

The Impact of Art on Children's Clinical Treatment Outcomes: A Pilot Project

Lindy LeDuc-Wilson

Cory Saunders

Windsor Regional Children's Centre

Abstract

The present study examined the impact of enrollment in creative arts programs on treatment outcomes among children receiving mental health services. Quantitative and qualitative analyses were performed on data obtained from questionnaires (pretest-posttest design) and from feedback forms for all children attending art, dance, or music classes, as well as attending ongoing therapy. A control group was used, receiving only therapy. Data analyses for overall treatment outcomes related to enrollment in specific art groups failed to find statistically significant differences. However, more detailed analyses revealed specific improvements in treatment outcomes. Specifically, participation in arts-based groups in addition to traditional therapy revealed improvement in children's adaptive and prosocial behaviors. Case studies illustrating in detail the effects on participants from each group, and implications for future research are discussed.

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The Impact of Art on Children's Clinical Treatment Outcomes: A Pilot Project
Children's Mental Health Ontario (CMHO) was approached by the Ministry of Culture to undertake a project to demonstrate the effectiveness of children's mental health interventions that make use of the creative arts. The Windsor Regional Children Centre (WRCC) is one of three existing programs using the arts as pilot service evaluation projects that were selected to participate by the CMHO through its Evidence-Based Practices Committee.

The WRCC falls under the umbrella of the Windsor Regional Hospital, and has a mandate to provide mental health services to emotionally, behaviourally and socially troubled children/youth ages 6 through 18, and to their parents/families. The centre offers programs and services delivered by interdisciplinary teams that provide specific goal-oriented programs including in-school, in-home and on-site services. In conjunction with using the "traditional" methods of treatment (i.e., family, individual, parental and group therapy; psychiatric and psychological assessments; etc.), the WRCC established the Healing Arts Program in 1995, incorporating the creative arts with various treatment modalities.

The Healing Arts Program manifested as a natural response to the clientele's individuality and intrinsic motivation toward expression, and uses these insights to supplement traditional treatment approaches and maximize client potential. To accomplish this, the centre makes use of music therapy and art lessons (drawing and painting). In addition, various therapists individually employ art therapy, creative writing and sculpting. Examples of this approach "in action" include on-site music therapy made available (in partnership with the University of Windsor) to children with autism or with severe behavioural and emotional issues who are receiving treatment in a milieu program; a regular exhibition of art submitted by local schools and art classes; regular art sale events to support the Art Fund sponsoring children in their artistic endeavors; and regular featuring of clients' artwork along the hallways of the centre.

To better understand the role and power of art within treatment made evident to those involved in the above initiative (and this study), it is necessary to include a brief overview of the literature pertaining to three creative arts therapies (art, dance and music)

from which were drawn the means of evaluating therapeutic components of this program and contextualizing its outcomes.

Art and Mental Health

While the process of creating artwork has alone been recognized as nurturing growth and reconciliation of emotional conflict (LaRose, 1987), aspects of both the product and process can be used by therapists to gain insights that assist in resolving problematic incompatibility between the child's inner state and his external reality (Kramer, 1979). Art therapy employs the modality of art media to facilitate the expression of personal experience, thoughts, and feelings (Saunders & Saunders, 2000). The arts have been described as functioning as "transitional objects," with a relative ambiguousness that allows them to take on projections of emotions and ideas, allowing the creator to express deep meanings without assuming full responsibility for their manifestations (Blatner, 1992). This ability to promote communication of feelings makes less likely their unhealthy internalization or inappropriate acting out (Saunders & Saunders, 2000; Wolf, 1975), and establishes art therapy as a preferred modality among persons experiencing difficulty in articulating their feelings for a wide variety of reasons, including mental illness (Riley, 1987). According to Blatner (1992), in some of these cases it may be attractive to identify with a tradition that has historically been represented by those who have found themselves on the fringe of society, but who have brought value to that fringe because of its creativity.

The above factors allow the arts therapies to transcend the emphasis placed in traditional verbal therapies on problem-oriented tasks (Blatner, 1992), and to be appropriate for a wide range of clients, including those in outpatient settings (Riley, 1987). According to Wolf (1975), art therapy can be used successfully with adolescents going through a period of tremendous mood swings and ambivalence, and the case of a child's individualized art therapy experience is used to illustrate how unsuccessful traditional techniques can be overcome by using artwork to engage the child in a therapeutic relationship. The child participating in the study progressed from antisocial expressions of feelings (e.g., setting of fires, violent outbursts, severe

depression/withdrawal), to more constructive ways of ventilating and reflecting on conflicts (i.e., expressing feelings creatively via art media).

The relationship between drawing and disclosure among children has been evaluated as well, with results implicating the opportunity to draw as a facilitator of children's disclosure of past, personal experiences (Butler, Gross & Hayne, 1995), and leading to Gross and Hayne's (1998) finding of significantly more information being disclosed as compared to children asked only to disclose. These results held irrespective of age and the target's emotional characteristics, and without compromising the accuracy of the reports. The authors describe the enhanced and accurate disclosure of emotionally laden experiences – often difficult for children to articulate to themselves and others – as having tremendous ramifications in clinical contexts (e.g., when used for assessments, treatments, etc.) as well as in legal contexts (e.g., sexual abuse cases, custody hearings, etc.). This is evidenced in common observations by clinicians dealing with sexual abuse cases, and formally evaluated in a study by Summit (1983) that attributed the prolonged delay in children's initial disclosures to their feelings of embarrassment or shame. The advantages of using art therapy in cases of sexual abuse are in fact multifaceted, providing help in preparing children for court testimony and in working through their trauma (Levens, 1994), as well as improving self-esteem (Brooke, 1995).

Art therapy has been applied successfully to other types of trauma. Lantz and Raiz (2003) examined cases in which the child in treatment had been traumatized by abuse or neglect from their biological parent(s) and had since come into the care of a foster family. In relating their observations to the literature, the authors noted that by using art (and play) the channels of communication between the child and his/her parent(s) were made deeper and more effective, in terms of promoting a dynamic that nurtured the healing process. As well, Lantz and Raiz indicate these modalities as providing an opportunity for the child and foster parent(s) to develop a sense of mastery over the pain associated with their trauma. Other studies have also confirmed the utility of art therapy for children and families in a variety of cases of trauma (Franklin, 1992; Kramer, 1979).

While it remains unclear what underlying processes account for some of the positive effects of art/drawing for children (Gross & Hayne, 1998), a study by Saunders and Saunders (2000) brings to light several aspects of engagement in therapy affected by

the therapeutic relationship. In their evaluation of an art therapy program, these authors observed decreases in the frequency and severity of participants' behaviours, including defiance and avoidant behaviour. Also noted in the study were improvements in communication and verbal expression, as well as improvements in the level of trust felt by the child toward the therapist, accompanied by an increase in eye contact.

Dance and Mental Health

Dance/movement therapy (DMT) has been defined by the American Dance Therapy Association as "the use of movement as a process which furthers physical and emotional integration of an individual" (Sandel, 1975, p. 439). It has the general goal of holistically integrating the cognitive, emotional and spiritual aspects of self with the environment, and is based on the conceptualization of movement and emotion as being interdependent (Rossberg-Gempton & Poole, 1992). Implicit in the latter concept is the understanding that the various aspects of a child's physical disposition represent a particular mental state, with maladaptive affect manifested in corresponding physical patterns (Feldenkrais, 1966). Also extended from this perspective is the evaluation of DMT as merging body and mind in a way that captivates both the dancer and viewer, making this modality an especially powerful communicational tool (Hanna, 2001). Five principles of dance/movement therapy as outlined by Goodhill and Morningstar (1993) include the ideas that:

- 1) the body and mind are linked in growth and development;
- 2) movement promotes the body-image as a dynamic (vs. static) aspect of self-concept;
- 3) we can use movement – the first communication system we establish – to supplement intra- and interpersonal communication in a therapeutic context;
- 4) communicating through movement is sufficient to establish the therapeutic relationship; and
- 5) the creative process itself is therapeutic in nature.

Among the several healing processes Hanna (1988) identifies in creative dance – with which features of therapeutic dance understandably overlap – is the experience of socialization, realized through synchronized movements among group members with a

common purpose (i.e., collective symmetrical dance presentation). This experience can positively affect feelings of isolation, which are reduced by participants' use of creative dance to relate to their environment and communicate with others (Chace, 1953, as cited in Ritter & Low, 1996). In fact, Hanna suggests the element of touch in dance can alone rid the individual of walls perpetuating their sense of isolation. She also includes the development of a sense of community and cohesion – through the opportunity to dance with others – and the opportunity to experience the vitality produced from the symbiosis between movement and group interaction, as healing processes within creative dance.

The opportunity creative dance provides for dancers to share ideas and physical space promotes bonding and an increase in leadership skills (Gilbert, 1992), as well as the chance for self-mastery (i.e., in charge on their body), which enhances body image and improves esteem (Hanna, 1988). Results from a study by Rossberg-Gempton et al. (1999), indicated that creative dance activities gave participants the chance to demonstrate their ability to cooperate, communicate, experience belonging, lead, follow and be aware of others while dancing. This healthy use of the body creates self-esteem, a dynamic body image and the development of appropriate body boundaries (Loman, 1998). This is especially important in cases of abuse among children, for whom Goodhill (1987) endorsed the application of DMT as a means of correcting otherwise confused senses of personal space. According to this author, exposure to DMT allows abused children the forum within which to appropriate such space and reclaim ownership of their bodies. Also reported in Rossberg-Gempton et al.'s (1999) study, was the positive effect of creative dance on social skills, and the positive impact that developing listening skills and refinement of focus on musical changes can have on self-expression and creativity.

Children, the most frequent participants in DMT research (Ritter & Low, 1996), are more willing to disclose information when they experience a sense of trust and safety in their environment (e.g., Mendelsohn, 1999). A mutual understanding obtained on a kinesthetic level can allow for these features to be securely established (Kestenberg, 1985; Stern, 1985), placing the dance/movement therapist in a position to assist the child in verbally and nonverbally processing challenging experiences (Lewis & Loman, 1990). Among the literature documenting the effectiveness of DMT for various diagnoses, is Wislochi's (1981) finding of changes in attention, participation and relaxation in a group

of children with varying psychological and physical disturbances during a DMT intervention. These results were later statistically confirmed by Ritter & Low (1996), who also reported significant improvements in anxiety and increased relaxation across various populations due to DMT, as well as its effectiveness with a range of childhood disorders.

Benefits have been observed when applying DMT to other groups as well, including reductions in anxiety among hospitalized psychiatric patients, and findings among mentally retarded children of improvement in balance skill and various positive psychological changes (i.e., increased creativity, expressiveness, sensitivity and leadership) (Boswell, 1993; Brooks & Stark, 1989; Kavalier, 1973; as cited in Ritter & Low, 1996). These same studies have even documented improvement among passive observers of DMT.

Music and Mental Health

The transcendental and healing qualities commonly attributed to music are evidenced historically in the prevalence of music in various spiritual practices and religious forms of worship (Alvin, 1966). Emotional responses have been shown to be unconstrained in persons with mental illness (Nielzen & Cesarec, 1982), which has allowed for its manifestation within psychoanalytic models of therapy (Walker & Boyce-Tilman, 2002) and its early use in multidisciplinary approaches to healing in hospitals (Wilson, 1990). Pioneering work by Nordoff and Robbins (1971), who wrote about and gave instructions on the use of music with disabled children, has contributed to the success of music therapy with clients reluctant to seek treatment or experiencing difficulty in expression (de l'Etoile, 2002).

Walker and Boyce-Tillman (2002) report the potential benefits of music lessons (above the acquisition of musical skills) as including the following:

- 1) increased sense of self-efficacy, self-confidence and self-esteem
- 2) increased ease and confidence in new social environments
- 3) increased independence
- 4) improved social relationships in the home and outside
- 5) self-expression through creativity
- 6) emotional release and expression of emotions

7) control over unpleasant feelings, thoughts and emotions

These benefits can be attributed to a group of curative factors used in the evaluation of a study by de l'Etoile (2002). These included acceptance or cohesiveness, self-understanding or insight, interpersonal learning and self disclosure. Of these de l'Etoile observed the largest improvement in cohesion, and cites the literature establishing this factor as one required for therapy to be effective (Evans & Jarvis, 1980; Yalom, 1995). Studies of the structure of the music itself have also helped to identify the particular elements (e.g., melody, harmony, rhythm) that contribute to the therapeutic dynamic (Alvin, 1966; Nichols & Honig, 1997).

As the therapeutic benefits of music to a child's communication, self-expression and personal growth have become increasingly accepted (Lefevre, 2004), the successful application of music therapy has been reported across a variety of cases. A study by Alridge, Gustorff and Neugebauer (1995) examined the role of creative music therapy for developmentally-delayed kids, guided by the understanding that acquiring the ability to communicate meaningfully is an important feature in childhood. These authors demonstrated the ability of MT to promote communication among children without language. The underlying mechanisms that allow for this communication however, remain unknown.

According to Lefevre (2004), because children lack the language and/or cognitive development to articulate their experiences with words alone, they will come to rely on the use of symbolic expression in their communication. This requires the social worker to supplement his/her assessment and intervention with corresponding modes of communication and engagement, especially in cases when a child's traumatic experience makes them increasingly dependent on nonverbal communication. In particular, this report suggests that directed exercises, with an art medium of the child's preference – itself associated with improved mental health (Lai & Good, 2002) – can benefit both assessment and therapy by drawing out the child's feelings and perspectives of their life situation.

The use of music has also been applied to anxiety disorders, the most common of psychiatric conditions in the pediatric population (Labellarte, Ginsberg, Walkup, & Riddle, 1999). Addressing the predominance of the biomedical model and its

corresponding emphasis on diagnosis and treatment of symptoms in cases of childhood anxiety, Walker and Boyce-Tillman (2002) proposed that the acquisition of musical skills would benefit personal development in cases of anxiety disorders in children. The study reported positive changes in anxiety-related symptoms and quality of life over the course of the study/music lessons for all participants, including improvements in relationships between participants and their friends and families, and reductions in physical and social symptoms of anxiety (i.e., social phobia and separation anxiety). Most startling among the results was the report of no further therapy being required for 75% of participants two years following their completion of the study. Interestingly, different children appeared to respond in various ways, with equal diversity in their explanations. For example, among the outcomes for participants was the establishment of control over physical symptoms of anxiety, increased social acceptance, and the realization of independence, self-confidence and self-esteem.

In addition to its multitudinal therapeutic advantages, Nichols and Honig (1997) observe that music and song can introduce children to other cultures and languages in an enjoyable way. These authors cite the importance of the child creating new sounds and patterns as a means of self-expression. In particular, their report suggests that the inherent qualities of harmonies can effect changes in mood, allowing the child to become more in touch with their feelings and those of others. This influence over affect is of particular interest in working with various mental disorders. Indeed, the therapeutic benefits of music on depression have been documented, and attributed to a change in mood produced by the physiological response (of relaxation) to soft music (Hsu & Lai, 2004). The latter process may be responsible for Muller-Busch and Hoffman's (1997) finding of significant decrease in pain intensity and disability related to pain through the use of music therapy, as the communicative and emotional aspects of chronic pain were those especially affected.

Several themes consistent in the preceding literature review have demonstrated the unique characteristics found primarily in group settings. The intrinsic value of group work has been identified as being helpful with patients and their family members coping with emotional distresses or changes occasioned by illness or disability (Lonergan, 1980;

Northern, 1983). This may be attributed to its role in establishing or re-establishing supportive relationships with significant others. According to DeMocker and Zimpfer (1981) the group setting "allows its members to develop and rehearse new behaviours in a setting that is non-threatening" with group feedback providing "the mirror by which a person may examine the new behaviour patterns" (p. 257). The use of groups within healthcare settings has also been evaluated (Gitterman, 1982), with observed advantages including the opportunity for patients and family members to be free to express themselves and be different, while in the presence of other members (Douglas, 1976).

Buchanan (1977) found that group members could be motivated to try new solutions to their problems by observing the progress, various behavioural changes and the successes of other group members. Indeed, being able to model the successful behaviour of other members in a group can allow for the participant to overcome specific problems in their life (Spiegel & Yalom, 1980). In essence, the hope that group members provide for one another is described by these authors as an "essential ingredient in the motivation and rehabilitation of chronically ill patients," and "is offered by the presence of other patients who have had similar problems and weathered the storm. Essentially, these groups utilize the experienced patients to help the inexperienced ones by being role models..." (p. 430)

The predominant use of qualitative evaluations of the arts therapies revealed in the literature (Saunders & Saunders, 2000) is understandable given the sensitivity their aesthetic nature imposes on the interpretation of quantitative results (Ritter & Low, 1996). Although the influence of some of these modalities has been described as being more accurately represented through qualitative analyses of single case studies (Muller-Busch & Hoffmann, 1997), combining qualitative and quantitative information can provide insights otherwise unattainable through their separate analyses (Heyink & Tymstra, 1993, as cited in Alridge, Gustorff & Neugebauer, 1995). The current study therefore employed both methods to most effectively capture the results.

Review of the literature reveals a limited amount of research pertaining specifically to the use of arts in their "pure" form (i.e., use of art instructors as opposed to art therapists) and the impact it has on children's mental health. The current study explored this relationship, and hypothesized that children participating in the art groups

would experience significantly greater results in their concurrent therapy as compared to children in therapy only. That is, that children's exposure to the creative arts curriculum offered through this project, would enhance their clinical treatment outcomes. The insights resulting from this pilot project are hoped to provide a supplementation to the lack of literature available to practitioners interested in incorporating the arts into their practice, and to serve as a guide for future research.

Method

Participants

The sample was composed of 28 children (16 males and 12 females), ranging in age from 7 to 13 years ($M = 9.89$). Participants in this study were recruited from a treatment program for children at a regional children's centre. All participants were involved in ongoing therapy sessions for a variety of concerns, but no differentiation was made on the basis of referral concerns in the selection process. Eight of the initial thirty-six children in the study were eliminated from the analyses due to either incomplete data or a significant number of absences from either treatment or art sessions, leaving 19 participants in the art/treatment groups and 9 in participants in the control group.

Measures

The impact of the use of art on clinical treatment outcomes was measured using a pretest-posttest design. An original questionnaire used was developed specifically for this investigation, and consisted of four items. Two items were designed to measure changes in the severity of internalized and externalized behaviours, which included feelings of sadness, fearfulness, and social withdrawal (item 1), and coping abilities (item 3). The two remaining items captured any differences in the severity of externalized behaviours, including noncompliance, hyperactivity, and impulsivity (item 2), as well as social skills (item 4). These items were scored on a visual analog scale, with endpoints defined as "not concerned" and "very concerned."

A feedback form was designed for the primary purpose of supplementing the questionnaire, with different versions administered to the participant, therapist and

primary caregiver. The therapist's version provided information regarding the number of times the participant was seen over the course of the study, the type of therapy employed during the sessions, the overall length of time the participant had been in therapy, and the therapist's observations of the child's behaviour over the course of the study.

The version completed by the primary caregiver generated information regarding extracurricular activities in which the participant was enrolled, and any behavioural observations during the study. Information requested in the participant's version included how they felt about their particular art group, both at the beginning and end of the study, what they liked best and least, three ways in which their participation helped them, and what they would tell other kids about the art program.

Procedures

After approval for the study was obtained from the Windsor Regional Hospital's Research Ethics Committee Board, therapists/service coordinators at the Regional Children's Centre approached families of children they thought may be interested in the program and made their referrals accordingly. Among the parameters set for participants were the requirements that they attend therapy/consultation a minimum of four times over the seven-week span of the study, have a means of transportation to and from the study's art sessions, be between the ages of 7 and 13 years, and have an interest in participating in the study. Participants who attended a minimum of two therapy sessions and for whom both pretest and posttest data were available were included in the final analyses

Qualities sought in the selection process for instructors included reliability, openness to be flexible, substantial experience in their area of art, willingness to work with participants who displayed mental health issues, no clinical/therapeutic experience, and a keen interest in the project.

All of the art group sessions were held on-site in the Windsor Regional Children's Centre. The dance group occupied a cleared boardroom, and used a portable stereo, dance shoes, scarves and a variety of music. The art group took place in staff room, and used a range of supplies, including watercolour paints, watercolour pencils, drawing pencils, masking fluid, watercolour paper, sketchpads, and brushes. The music sessions were

located in a group/meeting room, and involved the use of a variety of instruments, including the recorder, guitar, tambourine, drum, keyboard and triangle.

Once 36 participants were recruited, an explanation of the project was given to their parents in groups, and in cases when the parent/legal guardian could not attend the group presentation this was done individually. This explanation was also provided in written form. Consent forms for all participants were signed by the legal guardian, and confidentiality was assured.

The assignment of participants to different treatment groups depended on their listed preferences and availability of space (i.e., if the participant's first preference was full they were assigned to the group of their next preference). Ten children chosen from similar age ranges and presenting with similar referral concerns were referred for participation in the control group.

Each participant's primary caregiver and therapist or service coordinator completed the questionnaire at the onset and conclusion of the study, as well as the feedback form at the end of the study. Participating children were administered the feedback form individually in an interview format. This was done to accommodate for the variability in their writing skills.

Results

The number of therapy sessions attended (out of 7) among participants in the art group ranged from 2 to 6 ($M = 4.0$), in the dance group ranged from 2 to 5 ($M = 3.5$), in the music group ranged from 2 to 5 ($M = 3.7$), and in the control group ranged from 3 to 6 ($M = 4.3$).

The types of therapies employed by the participants' therapists included individual, family, sibling and group therapy. Unfortunately, responses from therapists regarding the overall length of time the participant had been in therapy were confounded by misinterpretation of the question. Among the extracurricular activities reported by participants' parents, were brownies, swimming, a range of sports, and cycling.

The number of art/treatment sessions attended among participants in the art group ranged from 3 to 7 ($M = 6.0$), in the dance group ranged from 4 to 7 ($M = 5.7$), and in the

music group ranged from 5 to 6 ($M = 5.9$). Extracurricular activities reported by participants' parents included brownies, swimming, a range of sports, and cycling

The ages of the participants included in the final analyses from the art group ranged from 8 to 12 years ($M = 10$ years), in the music group ranged from 7 to 13 years ($M = 9.14$ years), in dance ranged from 9 to 12 years ($M = 10.33$ years), and in the control group ranged from 7 to 13 ($M = 10.11$).

A review of the difference scores generated for each of the four questions within each of the arts-based treatment modalities, as well as the treatment-only control group, revealed positive changes in outcome in almost all cases. However, considerable variability in the treatment outcomes was noted. Means and standard deviations are reported in Table 1 and illustrated in Figure 1.

Examination of univariate F -scores for the total difference scores (i.e., global treatment change) generated across the four questions revealed no significant differences for either parent report ($F = 0.733$) or clinician report ($F = 0.700$). Post Hoc Bonferroni testing indicated that no significant differences existed between any of the specific treatment modalities for either parent report or clinician report. However, an analysis of power revealed a score of 0.28, suggesting that the size of the sample was too small to provide significant differences between groups unless treatment effects were dramatic.

Paired sample t -tests conducted for the pre and post results of each of the four questions indicated that almost all participants displayed a significant treatment effect. Parent report measures indicated improvements in internalized behaviors ($t = 2.48$, $p < 0.05$) and social skills ($t = 2.46$, $p < 0.05$), with no significant improvements in externalized behaviors ($t = 0.68$) and coping skills ($t = 1.24$). Clinician report measures displayed significant improvements in all areas: internalizing behaviors ($t = 3.21$, $p < 0.01$), externalizing behaviors ($t = 3.17$, $p < 0.01$), social skills ($t = 3.50$, $p < 0.01$), and coping skills ($t = 2.73$, $p < 0.01$).

Independent sample t -tests conducted between each arts-based treatment modality and the treatment-only control group across all four questions revealed few significant findings. Dance classes in addition to traditional therapy did not result in significant differences on any of the parent report measures: internalizing behaviors ($t = -1.13$), externalizing behaviors ($t = -0.62$), social skills ($t = -1.13$), and coping skills ($t = -0.49$).

However, clinician report measures suggested significant increases in social skills ($t = 2.21, p < 0.05$) and coping skills ($t = 2.40, p < 0.05$), with no changes to internalizing ($t = -0.51$) or externalizing behaviors ($t = 0.42$).

Music classes in addition to traditional therapy did not result in significant differences on any of the parent report measures: internalizing behaviors ($t = -0.02$), externalizing behaviors ($t = 0.37$), social skills ($t = 0.36$), and coping skills ($t = 0.40$). However, clinician report measures suggested significant increases coping skills ($t = 2.37, p < 0.05$), with no changes to internalizing ($t = -0.36$), externalizing behaviors ($t = 0.61$) or social skills ($t = 1.33$).

Art classes in addition to traditional therapy did not result in significant differences on any of the parent report measures: internalizing behaviors ($t = -0.35$), externalizing behaviors ($t = -0.40$), social skills ($t = -0.97$), and coping skills ($t = -0.46$). However, clinician report measures suggested significant increases in social skills ($t = 3.10, p < 0.01$), with no changes to internalizing ($t = -1.56$), externalizing behaviors ($t = 0.85$), or coping skills ($t = 1.74$).

Case Vignettes

Precedent has been set for the inclusion of case vignettes within reports of research results as a means of encompassing, both quantitatively and qualitatively, the effects of creative arts programs on treatment outcomes. It is important for us to understand the clinical relevance of both statistical analyses of results from the questionnaire, and qualitative results captured by the feedback forms. We have therefore chosen one case vignette from each of the art groups to illustrate the multidimensional facets of the study's findings.

Case #1: Dance Group.

Susan is a 12-year-old young lady who, with her mother, migrated to Canada from the United Kingdom as an infant, in an attempt to escape an abusive spousal relationship. Susan's father has since migrated to Canada, but the relationship between Susan and her dad is quite poor – mostly due to his lack of involvement in her life. Her mother had an additional two children for whom Susan is often left responsible, as her

mother works long hours and has many of her own personal issues. Susan is currently in the sixth grade, performing academically at a level that is fair to below average, perhaps as a result of learning weaknesses. She periodically involves herself in some after school activities, and generally presents herself in black garb. Susan considers herself a Wicca, just like her mother. Due to her appearance and beliefs she tends to stick out. Susan came to the Centre as a result of self-mutilation, non-compliance and general feelings of sadness.

Initially Susan stated that she was somewhat nervous about participating in a dance class, given how she looked and that the type of music she envisioned being played while teaching hip-hop, ballet and creative movement certainly would not be what she listens to. She also worried about what others would think of her dancing abilities. With encouragement from her therapist (it was noted in therapy that Susan was very artistic and had lots of energy) Susan decided to risk trying something new. She participated in most sessions and found it to be quite energizing and fun. The instructors played a vital role in Susan's attitude towards dance and the group itself.

Susan identified in her feedback interview that the two instructors made things easy and fun for her, and that "if you're not sure of something then they'll help you through it." She appreciated their humour and light-heartedness. Susan felt that the dance group made her less self conscience about her own ability, helped her feel more comfortable about who she was and more creative, and it helped her express herself in a creative, physical manner. Her relationship with the instructors was an important one. At different times throughout the classes she would disclose issues or struggles she was having with them. She felt very accepted by her instructors and the other participants. Susan reported to her therapist that she has no longer been self -mutilating and has found positive ways to cope with her feelings of sadness. Susan's therapist noted that she sensed improvement in Susan's attitude and social skills at school over the course of the study. In her feedback form, Susan's mother mentioned that Susan's issue of compliance has improved, that she is more understanding to those around her, and that she has become more positive. Her mother also reported that despite the type of music not being her style, she was enjoying coming to the group.

Case #2: Music Group.

Steven is a 13-year-old young man who is a Crown Ward of the Children's Aid Society. He came into care at age four due to neglect and his mother's inability to manage his behaviour. He has been in and out of various foster homes throughout the course of his life, but has been in his current one for almost five years now. He has attended several intensive treatment facilities since a very early age, and has a Full Scale I.Q. score that falls into the low average range. As a result, his academic performance is very weak. Socially, he runs into a lot of difficulties while at school and in the community. His appearance and mannerisms tend to center him out. Steven came to the Centre as a result of extreme anxieties and irrational fears. His anxiety level is so high he pulls out chunks of his hair.

When Steven started the music class he reported that he was "kind of scared" because he did not know if he would have fun or not. With support from his foster parents Steven decided to try to participate in the program. He participated in all but one session and thought the music class was "really cool" and that he "had a blast." It was noted that due to severe acting out of another child in Steven's foster home, his anxieties were initially high as indicated by his therapist and foster mom. However, as the study progressed his therapist reported that his anxiety level began to decline.

Steven mentioned that he enjoyed it when the music instructor exposed the children to a variety of music and different instruments. He felt that he became more proficient at reading music, which according to his foster parents and therapist boosted his self-esteem and assisted him in taking more risks without increasing his anxiety level to uncontrollable heights. According to his foster mother, Steven was always excited to come to the group and discussed with her how he felt accepted, and how much positive feedback he was getting from the instructor. Because Steven had taken some music lessons prior to the study, at times he became a "helper" to the instructor. His foster mother reported that this had given Steven so much more confidence than he ever had before. As a result, he appeared to mature through the course of the study. Steven felt that by coming to the group he learned some self-control, in that it helped him to not bug other kids.

His foster mother noted that Steven's mood changed positively despite some significant happenings in the foster home that were totally unrelated to him. She also found him to be much happier, reporting that he would want to do more with music because he could make new friends. Given the rarity of friendships in Steven's life, his foster mother thought this statement in and of itself was a good sign. Throughout the study Steven's therapist observed increases in social maturity. Steven felt so positive by the music and the abilities that he had acquired that he envisioned himself one day becoming be a musician. According to the foster mother, Steven has said that he would "like to bring music to the world."

Case #3: Art Group.

Mary is an 11-year-old young lady who lives with both parents and two younger siblings. According to her parents, there were no known problems up until about a year ago, when Mary started to be bullied and picked on by other students at her school. Mary is about thirty pounds overweight and is developing into puberty faster than her same-age peers. Her best friend recently moved away and has since experienced difficulty in her attempts in finding another. She has also been crying a lot and displaying feelings of sadness. Mary has displayed some physical aggression towards her younger siblings, which according to her mother is totally uncharacteristic of her. Academically, Mary does well and has not presented any major school-related issues. Mary came to our Centre displaying suicidal ideation, saying regularly that she wanted to kill herself. There were no previous suicidal attempts.

Initially, Mary was very nervous when she came to the fine art group. Her therapist thought that she would benefit from the program as she was artistic and could capitalize on the social interaction with the other participants. Mary attended six out of the seven sessions, and stated that she felt good about coming to the art group and that she liked to have the ability to draw and paint. She felt that her instructor and children in the group were nice, and that the program helped her with the way she manages her anger. Her father observed that rather than her becoming argumentative she will now draw back instead of engaging in conversation that will get her into trouble. Mary is quoted as saying: "art helps me calm down and forget about bad things." Both her father

and therapist state in their feedback forms that they noticed an increase in Mary's self-esteem and level of confidence. As a result, her therapist reported that Mary has started to be more assertive and stand up for herself. According to her father, Mary has surprised even herself with her newfound abilities. He states that Mary loves the art program, that it is something she enjoys, and that she is able to "describe her feelings in her art." Her father concludes that he will most likely continue to involve her in art.

Discussion

The research data suggested that parents observed improvements in their child's internalizing behaviours and in their social skills. This finding was confirmed by information obtained on their feedback forms. Parents reported no change in externalized behaviours and coping abilities, but on the feedback forms reported positive improvement in their children's skills. This leads to the consideration that one area may have been more amenable to change than another.

Clinicians reported improvement in all areas of behaviour (i.e., internalized behaviours, coping abilities, externalized behaviours and social skills), which was also supported by their answers on the feedback forms. In their feedback interviews, most children reported feeling that they had made positive changes and were able to identify the areas they felt that they had improved upon. These included being able to interact better with other children, feeling like they belonged and were accepted, improvement in self-esteem and self-concept.

There are reported differences between the parents and clinicians' results with regards to externalized behaviours and coping abilities as measured by the questionnaire, perhaps attributable to differences in perspectives rather than accuracy in reporting. When assessing children's changes, clinicians are likely to view any changes as progress, no matter how small. On the other hand, because parents live with their child, are emotionally involved, or present with their own personal issues, they may view their child's externalized behaviours and coping abilities as more concrete, "in your face," and interfering with daily household functioning. As a result, it is difficult to notice changes

when you are in the midst of what is going on, lending credence to the saying that “you can't see the forest for the trees.”

Dance Group.

Results for the dance classes indicate significant improvement in social skills and coping abilities, as measured by the questionnaire. Information from the feedback forms also demonstrated positive changes in these areas, in conjunction with internalized and externalized behaviours. This was not only reported by parents and therapists, but as well by the participants themselves. One child stated, “I think that I did pretty well getting use to everybody.” Another child felt that he was not as shy as he once was. Some of the children in the group felt that in some ways their behaviours set them apart from others (usually in school), but that being in a group setting allowed them to feel less isolated and more cohesive with the group.

On average girls tended to be more social than boys. The age ranges of girls, from a developmental perspective, may have impacted such findings. The instructors were female and under 20 years of age, which may have influenced the results, perhaps by allowing participants to feel in some way more connected to them. The instructors allocated 5-10 minutes to “chat time” as a prelude to their classes, as a chance to hear about the participants' week, which allowed for a relative freedom to express. This may have contributed to one of the female participants feeling comfortable toward the end of the study to approach the instructors for advice on a topic that she was uncomfortable talking to her mother about. Although the week's happenings were also discussed in the music and painting groups, the forum for communication was less structured.

Creative movement allows one to express individuality and creativity. As stated by one of the children, “I feel more comfortable about myself, and the dance class helped me be more creative and taught me how to express myself.” The stretching exercises that took place prior to and proceeding the actual dance taught the children proper breathing techniques and body stretches that they could add to their repertoire of coping strategies. It helped them get in tune with their bodies and how they move, in turn making them more aware of physical change (i.e., the physiological changes that occur when anxious or angry).

Music Group.

In the music class there were positive improvements shown in the area of social skills and an almost statistically significant change in participants' coping abilities. These changes were noted from both parents and clinicians on the questionnaire, and confirmed by both groups – as well as by the participants directly – on the feedback forms. This group was composed of male participants and a male instructor over 25 years of age, challenging the stereotype of females being more than social than boys.

It appears that the “coming together” for a common reason provides group cohesion and feelings of belonging or acceptance for these children. On the feedback form, one parent reported that for the duration of the study her son had not been sent home from school, which was apparently an amazing feat according to his therapist. The therapist also felt that the music group not only helped him with his social skills, but also gave him something to feel good about. In general the children stated that once they became comfortable, they enjoyed meeting with their group, learning beats, playing different instruments, and making music with their friends. They report these factors as helping them concentrate more.

One parent made specific notes in his feedback form detailing the positive changes his son had made while in the music program in the following areas: listening skills improved, staying focused and remaining on task improved, and he was more attentive in his dealings with other people. The music instructor allowed the children to make their own music, and they responded with excitement about being able to create something, no matter how “good” or “bad” it sounded. Also observed as positively influencing self-esteem was the willingness to risk, having an outlet to create, and having a sense of control and mastery over newfound abilities.

One of the children who were diagnosed with a severe anxiety disorder felt the adverse effects of another child in his foster home while attending the music classes. Normally anything slightly out of routine for this child creates enormous amounts of stress and anxiety. His therapist and foster mother both reported that during this time his anxiety level actually began to decline. As part of the signs of maturity observed in him, he also started to help other children at home.

Another child stated that by coming to the music classes he felt happy and was not always grumpy. In fact, his parent stated that now when her son gets angry, rather than act out he will go around the house humming a tune, which seems to sooth him. The music helped elicit a better mood and helped things shift in a positive direction. Although several positive changes were reported by the parents, clinicians and children themselves on the feedback forms, these were not fully captured on the questionnaire, forcing one to wonder if the outcome would have been different if the sample size used in the used in the study was bigger, or that the statistical instrument used in the study was more specific.

Art Group

For the art group there were no findings of statistical significance in the areas of externalizing behaviours or coping skills, although in the area of social skills it was quite close. In addition, there was a statistical difference in internalizing behaviours. Results from clinicians completed questionnaires suggest significant increases in social skills with no statistical significance in the areas of internalizing behaviours, externalizing behaviours or coping skills. Here again we are seemingly confronted by a need for a larger sample size or an instrument with greater specificity.

When the same areas were evaluated in light of the parent and clinician's feedback forms, together with the children's interview feedback, clinical significance was revealed. Parents reported that it gave their children self-confidence, and helped them realize that they just like everyone else have abilities. In fact, a few parents said that their children were actually surprised by their own abilities. Parents and children noted that their drawings were unique unto themselves – that things did not have to be perfect. The art classes allowed for creativity and self-expression, captured in one child's statement: "our artwork is unique and our own style." Parents and therapists noted that art served as an outlet for their children, illustrated in the example of one child who stated that she could "loose herself and forget about all the bad things." A parent noted that her child was able to demonstrate her feelings in and through her artwork.

Children, parents and therapists all reported the impact the group itself made on their children socially. One parent said that prior to coming to the group her daughter was

“bossy” with her friends but that the group helped her to adjust better socially. Another parent said that because his child was able to make friends in the art class he actually took the initiative to seek out friends in his neighborhood. It would seem that in this case the art group was a “practice run” for the child and he was able to transfer skills he acquired from the group to the external world. This same child declared that he liked to come to the group because he had friends who did things with him. Another child said that the art group made her “less shy about talking with other people.” When asked what she would tell someone inquiring about the group but with no prior knowledge, she responded, “Once you get to know the kids in your classes it’s easier to work and you feel like you belong.”

Therapists perceived the children as more able to relax in group settings, to be less serious, to have fun and to look at things in a positive manner. Both parents and therapists reported positive changes in the children’s moods. Some thought their children to be less sullen, more spontaneous, less depressed, and happier in general. One child stated, “It made me loose my madness.”

Limitations/Recommendations

Although the study did include a means of capturing information pertaining to the participant’s extracurricular activities, inconsistencies in the depth of responses made it difficult to incorporate this data into final analyses. Of particular interest to the authors of this study is the amount of exposure participants have to art- related activities outside of the project, which may provide a better understanding of the artistic predispositions and involvement in inherently therapeutic modalities outside of therapy. Future studies may benefit from increased insight into the role of these factors in treatment outcomes.

Similarly, more extensive knowledge of the type of therapy being used with the child would help to more accurately describe the nature of a study’s results. Some therapists may integrate elements from the creative arts therapies into their practice, potentially influencing the results in ways that are difficult to anticipate. For example, a participant’s prior exposure to art therapy may predispose her to an enhanced outcome in the study, where she is provided a familiar forum for intra- and inter-personal communication, and using familiar physical and symbolic tools to accomplish

behavioural/emotional goals. Conversely, a participant who has experienced art therapy in the past may detract from study's results presumably more common in cases where children are introduced, for the first time formally, to a "new" mode of communication and expression. As in the case of the child's extracurricular activities, the creation and administration of more directive, structured questions may help to account for this potential source of error in measurement.

The use of attendance records within a statistical analysis may reveal important trends in the data. The present study referred to these records mainly to qualify participants for final analyses, as well to provide a fuller context for individual case study analyses. Their inclusion in analyses of correlation with treatment outcomes may benefit future studies.

Admittedly, increasing the number of items on the questionnaire may have provided more comprehensive quantitative analyses of behavioural changes. Although the information obtained through the feedback forms may have partly compensated for this, they presented their own limitations. Namely, the questions could have been more direct and less open-ended. To illustrate this issue we cite the example of one therapist who indicated little/no improvement (i.e., high level of concern was relatively unaffected by the end of the study), but who also described significant improvement in the same general areas when reporting on the feedback form. In a similar case, another therapist made notations clearly indicating improvement next to three of four scores on the questionnaire, but the actual scores themselves did not support this observation. This issue may be prevented by taking into account the specific symptomology of both externalized and internalized behaviours during the creation of the measurement device, thereby enhancing its ability to capture changes in specific behavioural and emotional problems.

As suggested by de l'Etoile (2002), increasing the length of the study may provide the opportunity for natural development of the group process to unfold more fully. The additional information gathered may give a more detailed understanding of the dependent variables involved, thereby increasing the accuracy of the evaluation of changes, and potentially leading to a more statistically significant outcome.

Lastly, the issue of sample size should be considered when interpreting the results of this study. Although significant results were in fact obtained with the current sample (of 30 participants), behavioural changes may have been more pronounced using a large number of participants. This is suggested by the level of power indicated in the statistical report (.28), a level of sensitivity that renders the results of the study all the more impressive. Stated simply, with a larger group (and higher power) and an extended period of time, we may be able to better identify the impact that participation in the various arts has on children's mental health treatment.

Conclusion

The natural energy and enthusiasm of the children in the study flowed spontaneously throughout the centre, provoking curiosity and charging the atmosphere with an element of excitement and anticipation. Staff members were eager to learn more about the study, and made several inquiries about its status and findings. In some cases there was clear indication of a personal connection to the study's emphasis on creative arts, and of how the arts had impacted their own lives.

The primary themes that were prevalent throughout our study demonstrated the importance that the creative arts play not only in the clinical realm of treatment, but also in our everyday lives. It was found that from the moment the child entered the class, the instructor played a vital role in how that child responded to what would take place. These roles ranged from being a positive role model to a good listener. Another important theme was how the children were willing to take risks with something new, thereby acquiring new skills transferable to the world outside the group. Having the opportunity to interact with other children enhanced the child's capacity to feel less isolated, feel more accepted, have a sense of belonging, and to help generally in getting along with others in a safe, non-competitive environment.

The opportunity to be creative, to learn to be comfortable with whom you are, having your own style and realizing that things do not have to be perfect, allowed for more of a free flow of emotional release and expression. This in turn allowed the child to make use of non-traditional modalities to work on developing appropriate coping skills that would address issues such as anxiety, anger, depression, and relaxation. Many of the

children in the creative arts groups had very low self-esteem and poor self-concepts. The group settings allowed for participants' renewed self-perceptions to develop naturally over the course of the study, resulting in their becoming progressively less vulnerable to, and more willing to change unhealthy views of themselves in a safe and nurturing surrounding. In conjunction with this they were able to acquire new skills, thereby achieving a sense of mastery and control over their environments. As one of the children stated, "It's all about art!"

Table 1.

Means and Standard Deviations for the difference scores generated for both parent- and clinician-report measures across the treatment modalities.

Difference Scores	Dance		Music		Art		Control		Total	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Parent:										
Internalized	-1.67	36.56	19.00	29.14	14.50	23.83	19.38	31.21	13.58	29.55
Externalized	-2.67	9.75	8.86	22.56	-5.00	15.59	4.00	28.16	2.55	20.10
Social Skills	2.33	17.36	19.29	20.41	3.25	24.07	15.12	24.98	10.21	22.33
Coping	2.83	14.91	14.00	38.54	1.12	33.03	7.50	20.49	6.34	27.59
Total	0.83	64.11	61.14	88.48	18.38	80.69	46.00	88.86	32.69	80.88
Clinician:										
Internalized	14.33	32.93	17.57	27.67	4.83	17.80	22.44	25.94	15.71	25.92
Externalized	22.67	24.07	23.43	17.71	0.67	46.62	17.78	19.36	16.57	27.71
Social Skills	21.83	15.14	14.00	19.47	36.00	21.18	-0.44	23.84	15.75	23.79
Coping	17.67	14.28	18.14	16.74	16.83	23.83	-3.78	20.28	10.71	20.75
Total	76.50	48.85	73.14	55.27	58.33	82.26	36.00	58.46	58.75	60.68

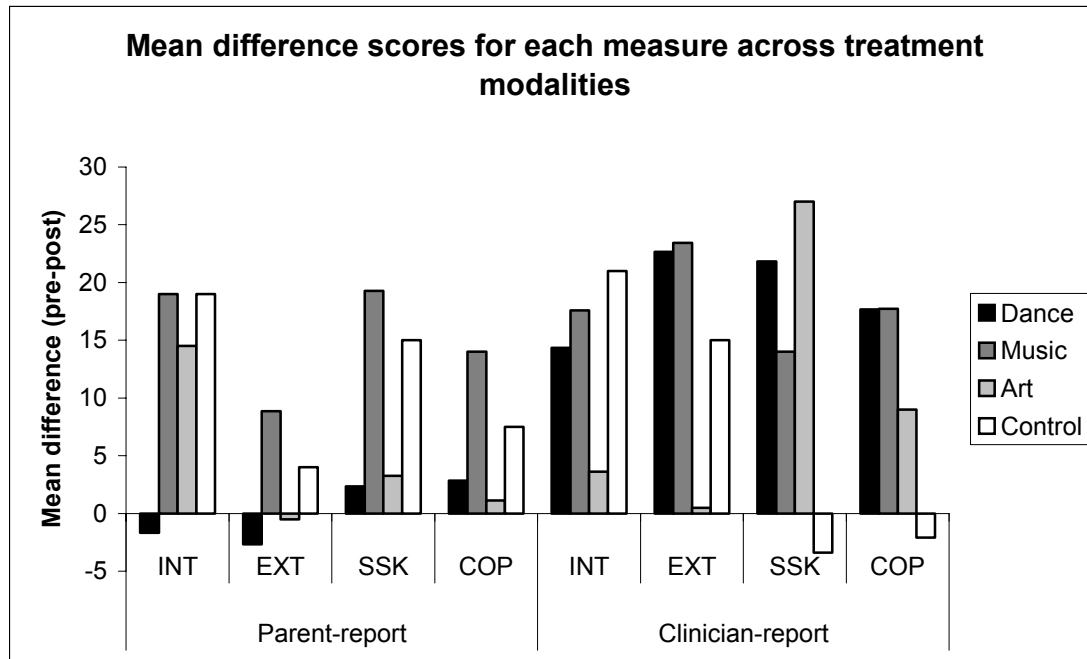


Figure 1.

Difference scores generated for both parent- and clinician-report measures across the treatment modalities.

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