

## Mothers' perception of their involvement in expressive and creative therapy provided to their children at a special education school

Gal Abramovski

Doctoral School of Psychology, Department of Psychology and Education,  
Alexandru Ioan Cuza University, Romania.

Lecturer, Academic College of Society and the Arts, Netanya, Israel.

### ABSTRACT

**In light of the paucity of evidence on mothers' involvement in expressive and creative therapy for adolescents with learning disabilities (LD) studying at special education schools, the current study examined mothers' perceptions of their involvement in the therapy and of the relationship with the therapist. The sample comprised 18 mothers to adolescents with LD who were in therapy for at least one year. Data was collected via semi-structured interviews. The findings indicated several therapeutic issues as well as the special encounter that occurs between the therapeutic and educational domain. The discussion presents three main styles of maternal involvement. The theoretical implications of the results and their practical implications for expressive and creative therapy within schools are discussed.**

**Keywords:** Expressive and creative therapy, Special Education, parental Involvement, adolescents, Perception and expectations, school children, learning disabilities.

This study explored the involvement of mothers in expressive and creative therapy provided to their children at a special education setting in Israel, from the mothers' perspective. The study focused on mothers' perceptions and expectations regarding expressive and creative therapy as well as on contact and communication with the therapist. It addressed the issue of maternal involvement in topics and issues from the therapeutic domain as well as concerning the challenging encounter between the educational domain and the therapeutic domain, with the aim of formulating models for working with parents in educational settings.

The professional literature relates to the concept of parents in a variety of ways. Some of the research literature tends to note the parents' gender (mothers or fathers) while others relate to the parental attitude and role – parents. In addition, some of the professional literature tends to combine the two and to note, in general, that these are parents, while providing further information on the parents' gender in the methodology chapter. Throughout the current study, the gender orientation – mothers, will be combined with the attitude and role – parents.

Expressive and creative therapy is a process that bypasses words. It utilises and recruits the language of art in order to form insight, growth and personal progress (Malchiodi, 2012; Rubin, 2016). Articulation through expression and creativity is a tool for connecting the inner experience to the external world and it constitutes a way of communicating emotions and feelings that people find hard to express in words (Amir & Or, 2005; Case & Dalley, 2014).

In recent decades, expressive and creative therapists (art, movement, drama, psychodrama, bibliotherapy and music therapists) are gradually becoming integrated in educational systems

around the world. The Israeli Ministry of Education has gone so far as to include expressive and creative therapists among the educational staff in the special education system (Abramovski & Fogel Simhony, 2019). Expressive and creative therapists are employed directly and indirectly in a range of educational settings, special education schools, mainstream schools with special education classrooms, local therapy centres and therapeutic centres at hospitals (Moria, 2000). All these provide a response only to pupils eligible for therapy according to the Law of Special Education (1988). The purpose of school-based expressive and creative therapy is to allow pupils to be more significantly available for learning and for experiencing efficacy, self-confidence, success, self-acceptance and meaning in their subsequent life as adults (Ministry of Education, 2016; Nissimov-Nahum, 2013; Ofer-Yarom, 2007).

In recent years, there is a growing understanding and awareness of the need to include parents in the therapeutic process. Acceptance and understanding are very important for identifying parents' attitudes to the therapeutic process undertaken with their children within special education settings and in general. This topic is receiving further focus due to the understanding of how the family unit is formed, its roles and the conception that both parents can contribute to the proper development of adolescents, which will stay with them for many years (Cohen, 2007). Parents' attitudes to the therapy provided to their children are directly related to their parental attitude, both at the foundation of their self-perception as meaningful and central figures in their children's life and in their perception of their involvement in the children's therapeutic relationship (Oren, 2012). Another aspect of parent involvement relates to the parent's contact and communication with the therapist. This is a significant element that is important for the success of the therapy and for understanding the adolescent's emotional and environmental world (Ishai-Karin, 2004; Greenbank, 2016). When working at a school, the conception of how parents see and experience the therapeutic and educational staff as a supportive, educating, present and reliable source within the adolescent's life, is extremely important. In addition, parents can receive support and assistance from the therapist throughout the adolescent's therapeutic process. This is evident mainly in moments of crisis involving the adolescent (Ishai-Karin, 2004; Katzenelson, 2014). For many parents, involvement in the initial stages of therapy, namely identifying and formulating the therapy goals, the relationship with the therapist and creating a therapeutic alliance platform before beginning therapy, has a considerable effect on the ability to build the parent-therapist relationship and contract (Odhammar & Carlberg, 2015).

Expressive and creative therapists working in the educational system operate in the space between the patient (the adolescent), the parents and the educational system. Their role is to work with the three of them together as clients. This demands of the therapists high creativity and integration between theories from the psychotherapy field and systemic theories. Emphasising the connections between the adolescent, the parents and the educational system allows the therapist a range of therapeutic interventions, as well as inclusion in multisystemic work that invites the parents to be partners in the process and consequently to see themselves as active, involved and meaningful parts of the child's therapeutic process (Snir & Regev, 2018).

Israel's Ministry of Education defines the expressive and creative therapist's contact with the parent in a professional pamphlet as follows: "Maintaining continuous contact with the parent is part of the therapist's intervention process with the pupil. This contact should be held at defined points in time throughout the school year: at the beginning of the school year, in the middle and at its end. In addition, the therapist may also meet with the parents throughout the year according to professional need or upon the parents' request (Ministry of Education,

2016). The frequency of the encounters and the parents' contact with the therapists at the school are very important but often hard to implement and significantly dependent on the therapists' ability, age, experience and perception of the significance of creating a fabric, relationship and trust that will contribute to forming a therapeutic alliance (Regev, Snir, Alkara & Belity, 2016). One of the main aims of meeting with parents is to build a trustful relationship and to form a therapeutic alliance that expresses consent with the therapy setting, therapy time, significance of the therapy, aims of the therapy, communication with the therapist, parental guidance and more (Nissimov-Nahum, 2013; Kelner, 2009).

Few studies have been conducted on parents' perception and expectations of the therapy and the therapist (Edwards, Brebner, McCormack & Macdougall, 2016). At present, there is an understanding that in order to provide a child with effective therapy the parents' cooperation is essential. Although the educational system is responsible for the child during the school day, it is important to communicate with the parents and to include them. Enlisting the parents in the therapeutic process will improve the outcomes for all those involved, mainly to the benefit and advancement of the adolescent (Ishai-Karin, 2004; Greenbank, 2016). Parents often ask to be part of the process and see the considerable significance of accepting and integrating their experience and knowledge as a way of enlisting them and of facilitating the therapy's success (De Geeter, Poppes & Vlaskamp, 2002; Ladarola et al., 2015).

Within the therapist's work relations at the school it is extremely difficult to hold encounters with parents. The current study focused on the population of mothers, who in most cases can be enlisted most effectively in favour of involvement in the therapeutic process. In view of the increasing use of expressive and creative therapy in general and for children within schools in particular, on the one hand, and the paucity of empirical evidence regarding this phenomenon, on the other, the present study aims to examine a major aspect of this type of therapy. The study focuses on the involvement of mothers with adolescents in a special education school, regarding expressive and creative therapy and their children's therapist.

## RESEARCH DESIGN

The qualitative study included an attempt to understand the research subject as seen by the participants. The purpose was to understand their worldviews and thoughts. Qualitative research claims that phenomena can only be understood in the context of the time and place in which they occur. Such a study enables a unique understanding of the studied phenomenon and its complexity. The premises of qualitative research lead to a study that implements techniques of active listening, discourse and presence in the natural environment studied (Sabar Ben-Yehoshua, 2016).

### Participants

The sample comprised 18 Hebrew speaking mothers of children aged 14-18 (grades 9-12), whose children have learning disabilities and had been receiving expressive therapy for at least one year. All the mothers had a child who was participating in a therapeutic process at the time of the study. The study was conducted at a large special education school in central northern Israel. The school was located in an area characterised by a medium socio-economic status. The mothers were recruited by contacting all the mothers whose children had been treated for at least one year by one of the 10 therapists working at the school. The rate of refusal to participate in the study was 9%.

### Research Tool

This study utilised semi-structured in-depth interviews: The in-depth interviews are the study's major source of knowledge (Glaser & Strauss, 2017). The purpose of interviews is to

understand people's experience and the meaning they attribute to this experience (Shkedi, 2003). The interview guide focused on topics related to parental functioning and to the perception and expectations of parents with adolescents who receive expressive therapy at a special education school. Major topics on which the semi-structured interview focused are perceptions, prejudices, involvement, relationship with the therapist, setting therapeutic goals, guidance and more. The interview guide was constructed on the basis of a literature review regarding parent perceptions and expectations of expressive and creative therapy and therapists (e.g., "To what degree would you like to be involved in your child's therapy?" "In your opinion, should the parent be included in determining the aims and goals of the therapy?" "During your child's therapy at school, did any incidents occur that created a conflict in your attitude to the therapy or to the therapist?" "Do you think that you should speak to your child about your conflicts/criticism of the therapist?").

### **Data Analysis**

The interviews were analysed based on the principles of grounded theory in order to identify and define main ideas, themes and categories (Carmaz, 2006). The data analysis process was based on the three stages proposed by Strauss and Corbin (1990). In the first stage, the transcripts of the interviews were read several times, for initial familiarisation with the text and to note central themes. In the second stage, axial analysis was performed in order to detect most of the categories that arose from the interviews as a whole. In the third stage, selective encoding was performed and the story of the studied phenomenon was constructed (Agar, 1980). Later, another reading was carried out in order to organise and link the main themes and to create a sequential structure between the categories (Sabar Ben-Yehoshua, 2016).

In the findings section, use is made of uniform terms: "Most mothers" refers to concepts found among 14-18 of the interviewees. "Some of the mothers" refers to ideas found among 7-13 of the interviewees. "A few mothers" refers to 4-6 mothers. Themes raised by less than three mothers were not included in the findings. Nevertheless, in certain cases the term "individual mothers" was used for a topic raised by three or less mothers.

### **Procedure and Ethics**

At first, the researcher approached the school principal to receive her approval to conduct the study, as required by the procedures and by the customary ethics principles. After receiving approval, the researcher approached teachers in classrooms, who were asked to locate mothers who meet the research criteria. The teachers at the school helped locate suitable mothers and then explained to the mothers the nature of the study and received their initial consent to participate in the study. After receiving approval, the researcher contacted the interview candidates. Each interviewee received an explanation of the research purposes and assurance of full confidentiality with regard to revealing their name or any other detail that might identify them.

## **FINDINGS**

The research findings shall present the perception of mothers with regard to their involvement in the therapy provided to their child in a range of aspects related to the therapeutic intake, setting therapeutic goals and parental direction and guidance. In addition, the research findings will discuss issues related to the mothers' perceived involvement with regard to the child's conflicts and resistance to therapy and to the therapist. At the conclusion of the findings, three involvement styles demonstrated by the mothers will be presented.

### **Involvement in the therapeutic intake**

Most of the mothers perceive the intake as significant and see it as an opportunity to provide as wide a picture as possible of their child's condition in the context of his or her development. *"In my opinion, it is important to share anything relevant. The parents' role is to illuminate and to provide the therapist with all the information"*. At the same time, some of the mothers do not perceive the intake as a precondition for therapy: *"It isn't always possible to meet with us at the beginning of the year. It isn't a good idea to wait and prevent the therapy"*.

### **Involvement in setting the therapeutic goals**

Many mothers expressed a desire to be involved in suggestions for setting therapeutic goals and saw this as a significant contribution to the effectiveness of the therapy. The mothers expressed dissatisfaction when their child's therapy goals were determined and formulated without their inclusion. *"I would like to be included in setting the therapeutic goals, to be involved in it. If I were to present the current situation and the aims and our story, then the entire therapy would be more effective"*. At the same time, a small proportion of the mothers shared that they indeed took part in setting the therapeutic goals. *"We met with the therapist and defined goals. There was a mutual discourse on how she sees things and how we do, and we coordinated expectations and defined goals."*

### **Perceiving the need for direction and guidance**

Most of the mothers expressed a longing to receive direction and guidance, in recognition of their contribution. Some of the mothers noted the significance of parental guidance even if this involves a fee. Or alternately, in the absence of individual guidance, the mothers raised the possibility of group-based parent guidance. *"I truly need it. I really believe in parent guidance and I would like to receive as many tools as possible. Because the child is a holistic being and the more tools we as parents have to work in cooperation with all the child's factors, the better off we will all be"*. With regard to the frequency of the guidance sessions, the mothers' need appeared to be diverse, with some of the mothers expressing a need for intensive weekly sessions. *"It is important to provide guidance once a week. Once the parents will receive guidance they will know how to conduct themselves with their child and this will also reflect on their conduct with the school"*. Other mothers raised a need for sessions at a frequency of once every few weeks. *"4-6 sessions throughout the year would be ideal, there is some monitoring, there is a process. I always ask: What can I do at home with the child? What tip can I receive in the guidance session?"*

### **Perception of the parent's function in cases of resistance to therapy**

Some of the mothers expressed full identification with their child's resistance to participate in therapy and asked the therapist to avoid forcing the therapy on the child. *"I would completely respect it and understand that at the moment he can't because it may be hard for him, maybe it is touching on a wound"*. The mothers' desire that their child participate in therapy was not diminished, at the same time, several mothers noted that in such situations they expect the therapist to persevere and to continue wooing the child. *"I asked the system not to force her to come for therapy. But at the same time I did not give up on having the therapist try and motivate her to come for therapy."* A few mothers shared that they would try to more deeply understand the source of the resistance and to what it is attributed. *"I would check to what the resistance is connected: To my child? To the therapy? To the therapist?"*. *"I talked to his therapist and together we tried to more deeply understand the reasons for the resistance."*

### **Criticism and conflicts regarding the therapists or the therapy**

Conflicts and difficulties involving the therapist or the therapy were perceived by the mothers as a topic that is directly related to them and unrelated to their child. Some of the mothers expressed their understanding of the need to maintain the relationship between the therapist

and their child and noted that in case of conflict they would first of all contact the homeroom teacher or school headmaster in order to avoid damaging the therapeutic process. *"If I had a difficulty with the therapist or criticism of the therapy I would first of all contact the homeroom teacher and maybe further on the headmaster, because it is very important for me to avoid any damage to my child's trust and relationship with the therapist"*. A few mothers noted that in case of conflict, the topic should be resolved directly with the therapist and/or the educational system. These mothers expressed their understanding that including the child in the conflict might harm the therapy as the child is strongly influenced by their opinion and thoughts. *"If there is a conflict, it is between me and the therapist. Including the child can, in my opinion, harm the therapy. He is strongly influenced by us and by what we think"*.

### **Styles of involvement**

The study found three styles of maternal involvement in the therapy: observing and enabling involvement, initiating involvement, passive aggressive involvement.

#### ***Observing and enabling involvement***

This involvement is characterised by mothers' interest in the therapy and its contents, a desire for contact and communication offered to the child by the therapeutic expance, and expressing trust in the therapist who will invite them to be more involved if necessary.

*"I trust the therapist that if important matters come up she will include us. I see that both the school and the therapist are in control. I trust the therapist that we will be included and involved if necessary. I'm not a pushy parent."*

#### ***Initiating involvement***

This involvement is characterised by an active maternal attitude with regard to involvement in the child's therapy. These mothers initiate contact, show a wish to be included, update and also initiate encounters and telephone calls with the therapist. They are in constant contact with the therapist and use the various possibilities that are available to them in order to be meaningful for the therapeutic process. *"I initiate contact with my child's therapist as necessary, text her or call as needed. We're not a separate unit, we as parents have lots of knowledge and we can take part"*.

#### ***Passive aggressive involvement***

This type of involvement is characterised by a passive aggressive maternal attitude to involvement in the therapy. As these mothers see it, the therapist is obliged to update and share with them the contents of the therapy. They spoke about their anger and frustration at not being part of their child's circle of support and therapy. Individual mothers reported complete dissociation from any involvement in the therapy, to such a degree that sometimes they did not even know that their child was receiving therapy. *"I contacted the homeroom teacher to receive an update on my child's therapy. I asked what was happening in the therapy. The teacher invited me to contact the therapist. I don't think It's my duty to contact her. I think it should come from the therapist. If she really cares, she should contact me."*

*"The therapists who are interfering with my daughter's soul are my most vulnerable point as a parent. I am supposed to know what's going on and it is not right that at the end of the year, at the most, they call me and tell me what happened in the therapy. They didn't contact me! I have no idea who is my daughter's therapist. I don't even have the therapist's number."*

## **DISCUSSION**

In light of the developing understanding that parent involvement has a dramatic impact on the success of the therapy, this attitude by parents is a strong foundation for the success of the

therapy, of course excluding abusive and pathological parent populations. The discussion shall deal with how the findings are manifested in each of the involvement styles found, in connection and affiliation with the parents' initial attachment patterns and how they affect their parenting style (Bowlby, 1979; Holmes, 2014) as well as the characteristics of their communication with the therapist (Greenbank, 2016; Spangler & Grossmann, 1993).

### **Observing and enabling involvement**

This style is characterised by extensive parent involvement in the **intake and in the therapy goals**. This type of involvement transforms the parent into a significant element in shaping the child's mental life. The fact that the parent is involved and takes part in the therapy and its aims is a beneficial experience for the child as well, contributing to the formation of a parental representation in the child's world. In addition, it encourages and empowers the parent and generates motivation for continuous involvement and partnership. In this way, it reinforces the parent's relationship with the child. The parent's active partnership imparts an experience of visibility and may moderate the complexity of the parent-therapist relationship. At the same time, it is notable that since the therapy is provided in the morning as part of the school schedule, it is hard to hold encounters since most parents are at work during these hours and such encounters require the parents to make more of an effort. Moreover, if there is an intake encounter, usually only one parent can attend (most often the mother). Difficulties with holding intake encounters and with setting therapeutic goals might harm the parents' motivation to maintain continued contact with the therapist and might be experienced as a rejection of the parent's role. This might disrupt the fabric of the relationship between the parents and the therapist, consequently damaging the parents' readiness and investment in the child's therapeutic process.

It may be assumed that parents with this involvement style will comply with the call by therapeutic elements to hold an intake session as well as with the invitation to be partners in setting therapy goals. These parents will see themselves as partners and will also assume some of the responsibility for the therapy's success. In cases of **the child's resistance to therapy, criticism and conflicts concerning the therapist or the therapy**, in this type of involvement we may be able to discern two major stages: In the first stage – the parent will try, together with the therapist and the child, to understand the source of resistance. In the second stage – there will be a joint attempt to find solutions from an attitude of mutual inclusion, together with the child. Parents with this style of involvement will focus on the child's needs and will give the child considerable room for expression. In addition, in this style we can discern parents who are capable of bearing resistance and of absorbing it without reacting immediately. Moreover, when there are conflicts and crises the parents will be able to suggest coping strategies and various solutions. **Direction and guidance** – In 2016 the Ministry of Education issued a directive that approximately three sessions with parents may be held throughout the school year.

Nevertheless, due to many constraints and limitations that are often not up to the therapist, this is not an easy task. Hence, in this involvement style we can combine two major parent guidance styles (Oren, 2011). The first is parent direction, consultation and guidance – In this guidance style the focus is on the child and the parents' style of communication with the child. This guidance style appears to be the most effective for use within a school setting. The second style that can be utilised in the current style of involvement is parent-focused psychodynamic guidance. The choice of this guidance style is based on the assumption of a significant disparity between parents' conscious elements, those manifested in the parent's desire for involvement and inclusion in the therapeutic process, versus the parent's unconscious elements – shame, prejudice, experiences of failure, competitiveness, narcissistic wounds, visibility and more

(Oren, 2011, 2015; Manzano, Palacio-Espesa, & Zilka, 2005). The nature of the direction and guidance provided to parents characterised by observing and enabling involvement will be chosen following identification of the parent's attachment style by the therapist and matching the best type of direction. Some parents may need more practical tools and aspects while others will need an emphasis on their personality and functional aspects.

In this style of parent involvement we can identify two groups of parents with different attachment styles (Holmes, 2014). One group has an involvement style based on the secure attachment style, and the other is based on the avoidant attachment style. With regard to the first style, parents with a secure attachment style who trust the world, express less concerns and fears, will feel certain of their relationship with the child and of the therapist's relationship with the child. Parents with a secure attachment style will feel confident to allow the child to receive therapy, with no concern that emotional contents that might arise in therapy will harm the parental foundation and thus threaten the parent's existence. From this attitude of confidence, parents can have an attitude of observing the process the child is undergoing and enabling the child to grow and develop. In contrast, parents with an insecure, avoidant attachment style within the (allegedly) observing and enabling involvement style might stem from their avoidance of meeting their own pain and difficulty when the child needs emotional therapy. These parents might act in many ways, both conscious and unconscious, to avoid encountering negative and disappointing feelings with regard to their parenting and to themselves, and hence the observing and enabling attitude will be merely artificial. Therefore, identifying the parent's attachment style by the therapist has a central place in order to match the best type of direction and guidance. Hence, the success of the child's therapy is strongly related to the therapist's success in preserving the parent as a partner by letting the parent express the full range of parental feelings, both positive and negative, freely and safely (Winnicott, 1977).

Notably, the style of parental involvement has an impact on the interventions used by the therapist and is often related to the therapist's own type of attachment. The encounter between the parents and their style of involvement with the therapist's style of attachment often generates a complex process and requires the therapist to develop internal observation abilities in order to examine the relationship with the patient and the parents. Encounters with the parents might generate two main reactions in the therapist: First, if the parent trusts the therapist and allows him or her to reach deep levels in the therapy, then the therapist can carry out a variety of therapeutic interventions that aim to advance the therapy, with no concern. The second reaction is related to another experience that might emerge within the therapist in response to parents' wariness, judgementalism and invasiveness, whereby the therapist will be more careful in the concern of being exposed to attacks by the parents, which will lead to minimisation of the therapeutic interventions.

### **Initiating involvement**

Parents with initiating involvement will be interested in taking part in the therapeutic process at the **intake** stage and thus to be a significant factor that will shape the type of involvement and the nature of cooperation with the therapist from the first stages of the therapy (De Geeter, Poppes & Vlaskamp, 2002; Ladarola et al., 2015). In the process of **setting the therapeutic goals**, these parents understand that their inclusion and initiative in setting therapeutic goals and defining mutual expectations will lead to better outcomes for their children (Bachner et al., 2006; Edwards et al., 2016). Nonetheless, the therapist must be aware that the nature of the goal selection by the parent might be associated with narcissistic implications for the child and might be related to an unconscious need to effect corrections in the parent's inner world (Manzano, Palacio-Espesa, & Zilka, 2005). In this process, in a conscious or unconscious way,

parents choose therapeutic goals that relate to themselves rather than to the child. This may leave the child with the experience that the parent does not see and understand him or her, which might affect the efficacy of the therapy and its outcomes.

With regard to the issue of **the child's resistance to therapy, criticism and conflicts concerning the therapy** in this involvement style, despite the child's resistance to therapy and despite the existence of conflicts with the therapist, the conception concerning the significance of therapy at the school will not change. In this type of involvement the parents may be more inclined to attempts to try and convince the child to continue therapy despite resistance, with less of an attempt to understand the source of the resistance. In this involvement style parents often expect their child's therapy to continue despite difficulties and barriers (Nock & Kazdin, 2001). A parent who is convinced that the therapy will be effective and efficient for the child will enlist in the therapy. The nature of therapeutic practice at the school, characterised by multisystemic work, will constitute fertile ground and become integrated with the parent's need to be active. It is possible to expect that if there is **criticism or if a conflict will emerge** between the parent and the therapist and the parent will not receive the response he expected from the therapist, it is possible to initiate contact with other figures of authority at the school (headmaster, educational counsellor, homeroom teacher). In the current parenting style, **direction and guidance** will focus on parental direction and consultation concurrent with the child's therapy, where the focus of conversation is the child (Oren, 2011). In this style, parents may demand regular direction and guidance. Demands may be more often related to the parent's need than to the child's need. We may discern parents who find it hard to feel free to try and understand their child better and who are busy with receiving concrete tools and guidance.

In the initiating involvement style the parent often seeks to reach rapid results. The parent expresses a strong wish to solve the difficulty promptly and expects clear solutions. Therefore, in the guidance sessions more conflicts and tensions may emerge with regard to contact and communication with the therapist, mainly when the therapist's suggestion and point of view are not compatible with the direction for which the parent is aiming. We may often associate the initiating and active involvement style with a parent's difficulty to be in an unclear situation and/or with parents who suffer from heavy guilt feelings and as a result must act purposefully in order to relieve and absolve themselves from this guilt. It is to be assumed that if the parents will not receive a response in the school's guidance system they will contact other factors within the school (psychologist, educational counsellor) or outside it.

With regard to attachment patterns among mothers with initiating involvement, two main attachment patterns can be noted: The first is the secure attachment pattern, where the parent maintains continuous contact with the therapist, believes in the therapy and in the therapist. The parent initiates and is involved in the therapy with the aim of helping the therapy succeed. The second attachment pattern – anxious/resistant insecure attachment. In this attachment pattern, the parent indeed forms contact and communication with the therapist but this comes from the parental attitude of needing constant updates concerning the therapy and often stems from a place of invasiveness and difficulty with separatedness. Parents may find it hard to send their child for therapy at school and to release the child to form a connection with another meaningful figure. These parents may have difficulties coping with feelings of vagueness and lack of precise knowledge concerning what is happening in the therapy room and in the relationship between the therapist and the child. This might often be threatening for the parent, leading to the conclusion that initiating involvement with an insecure/anxious attachment style might be harmful to the therapeutic relationship.

### **Passive aggressive involvement**

Among parents with a passive aggressive involvement style, the **intake** stage might take one of two main forms: First, the passive form where parents find it hard and may be concerned of recognizing their own meaning as part of the child's proper mental development, particularly in adolescence that requires wider observation abilities. In this way, parents indeed come to the intake session but will probably reduce or perhaps even completely empty the session's content from any meaning that will arise in it. In addition, parents will not see any value to this session. The parents will indeed come to the intake session but only because they were "invited" to it. The parents will probably hold the view that they have nothing to receive or to give from the session. The second form is the aggressive form. This form will be characterised by parents' utilisation of an aggressive attitude. They will take control of the intake session, leave the therapist no room for expression, and be busy attacking and accusing. It may be assumed that these parents will operate from an experience of threat and that for them aggressiveness will constitute a defence from their sense of threat.

With regard to inclusion in setting **therapeutic goals**, in the passive form of the involvement style we may discern that the parent transfers all the weight to the therapist. The parent will be concerned of taking responsibility for shaping the therapeutic goals. Such situations may arouse and express in the parent a low sense of self-value and a difficulty with figures of authority. In contrast, in the aggressive form the parent may insist on being the one to set the therapeutic goals, leaving no room for joint thought with the therapist and for holding a discussion. In addition, the parent may demonstrate rejection, cancellation, devaluation or aggression towards any goal suggested by the therapist.

With regard to **parent guidance** in the form of passive involvement, on the surface we may detect cooperation: The parent will come to encounters and share. But the parent's explicit passivity will be experienced within the room as aggressive. The parent will seemingly be enlisted in the guidance and in the process, but we will be able to discern implicit behaviours of resistance, avoidance, and transferring responsibility to the therapist or the environment. Notably, patients at the school are teens who are dealing with processes of separatedness and identity formation, as are their parents, and it is evident in the professional literature that there are different therapeutic approaches to the question of whether the child's therapist should be the element that will direct and guide the parents or perhaps parental guidance should be provided by another therapist (Cohen, 2007; Siskind, 1997).

**The child's resistance to therapy** is often related to the parents' ability to deal with their conflicts and confrontations with the child. This ability originates from the parent's history and the nature of the parent's relationship with his or her own parents (Berman & Caspi-Yavin, 1991). This ability is related to the parent's tolerance for situations of discomfort, vagueness and frustration. In such situations the question is to what degree the parent can bear anger, disagreements, aggression and so on. The parent's ability to deal with **conflicts and resistance** with regard to the therapy is related to the parent's degree of exposure to the child's therapy. A parent who has less appreciation for the advantages and significance of the therapy may join the child's resistance instead of trying to understand and help the child deal with the difficulties. Hence, we learn that the therapist's therapeutic interventions, imparting knowledge and the parent's cooperation with the therapist affects the level of resistance that might emerge during the therapy (Patterson & Chamberlain, 1994). When the child displays resistance to the therapy, the passive parent will allow the child's removal from therapy. The parent will choose (often unconsciously) to disregard the child's recurring pattern, where every time a difficulty arises it leads to resistance. The passive parent will make no effort to

invite the child to a joint thinking process in an attempt to understand the source of the resistance.

In the aggressive manifestation of this type of parental involvement, we may discern a parent who directly blames the therapist, with no ability to see his own responsibility or that of the child. An indirect way of expression that may be discerned is when the parent attacks the therapeutic approach (rather than the therapist directly). It is also notable that in such cases of resistance, a process of "wooing" the child by the therapist may be perceived by the aggressive parent as invasiveness and coercion of the parent and child by the therapist. With regard to **criticism and conflicts concerning the therapy**, parents with the current involvement style will have little emotional conflicts because they are less inclined to perceive their involvement as valuable and may even see no value in the therapy. Among such parents there will be less room for emotional aspects because this requires additional energy and resources that the parent will withhold.

In this style of involvement the attachment style is based mainly on insecure ambivalent/resistant attachment. It is apparent that in this style of involvement parents recreate attachment patterns from their early childhood. The current attachment pattern is manifested on one hand by parents' passive response, feeling that they are not part of the process, which leads to narcissistic vulnerability and as a result entrenchment in a victimised attitude and avoidance of involvement in the therapy and of contact with the therapist. Another response on the opposite end may be an aggressive response. Parents perceive the therapist as excluding them from the child's therapy, and this arouses anger and aggression towards the therapist.

When the therapist encounters a passive aggressive pattern of involvement this may affect the therapist and the therapy in two main ways: First, an experience of injury to the therapist's ego, sense of self-efficacy and therapeutic independence. In this state, the therapist might develop antagonism towards the parent and unconsciously also towards the patient. In response to these feelings, the therapist's interventions might be very superficial and not advance the therapy. The other therapist attitude that might arise is identification with the patient. In such a situation the therapist will occupy the parent's place and act out a "rescue fantasy". Of course, both these therapist responses are not beneficial and do not contribute to the relationship between the patient, therapist and parent.

## CONCLUSION

The therapist's encounters with the patient's parents are very significant and sometimes even crucial. We now know that when the therapist meets with the parent it is possible to receive a great deal of information about the parental ability to enlist in the therapy and be involved in the therapeutic process. The interpersonal encounter between the therapist and the parent enables the therapist to assess the parent's strengths, receive an impression of the parent's mentalisation capacity, identify initial patterns of communication and attachment. All these are essential for the success of the child's therapy and give the therapist a fuller picture that cannot be received from the personal file or attendant reports at the school. Therapy within the educational system is defined as child-centred therapy. We often see, however, that the source of the difficulty originates with the parents who have blocked mental areas that do not allow them to maintain beneficial parenting of their child. Assumedly, this blocking is a defence mechanism that keeps the parents from encountering their painful elements and it emerges when something in the encounter with the child arouses these painful elements. Hence, the fact that the therapy is provided at school, with almost no parent involvement, further limits the

possibility that the parents themselves will directly encounter painful experiences from their childhood, thus preserving the difficulties.

The lack of parental involvement prevents the parents from encountering life events in which they felt abusive, hurt, disappointed, or disappointing. Encouraging parental involvement by encounters and guidance often reduces the parents' guilt feelings with regard to their parenting ability and standards. Direction and guidance within the school setting raise the chance of parent cooperation. In addition, when parents do not meet with the therapist at the school they are not aware of the therapy's benefits and in cases of child resistance to therapy or when there is a conflict with the therapist this might affect the parents and distance them from involvement in the therapy, sometimes unconsciously. Lack of communication or nonbeneficial contact between the parent and the therapist might cause the parent to detract from the therapy's significance and sometimes even to contradict the therapist's opinion or voice an opinion about the therapist in the child's presence. At the same time, the advantage of working within the school system is manifested in multi-professional systemic work that combines all the educational and therapeutic elements. In such a situation the parents can receive a wider picture of the child and the child's functioning and raise questions and issues in cases of emotional functional disparities manifested at home or at school, and vice versa.

### **RESEARCH LIMITATIONS**

1. The research population consisted only of mothers of adolescents with learning disabilities (no fathers participated in the study). It may be assumed that if fathers would have taken part in the interviews there would have been a difference in their expectations and perceptions concerning involvement in the therapy and in their relationship with the therapist.
2. The research population consisted of mothers from a special education school for adolescents with learning disabilities. The perceptions and expectations of mothers with adolescents who study in special education settings and have other difficulties, such as emotional difficulties, cognitive difficulties, communication difficulties, were not examined.
3. The data were gathered from the mothers only! The therapists' voice regarding the relationship and communication with the mothers was not heard.

### **SUGGESTIONS FOR FUTURE RESEARCH**

1. It would be desirable to examine the research questions among diverse schools serving special education populations such as behavioural difficulties, emotional-mental difficulties, communication difficulties and others. It is also possible to expand the study to younger patients.
2. It would be commendable to try and recruit fathers for studies on perceptions of therapy and therapists and to compare them to the population of mothers.
3. It would be commendable to examine the perceptions and attitudes of parents whose child is diagnosed but does not take part in therapy offered by the school.
4. It should be examined whether parent involvement develops and changes throughout their children's development, from infancy through the latency period to adolescence.

### **APPLIED RECOMMENDATIONS**

- Parents should be given a comprehensive frontal/written explanation of expressive and creative therapy and its contribution to them and to their child. In addition, as much as possible, parents should be given an explanation regarding therapists' training and previous experience.

- The option of providing regular parent guidance within the school (beyond intake sessions and annual update encounters) should be possible without coming at the expense of the child's therapy. First as a pilot, and then by proposing regular guidance at a high frequency to parents who are interested. In addition, if possible therapists should be given the possibility of offering to hold intake encounters/parent guidance in the evenings (for a fee). Moreover, it is very important to match the style of parental guidance to the parental attachment style.
- With the help of the educational staff, it is necessary to try and encourage parents to be involved in their children's therapy process and in contact with the therapist. It is also necessary to enhance the cooperation in the parent-teacher-therapist triangle.

Note: The article was produced with the assistance of the Academic College of Society and the Arts in Netanya.

## References

- Abramovski, G., & Fogel Simhony, M. (2019). Integrating art therapy in schools: A systematic literature review. *Studia Universitatis Babeş-Bolyai Psychologia-Paedagogia*, 64(1), 45-58.  
<https://doi.org/10.24193/subbpsyped.2019.1.03>
- Amir, D., & Or, A. (Eds.) (2005). *Another language art therapies - Therapeutic stories*. Modan Publishing House Ltd. [Hebrew]
- Anthony, L. G., Anthony, B. J., Glanville, D. N., Naiman, D. Q., Waanders, C., & Shaffer, S. (2005). The relationships between parenting stress, parenting behaviour and preschoolers' social competence and behaviour problems in the classroom. *Infant and Child Development: An International Journal of Research and Practice*, 14(2), 133-154.
- Bachner, Y. G., Carmel, S., Lubetzky, H., Heiman, N., & Galil, A. (2006). Parent-therapist communication and satisfaction with the services of a child development center: A comparison between Israeli parents—Jews and Bedouins. *Health Communication*, 19(3), 221-229.
- Baker-Ericzén, M. J., Jenkins, M. M., & Haine-Schlagel, R. (2013). Therapist, parent, and youth perspectives of treatment barriers to family-focused community outpatient mental health services. *Journal of Child and Family Studies*, 22(6), 854-868.
- Bandura, A. (1993). Perceived self-efficacy in cognitive development and functioning. *Educational Psychologist*, 28(2), 117-148.
- Bandura, A., Caprara, G. V., Barbaranelli, C., Regalia, C., & Scabini, E. (2011). Impact of family efficacy beliefs on quality of family functioning and satisfaction with family life. *Applied Psychology*, 60, 421-448.]
- Barber, A. J., Tischler, V. A., & Healy, E. (2006). Consumer satisfaction and child behaviour problems in child and adolescent mental health services. *Journal of Child Health Care*, 10(1), 9-21.
- Berman, E. & Caspi-Yavin, Y. (1991). *Introduction to psychology* (Unit 10: Personality theories). Tel Aviv: Open University. [Hebrew]
- Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Tavistock.
- Case, C., & Dalley, T. (2014). *The handbook of art therapy*. New-York & London: Routledge.
- Cohen, E. (2007). *The parenthood experience: relationships, coping and development*. Jerusalem: Ach Ltd. [Hebrew]
- Cortina, M. A., & Fazel, M. (2015). The Art Room: An evaluation of a targeted school-based group intervention for students with emotional and behavioral difficulties. *The Arts in Psychotherapy*, 42, 35-40.
- De Geeter, K. I., Poppes, P., & Vlaskamp, C. (2002). Parents as experts: The position of parents of children with profound multiple disabilities. *Child: Care, Health and Development*, 28(6), 443-453.
- Edlund, M. J., Young, A. S., Kung, F. Y., Sherbourne, C. D., & Wells, K. B. (2003). Does satisfaction reflect the technical quality of mental health care?. *Health Services Research*, 38(2), 631-645
- Edwards, A., Brebner, C., McCormack, P. F., & Macdougall, C. (2016). "More than blowing bubbles": What parents want from therapists working with children with autism spectrum disorder. *International Journal of Speech-Language Pathology*, 18(5), 493-505.
- Esdaille, S. A., & Greenwood, K. M. (2003). A comparison of mothers' and fathers' experience of parenting stress and attributions for parent-child interaction outcomes. *Occupational Therapy International*, 10(2), 115-126.

- Garland, A. F., Aarons, G. A., Hawley, K. M., & Hough, R. L. (2003). Relationship of youth satisfaction with mental health services and changes in symptoms and functioning. *Psychiatric Services*, 54(11), 1544-1546.
- Greenbank, A. (2016). The unique relationships between educational crews and special families – families of children with special needs. (Nadala, B. 25.11.2016, Hebrew Psychology site, <http://www.hebpsy.net/articles.asp?id=3398> [Hebrew])
- Holmes, J. (2014). *John Bowlby and attachment theory*. Routledge.
- Ishai-Karin, N. (2004) Exposed in the turret – therapists' views of parents. [Hebrew] <http://www.hebpsy.net/community.asp?id=37&article=341>
- Katzenelson, E. (2014). Relationship between parents and their children's system of education. *Psychoactuality*, October, 40-45. [Hebrew]
- Kelner, N. (2009). *The camel's hump: on the technique of dynamic psychotherapy*. Ben Shemen: Modan. [Hebrew]
- Ladarola, S., Hetherington, S., Clinton, C., Dean, M., Reisinger, E., Huynh, L., & Harwood, R. (2015). Services for children with autism spectrum disorder in three large urban school districts: Perspectives of parents and educators. *Autism*, 19(6), 694-703.
- Law of Special Education (1988). *Book of laws*, 1256. 114. [Hebrew]
- Malchiodi, C. A. (Ed.). (2012). *Art therapy and health care*. New York & London: Guilford Press.
- Manzano, J., Palacio Espasa, F. & Zilkha, N. (2005) The narcissistic scenarios of parenthood – The therapeutic consultation clinic. Translated from French by Rama Ayalon. Tel Aviv: Tola'at Sfarim. [Hebrew]
- Ministry of Education (2016). *Guidelines for the work of educational personnel in the healthcare professions and of art therapists in the educational system*. Pedagogical Administration, Division A, Special Education. <http://cms.education.gov.il/NR/rdonlyres/0945FB48-542C-49DD-A6CE-D2816B4DD80D/207449/resource1625648987.pdf> [Hebrew]
- Moriya, D. (2000). *Art therapy in schools*. Ramat Hasharon: Turbo. [Hebrew]
- Nissimov-Nahum, E. (2013). *Colours of soul and mind: Art therapy for children who behave aggressively*. Tel Aviv: Mofet Institute. [Hebrew]
- Nock, M. K., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies*, 10(2), 155-180.
- Odhammar, F., & Carlberg, G. (2015). Parents' and psychotherapists' goals prior to psychodynamic child psychotherapy. *European Journal of Psychotherapy & Counselling*, 17(3), 277-295.
- Ofer-Yarom, M. (2007). *The culture of therapy under the roof of the culture of schools: The professional identity of art therapists working in the educational system*. Research paper, Faculty of Education, Bar-Ilan University, Israel [Hebrew]
- Oren, D. (2011). Parenthood therapy: Distinguishing between types of therapeutic interventions with parents and the unique place of dynamic parenthood therapy. *Psychoactuality*, 15-26. [Hebrew]
- Oren, D. (2012). Psychodynamic Parenthood Therapy: A model for therapeutic work with parents and parenthood. *Clinical Child Psychology and Psychiatry*, 17(4), 553-570.
- Oren, D. (2015). *Second thoughts about parenting: Being a parent – feelings, thoughts and deeds*. Pardes. [Hebrew]
- Patterson, G. R., & Chamberlain, P. (1994). A functional analysis of resistance during parent training therapy. *Clinical Psychology: Science and Practice*, 1(1), 53-70
- Regev, D., Snir, S., Alkara, M., Belity, I., Green-Orlovich, A., Daoud, H., . . . Keinan, V. (2016). Art therapy in the Israeli education system – An update. *Academic Journal of Creative Art Therapies*, 6(1), 575-591. [Hebrew]
- Rubin, J. A. (Ed.) (2016). *Approaches to art therapy: Theory and technique*. New-York and London: Routledge.
- Siskind, D. (1997). Working with parents: *Establishing the essential alliance in child psychotherapy and consultation*. Jason Aronson.
- Snir, S., & Regev, D. (Eds.) (2018). *When the creative arts therapies and Israeli educational system meet: Features and applications*. Haifa: The Emili Sagol Creative Arts Therapies Research Center, Haifa University. [Hebrew]
- Spangler, G., & Grossmann, K. E. (1993). Biobehavioral organization in securely and insecurely attached infants. *Child Development*, 64(5), 1439-1450.

Winnicott, D. W. (1977). *The Piggle: An account of the psychoanalytic treatment of a little girl*. London: Hogarth [reprinted, London: Penguin, 1991].