category; and children who did not show any change or who showed reverse performance were placed in the not improved category. Due to the small sample size, no statistical tool was applied, and the results are discussed as normative scores.

Figures 4.9 and 4.10 show the numerical figures on the number of children who improved and not improved in the post assessment session. Results indicated that in competence, DSM as well as syndromic scales, larger number of children showed improvement in the intervention group.

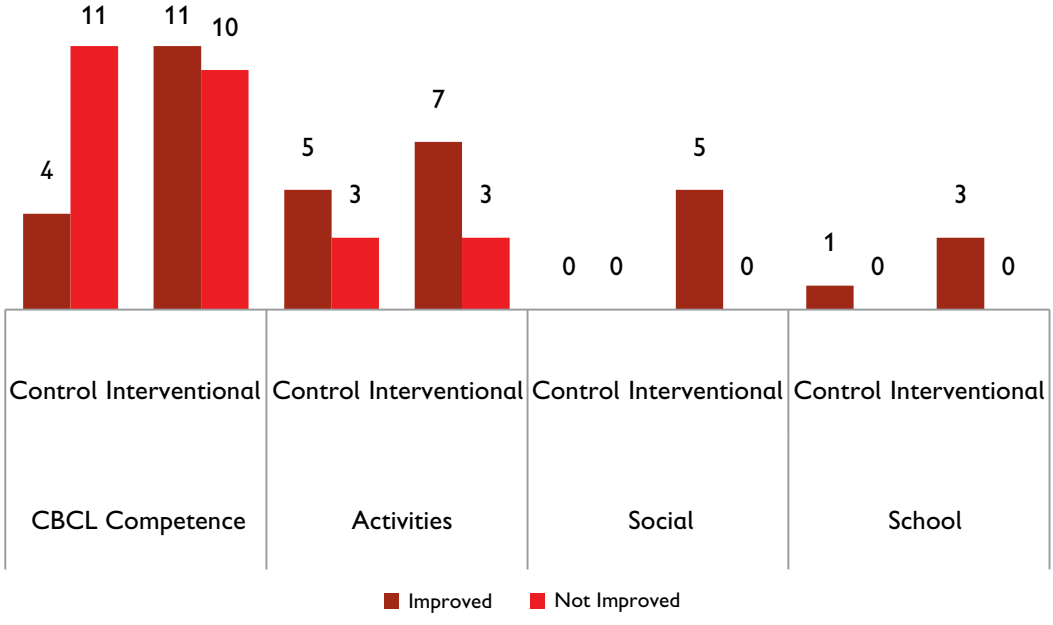


Figure 4.9: CBCL-Competence

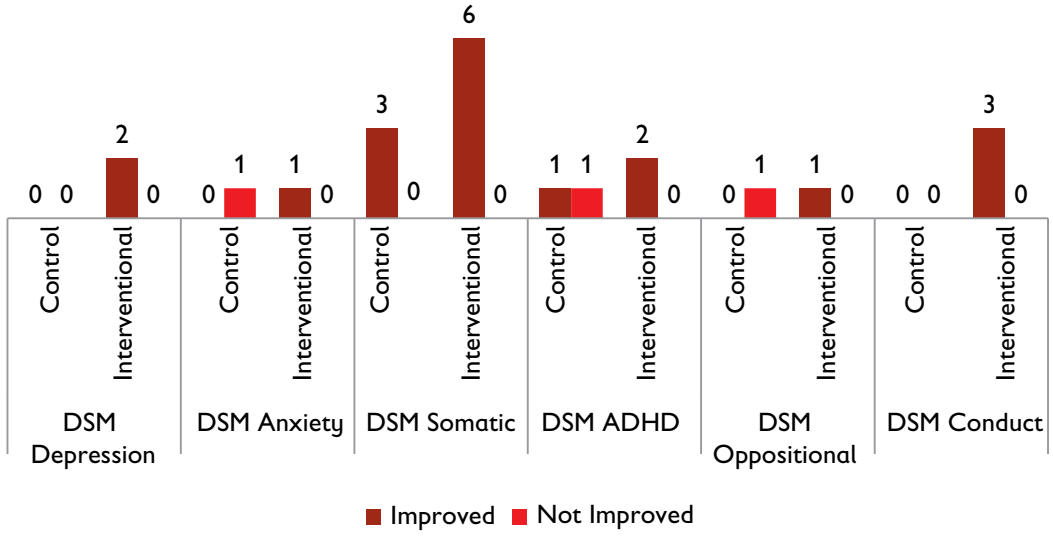


Figure 4.10: CBCL-DSM

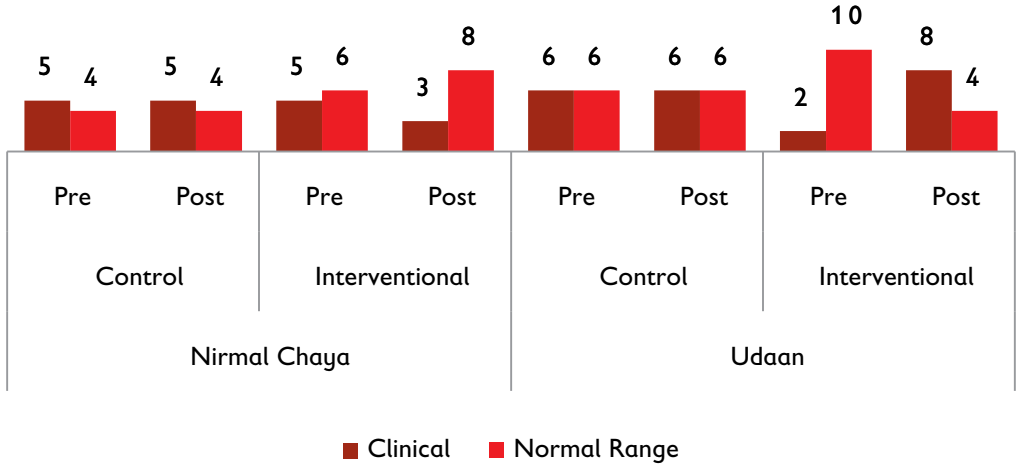


Figure 4.11: Emotional indicator on the HFD scale

Results indicated no statistically significant difference between the groups on emotional expression. When the scores were explored in terms of the differences in the homes, it was observed that there was a disparity in the pattern of improvement among the homes. Results indicated no difference in the pre and post scores among the control groups in both the homes. However, though an improvement in the scores was observed in the Nirmal Chaya home, a reverse pattern of performance was observed in the Udaan home where the number of children in the clinical range increased during the post assessment session in the intervention group. The rationale for this results could be due to the fact that since there were a number of administrative changes that were reported during the time of this assessment such as, frequent change of the care giver, recent return from home and friends being moved to another home. It is also possible that due to the intervention, the children were now more aware of their emotions but were still in a state where they were unable to control their emotions. Implementing the intervention further and continuing therapeutic goals for a longer duration would throw better light on this finding.

Results of the present pilot study indicated improvement in the scores on all the three assessment tools after arts based therapy as intervention, thus justifying ABT as an effective intervention on child survivors of trauma and abuse.

Hence, the hypothesis that there will be a statistically significant improvement in the therapeutic goals of self expression, behaviour, and cognition and group interaction in the post test scores among the interventional group as compared to the control group is accepted.

Qualitative Analysis

Case Studies: Dance Movement Therapy

Maitri

Maitri (name changed to protect identity) was a quiet, reserved girl and did not interact with others. She did not participate much in the activities and preferred sitting quietly in a corner and drawing. When she engaged in movement and dance, she enjoyed it and even said she benefited from it. However, she still continued to avoid full engagement. She preferred the verbal processing of the sessions when there was discussions on what participants experienced during the activities, such as how they felt, what they saw for themselves, as well as the connection to other life issues and topics. She was regularly late to the sessions but had good attendance overall.

Maitri regularly expressed feelings of sadness, helplessness and hopelessness. For example, Maitri had expressed a deep desire to study and become a lawyer. However, she said she felt very discouraged and that with the current situation of her life, she would not be able to pursue her academic dreams. She tended to repeatedly feel sorry for herself.

In one of the activities called "Paintbrush", participants were asked to imagine that they are painting the space around them with various body parts. During the verbal processing of that activity, Maitri started crying, saying that during the activity, she experienced being carefree and it reminded her of beautiful times when she could be a child who enjoyed playing.

In sessions, where participants had to pen down thoughts, feelings, dreams, perceived limitations, etc. and then use movement to go deeper into the emotions around them, Maitri used to write down her frustrations with herself in not being able to study or concentrate and how this was linked to her past. She was rigid in her movements and unable to fully release. However, as the therapy progressed she was able to recognize how she was viewing life (glass half empty vs. half), and that although she blamed her circumstances, including the residential home for not getting her the books to be able to study further, she had enough facilities to be able to make herself mentally stronger and ready to study. Maitri gradually came up with small steps that will fulfill her dream of becoming a lawyer. These included checking books out from the library, meditating for 5-10 min every day, borrowing textbooks and studying with other girls who are serious about pursuing an education.

During and as a result of the approximately 27 DMT sessions Maitri had attended, she verbalized improved levels of clarity/focus, hope, confidence, and sense of belonging. There was a change in her outlook on life, sense of empowerment to live a happier life, and level of openness, including in her personal movement language.

Akansha

Akansha (name changed to protect identity) attended approximately 25 DMT sessions and from the beginning exhibited different personality traits as compared to Maitri and the other girls in the sessions. She was very enthusiastic and she viewed it as a place to have fun, engage and release. She was dedicated and relatively on time to sessions as compared to the other girls. She was a leader in the group, helping gather the participants to be able to start the session. She was curious to learn and try, even with abstract concepts or activities that were not obvious to her. She also was more emotional and would openly express herself.

Akansha was explorative with movement, possibly due to her interest in dance. She was more alive and engaged during the movement parts of the sessions but also enjoyed the verbal processing when concepts from the activities would be discussed. At times she would giggle or become aloof as well.

Although Akansha was a positive force in the group, she did carry frustration, sadness and anger, especially when it came to her family situation. She expressed this feeling many times during the sessions. For example, during an activity, the participants were asked to entangle themselves and then form a circle without speaking. Then there was a series of activities in which the situation was less than favourable and they had to see how they got themselves into that situation and how they could find a solution to get out of it. During the verbal processing for this session and others, Akansha would refer to her family situation and her tumultuous relationship with her father. She would regularly say that there was no place else where she could express and release what's inside and that the sessions had become a safe haven for her to do that. We talked about how she could find ways to express herself positively in a safe manner outside of the sessions.

Akansha also said that people didn't always take her seriously and that she wanted to work on that. During one of the sessions, the participants practiced saying "Stop!" and "No!" to the person that was approaching. The exercise had to be done numerous times for the body language and verbal cues to match up. For many, including Akansha, giggling arose and they weren't able to make the eye contact to get the message across. By the end of it, the body language started to match up more and even Akansha said that she understood the importance of nonverbal communication.

Overall, for Akansha these sessions provided her a trusting environment to speak up and be heard. During the last few sessions, she cried and said that she doesn't know where she will find the same type of support. She eventually developed a pattern of becoming attached. This feeling of hers was processed through discussion, movement and painting and by the end she had reached closure and a sense of peace.

Bina

Bina (name changed to protect identity) is a 17 years old young woman who had always been outspoken. When she first started the sessions, she was known to have behavioural issues, primarily anger issues and would pick fights in which she would use bad language as well as violence. She always wanted to prove herself and even said that she always wanted to be a heart surgeon because then she would get respect.

During sessions, when working on emotions and finding ways to express feelings such as anger, loneliness, jealousy, joy, and love, Bina usually had hard time expressing anger, which was an emotion that she very easily showed outside the session room. In a session, when asked to think of a situation from past and act it out but react to it differently, Bina enacted a situation where she had used a brick to hurt the lady that had said things to her. In the session, she was encouraged to try reacting differently. Initially, she was unable to do so. After a few attempts and some guidance by her peers, she embodied a different way to handle the situation. Although uncomfortable with it, she did share that it was something that she couldn't imagine doing earlier. After many sessions, she started to understand that this may not be the case and that one can still express oneself without using violence. She started taking this back to her daily life, and started ignoring those who were triggering her, practiced walking away from situations, apologizing to others before the situation got out of hand, etc.

Through the sessions attended by Bina, she learned how to express and get her point across to others without reverting to anger/violence in common situations, avoid conflict more effectively and apologize in order to avoid escalation of matters. Her self-acceptance dramatically improved through her understanding of her own body, which allowed her to see her softer, more caring side, even in friendships made in the institution.

The findings of the study revealed significant effect of Arts Based Therapy and Dance Movement Therapy as an intervention to address the social, emotional and cognitive needs of children with a history of trauma and abuse. The findings of the present pilot study needs to be addressed carefully due to small sample size. Broad based replication of the study would give deeper insight. Awareness on mental health problem among children in institutions at all levels especially professionals and care takers related to the facilities would help in the interventional process.

CHAPTER 5

Conclusion and Way Forward

Rationale

The prevalence of psychological, emotional, cognitive, behavioural problems is higher in institutionalized children than those who have been living with their parents (Erol, Simsek, and Mu¨nir, 2010; Sushma, Padmaja & Agarwal, 2014). Institutionalized children have been found to have lower intelligence, attention deficit, memory difficulties, emotional problems, poor social skills, behavioural issues, inadequate coping skills, mental health problems, etc (Nelson, Zeanah, Fox, Marshall, Smyke and Guthrie, 2007; Zeanah, Smyke, Koga, Carlson, & the BEIP core group, 2005; Ford, Vostanis, Meltzer, & Goodman, 2007; Mullan, Mcalister, Rollock and Fitzsimons (2007)). Though institutional care is aimed at providing protection and care to the children, this may not always be the case.

The present study was planned as a need was felt to have an intervention which could address the pressing need to handle the delicate emotional, cognitive and social condition of the children living in the institutions. It was hypothesized that Creative Arts Based Therapy intervention and Dance Movement Therapy would address this need amongst the children and adolescents living in the homes in terms of human resources, their skills and infrastructure required to practice creative arts based therapy. With this hypothesis in mind, the present pilot study was planned with the aim of exploring the efficacy of creative arts based therapy on the cognitive, social and emotional problems of child survivors of trauma and abuse in government and NGO run Children's Homes in Delhi.

Brief Summary of Results

To summarize, on the CBCL checklist, results of the difference of the pre and post scores were observed to be statistically significant in all variables between groups of CBCL except in the variables of DSM Anxiety, syndromic behaviour, expression of somatization, oppositional defiance and internalizing behaviour problems. Though the Arts Based Therapy intervention had positive effects on the competence and emotional expression of the children, it was observed that the tendency to externalize emotions was more prominent.

Interpretation of the Human Figure Drawings on mental maturity as well as emotional expression indicated statistically significant difference in the quality of figures before and after the Arts Based Therapy intervention. No statistically significant difference in the scores of Emotional Indicators was observed indicating that though the mental maturity level of the children had increased, there was no statistically significant effect of the intervention on the emotional expressions of the children. Numerical scores, however, indicated that discrepancy in the scores could be due to the fact that though some children showed improvement in emotional expression, some children regressed due to other confounding factors such as sudden change of caretaker, vacation, interpersonal issues with other children etc.

Differences in the scores on ABT checklist indicated statistically significant difference in the pre and post scores on ABT checklist and its components. The intervention plan in the sessions of the present study was based on the deficits in the components of the ABT checklist. Results indicated that children showed improvement in the deficit areas after the intervention.

Limitations of the Study

- **Small sample size:** A limitation of the study was the relatively small sample size. For this reason, these findings cannot be generalized to the broader community based on this study alone.
- **Frequent changes in the homes:** There were some changes in the groups, both intervention and control group. During the course of the intervention there where children who were rehabilitated into their families or sent to another home, which decreased the sample size of the project and affected the outcomes as well.
- **Short-term study:** Considering that the study was a short-term project (8 months), a longer study (2-3 years) after would have yielded more perceptible changes.

Way Forward

- **Continuation:** As already mentioned, children in residential institutions do not have access to services to address their psycho-social needs, considering the lack of adequate human resource and skilled professionals. The pilot project reflected that alternative approaches such as ABT and DMT is beneficial and has helped children develop a positive-self attitude. Thereby, continuation of such long term projects (2-3 years) is a necessity for children enabling them to live a productive life.
- **Larger study:** The present study was an attempt to understand the efficacy of ABT intervention on child survivors of trauma and abuse in institutions. The findings of the study have reflected on the positive impact of ABT. Thus, extensive research and work on ABT is crucial to firstly strengthen the literature and secondly to reach out to the maximum number of children in institutions who are in critical need of such interventions.
- **Human resource:** The present project had limited human resources. To extend the ABT intervention to other residential homes for children, there is a requirement of professionals and skilled individuals who can use ABT as an intervention for children and adolescents.
- **Awareness:** Awareness on mental health problems among children in institutions at all levels, especially professionals and care takers related to the facilities, would help in the interventional process. Therefore, there is a need to work on addressing the existing gap in awareness and sensitization amongst key stakeholders through workshops, skill enhancement and exposure to better service delivery framework.
- **Collaboration:** To expand the scale of a future study and intervention, collaborations with technical institutes such as NIPCCD, NISD, IHBAS, VIMHANS needs to be explored.
- **Mainstreaming ABT:** In order to best utilize the skills, artistic space and artistic tools offered by ABT, there is a need to mainstream the approach by integrating with mainstream psychosocial, psychotherapeutic and psychiatric intervention for at-risk and special needs target group.
- **Diversification of target group:** The present study was undertaken with a focused target group of children in need of care and protection, who had a history of abuse and trauma. To widen the scale of the future intervention in a similar setting of a child care institution, the target group can be diversified to bring in a larger number of children who are broadly categorized under a child care institution as children in need of care and protection (CNCP).

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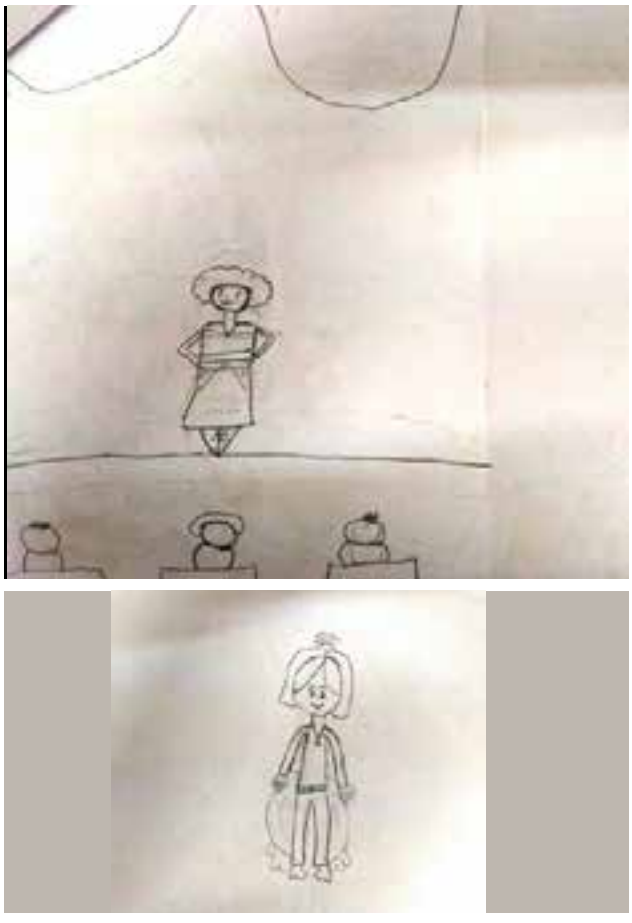

Pre and post Human Figure Drawings showing improvement in the quality of the drawings indicating higher scores in mental maturity

Puppetry and use of picture cards for story making and storytelling exercises to enhance self-expression, cognition and group interactions

Various visual arts media (using crayons, pastel colours, poster and props such as Popsicle sticks) to enhance self-expression and cognition

Picture cards used during story circles, derived from Philip C. Stead and Erin E. Stead's children's story book, Lenny and Lucy (contextualized as per need)

Drum circle, use of various percussion instruments and miscellaneous props aimed at enhancing self-expression, group interactions, body movement and behaviour issues

APPENDICES

Appendix I: CBCL Data Collection Sheet

Please print **CHILD BEHAVIOR CHECKLIST FOR AGES 6-18** For office use only ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl | CHILD'S AGE | CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year ____ | CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now.
(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)
PARENT 1 (or FATHER)
TYPE OF WORK _____
PARENT 2 (or MOTHER)
TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)
_____
Your gender: ☐ Male ☐ Female
Your relation to the child:
☐ Biological Parent ☐ Step Parent ☐ Grandparent
☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
☐ None								
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: video games, dolls, reading, piano, crafts, cars, computers, singing, etc. (Do ***not*** include listening to radio, TV, or other media.)

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
☐ None								
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
☐ None				
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: doing dishes, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
☐ None				
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

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Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)
☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. ☐ Does not attend school because _____

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects–for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?
☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start?

Have these problems ended? ☐ No ☐ Yes–when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe): _____
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sound or voices that aren't there (describe): _____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe): _____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired without good reason
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____

Be sure you answered all items. Then see other side.

Please print. Be sure to answer all items.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): _____
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____
_____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe): _____
_____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you answered all items.

APPENDIX 2: Arts Based Therapy Checklist

	BODY	1	2	3	4	5
B 1.a	Is physically alert and agile	Almost never	Rarely	Sometimes	Frequently	Almost always
B 1.b	Reacts and responds to tasks and activities appropriately after listening to instructions	Almost never	Rarely	Sometimes	Frequently	Almost always
B 2	Appears robust and healthy	Almost none	Little	Somewhat	Quite a lot	Almost all
B 3	Exhibits physical stamina and vigor	Almost none	Little	Somewhat	Quite a lot	Almost all
B 4	Has precision in using fine motor skills	No precision	Barely	Somewhat	Mostly precise	Very precise
B 5	Is able to regulate body movement appropriate to the stimuli/ environment	Almost never	Rarely	Sometimes	Frequently	Almost always
						TOTAL SCORE (BODY)
						Average
	SENSORY	**1**	**2**	**3**	**4**	**5**
S 1.a	Moves freely without inhibition (not rigid or static) during body work or sculpts	Almost never	Rarely	Sometimes	Frequently	Almost always
S 1.b	Complains of unpleasant sensations in the body, like pain, fatigue, irritation etc.	Almost always	Frequently	Sometimes	Rarely	Almost never
S 2	Speaks in a normal volume and pleasant tone during normal conversations	Almost never	Rarely	Sometimes	Frequently	Almost always
S 3.a	Can discriminate between similar sounding speech sounds (fear/hear)	Almost never	Rarely	Sometimes	Frequently	Almost always
S 3.b	Can repeat sound patterns which s/ he hears	Almost never	Rarely	Sometimes	Frequently	Almost always
S 4.a	Can learn movements taught, and repeat them with eyes closed.	Almost none	Very few	Some	Most	Almost all
S 4.b	Can discern shapes of objects, with his/her eyes closed, using touch	Almost never	Rarely	Sometimes	Frequently	Almost always
S 4. c	Is good at games, sports, athletics	Almost none	Little	Average	Farely good	Very good
						TOTAL SCORE (SENSORY)
						Average

Mindfulness		1	2	3	4	5
M 1	Is able to regulate actions when told to do so	Almost never	Rarely	Sometimes	Frequently	Almost always
M 2	Has the ability to regulate speech when told to do so.	Almost never	Rarely	Sometimes	Frequently	Almost always
M 3	Focuses/sustains attention on tasks at hand in the midst of distractions	Almost never	Rarely	Sometimes	Frequently	Almost always
M 4.a	Completes given tasks on time	Almost never	Rarely	Sometimes	Frequently	Almost always
M 4. b	Able to concentrate on a process until goal is achieved	Almost never	Rarely	Sometimes	Frequently	Almost always
						TOTAL SCORE (Mindfulness)
						Average
Cognitive Domain						
C 1. a	Can read appropriate to age and language familiarity	Almost	Little	Somewhat	Quite a lot	Fluently
C 1.b	Can Spell appropriate to age and language familiarity	Almost	Little	Somewhat	Quite a lot	Almost all
C 2.a	Can repeat 10 digit number sequence after 30 seconds					
C 2.b	Can remember information or instructions, and talk about it.	Almost none	Little	Somwhat	Quite a lot	Almost all
C 3.a	Is able to understand age appropriate number concepts.	Almost none	Little	Somwhat	Quite a lot	Almost all
C 3.b	Is able to tell how much of something he has, how much he needs and how much is left to spare (e.g. money, distance, time)	Almost never	Rarely	Sometimes	Frequently	Almost always
C 4.a	Can describe how to go from one place to another (age appropriate)	Almost never	Rarely	Sometimes	Frequently	Almost always
C 4.b	Is able to read Maps	Almost never	Rarely	Sometimes	Frequently	Almost always
C. 4.c	Can draw a floor plan of the therapy room	Almost none	No details	Some details	Many details	Very detailed
C 5.a	Can understand cause-effect relationship ('why' events happen)	Almost never	Rarely	Sometimes	Frequently	Almost always
C 5.b	Understands the rules of age appropriate games	Almost none	Little	Somewhat	Quite a lot	Almost all
C 5.c	Is able to solve simple problems by weighing options, considering alternatives, comparing & choosing	Almost never	Rarely	Sometimes	Frequently	Almost always
C 6	Is fluent in using mobile phone features, computer programs and other gadgets	Almost never	Rarely	Sometimes	Frequently	Almost always

Contd...

C 7.a	Can tell the 'moral/real meaning' of a story after listening to the story.	Almost never	Rarely	Sometimes	Frequently	Almost always
C 7.b	Can delay immediate gratification for more long-term goals.	Almost never	Rarely	Sometimes	Frequently	Almost always
C 7.c	Can make a 'goal-oriented plan' - deciding what is critical and how to start	Almost never	Rarely	Sometimes	Frequently	Almost always
C 8.a	Can pick up the 'mood/feelings' of other person by observing facial expression, body language & tone	Almost never	Rarely	Sometimes	Frequently	Almost always
C 8.b	Can examine an image/images and understand the picture's story-line, thereby arrive at correct conclusion	Almost never	Rarely	Sometimes	Frequently	Almost always
						TOTAL Cognitive Score
EXPRESSION DOMAIN						
EC 1	Can express him/herself through artistic media - Choose one answer	Only imitating (1)				
		Artistic medium keeps displaying repetitive artistic skill (2)				
		Improvises with group/ABT practitioner (3)				
		Improvises on small metaphors or images (e.g. factory) (4)				
		Creates a personal artistic expression which is rich in metaphorical meaning (5)				
						TOTAL SCORE (Expression)
						Average
COMMUNICATION DOMAIN						
C O M 1.a	Can carry on a conversation	Almost never	Rarely	Sometimes	Frequently	Almost always
C O M 1.b	Can express views and opinions and stand by them in a debate	Almost never	Rarely	Sometimes	Frequently	Almost always
C O M 2.a	Can disclose emotional states verbally within a given context	Almost never	Rarely	Sometimes	Frequently	Almost always
C O M 2.b	Can disclose emotions through creative writing within a given context	Almost never	Rarely	Sometimes	Frequently	Almost always
						TOTAL SCORE (COMM)
						Average

GROUP INTERACTION						
G 1	Speaks appropriately in a group	Almost never	Rarely	Sometimes	Frequently	Almost always
G 2	Is balanced and assertive in his behaviour with all group members	Almost never	Rarely	Sometimes	Frequently	Almost always
G 3.a	Includes others & their suggestions in team performances/group	Almost never	Rarely	Sometimes	Frequently	Almost always
G 3.b	Asks for help/ideas/material from group members when needed	Almost never	Rarely	Sometimes	Frequently	Almost always
G 3.c	Helps others in the group by sharing material, ideas etc	Almost never	Rarely	Sometimes	Frequently	Almost always
G 4.a	Wins games, performs well and achieves success.	Almost never	Rarely	Sometimes	Frequently	Almost always
G 4.b	Contributes in team tasks so that group goals can be achieved	Almost never	Rarely	Sometimes	Frequently	Almost always
						Total Score (Group Interaction)
						Average
						TOTAL
						Total Average

APPENDIX 3: Koppitz (1968) Scoring Manual for 30 Emotional Indicators

1. Poor integration of parts (boys 7, girls 6): One or more parts not joined to rest of figure, part only connected by a single line or barely touching.
2. Shading of face: deliberate shading of whole face or part of it, including "freckles," "measles," etc.; an even, light shading of face and hands to represent skin colour is not scored.
3. Shading of body and/or limbs (boys 8, girls 7)
4. Shading of hands and/or neck (boys and girls 7)
5. Gross asymmetry of limbs: One arm or leg differs markedly in shape from the other arm or leg. This item is not scored if arms or legs are similar in shape but just a bit uneven in size.
6. Slanting figures: Vertical axis of figure tilted by 15° or more from the perpendicular.
7. Tiny figure: Figure 2 inches or less in height.
8. Big figure (boys and girls 8): Figure 9 inches or more in height.
9. Transparencies: Transparencies involving major portions of body or limbs.
10. Tiny head: Height of head less than one-tenth of total figure.
11. Crossed eyes: Both eyes turned in or out.
12. Teeth: Any representation of one or more teeth.
13. Short arms: Short stubs for arms, arms not long enough to reach waistline.
14. Long arms: Arms excessively long, arms long enough to reach below knee or where knee should be.
15. Arms clinging to body: No space between body and arms.
16. Big hands: Hands as big or bigger than face of figure.
17. Hands cut off: Arms with neither hands nor fingers; hands hidden behind back of figure or in pocket not scored.
18. Legs pressed together: Both legs touch with no space in between, in profile drawings only one leg is shown.
19. Genitals: Realistic or unmistakably symbolic representation of genitals
20. Monster or grotesque figure: Figure representing nonhuman, degraded or ridiculous person: the grotesqueness of figure must be deliberate on part of the child and not the result of his immaturity or lack of drawing skill.
21. Three or more figures spontaneously drawn: Several figures shown who are not interrelated or engaged in meaningful activity: repeated drawing of figures when only "a" figure was requested; drawing of a boy and a girl or the child's family is not scored.
22. Clouds: Any representation of clouds, rain, snow or flying birds.
23. No eyes: Complete absence of eyes; closed eyes or vacant circles for eyes are not scored.
24. No nose (boys 6, girls 5)
25. No mouth
26. No body
27. No arms (boys 6, girls 5)
28. No legs
29. No feet (boys 9, girls 7)
30. No neck (boys 10, girls 9)

ROSY

Extensive use of clay primarily aimed at self-expression and cognition

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