Overcoming “You Can Ask My Mom”: Clinical Arts-Based Perspectives to Include Children Under 12 in Mental Health Research

Prudence Caldairou-Bessette1,2, Lucie Nadeau2, and Claudia Mitchell3

Abstract
As research with children (rather than research on children) gains popularity and researchers adapt methods to include children’s voices, continual reflection on the research methods themselves is needed. In this article, we explore the relevance of playing and drawing in qualitative research interviews to include and represent the voice of children under 12 years of age, particularly in the field of mental health research. We reflect on the conception of children’s voice in research and argue for an understanding of voice that goes beyond verbal language. We suggest a combination of perspectives from arts-based research and clinical interview practice to support our understanding of children’s voice in research. As an illustration, we draw on an example taken from a large research project in Youth Mental Health Collaborative Care during which 23 children under the age of 12 were interviewed using a talk-play-draw model. We discuss the multidimensional aspect of children’s voices and the ethical value of arts and play in research interviews. We highlight the importance of researchers’ ethical reflexivity and creative participation in their quest to understand children’s voices. While doing so, we emphasize the responsibility of researchers to interpret, translate and represent a multi-layered, complex and often disorganized voice into a form that is accessible to the linear world of academic research. Given that it is perhaps inevitable that researchers use their own voice in this process, we argue that in conducting research with children, we need to engage both the children as participants and the researchers as advocates for children’s perspectives.

Keywords
arts-based methods, children’s voices, research with children, interviewing children, drawing, play, ethics, researchers’ reflexivity

Introduction
The United Nation’s Convention on the Rights of the Child (UNCRC) (1989) states in Article 12 that children have the right to express their views. Since this is one of the most widely ratified conventions in the world, it is not surprising that there is a growing interest in involving children as participants in research (Lane et al., 2019; Palaiologou, 2014). With the increased interest in childhood studies along with the paradigm shift responsible for researchers doing research with instead of on children and prioritizing their voice (Christensen & James, 2017; Tisdall & Punch, 2012), a new sociology of childhood has developed, one that positions children as valuable social actors who should be heard (Darbyshire et al., 2005). Researchers from different fields have invested in this enterprise and this has led to the recognition that there is a need to adapt research methodologies to ensure that children are...
provided with adequate opportunities and vehicles for expression (Taylor, 2000). Since children learn to use a verbal language progressively, including them in research requires researchers to adapt their forms of communication, especially for younger children as Lomax (2012) has reminded us. This led to the development of alternative arts-based methods, also called creative or visual methods (see Blaisdell et al., 2019; Koller & Juan, 2015; C. Mitchell et al., 2011; Robinson & Gillies, 2012). Indeed, Article 13 of UN CRC (1989) draws attention to the rights of children to have freedom of expression and to “receive and impart information and ideas of all kinds . . . either orally, in writing or in print, in the form of art, or through any other media of the child’s choice”.

Although alternative research methods can contribute to making children more comfortable and allow them to express themselves (L. M. Mitchell, 2006; Nabors, 2013), we recognize that there is a need for more reflection on how we should interpret data collected using these methods (Darbyshire et al., 2005; Fargas-Malet et al., 2010; Kirk, 2007; Lomax, 2012). For example, research with children has highlighted the issues related to the power differential between child participants and adult researchers (Lane et al., 2019; Palaiologou, 2014; Ponizovsky-Bergelson et al., 2019). Since children generally depend on adults, they are in a vulnerable position in relation to them. Children may feel intimidated and become reluctant to share their views, especially with a stranger. To overcome these issues, researchers have argued for the use of participatory research methods with children because they empower children and because of the relationship building between researcher and participant that they allow (Bradbury-Jones et al., 2018; Langhout & Thomas, 2010; Mand, 2012; McTavish et al., 2012; C. Mitchell et al., 2017).

Furthermore, qualitative interviews most commonly used in research are based on verbal interaction (Ponizovsky-Bergelson et al., 2019). Although adults and adolescents may respond well to such qualitative interview situations, children are often excluded from research because of the challenges that interviewing them can present (Glass, 2006; Morison et al., 2000). Researchers can be discouraged by the challenge of adapting research tools to get children to talk. Additionally, children in interviews can believe that there is a right answer that they should articulate, so they may not elaborate very much, if at all. This compromises the right of children to participate in research and can lead to an under-representation of their voices. Principles of social justice and equity call for further development of adapted methods for interviewing children so that they can have suitable opportunities in which to express their views in research.

Up to now there has been relatively little guidance available on how to interview children (Docherty & Sandelowski, 1999; Ponizovsky-Bergelson et al., 2019; Spratling et al., 2012). We know, from Spratling et al. (2012), for example, that it is possible for children to talk about their experiences in interviews but little is known about how to foster this. Researchers have also highlighted the challenges encountered in working with children on sensitive issues (Akesson et al., 2014; Vanner & Kimani, 2017). Research has shown that children will mask or withhold negative or emotionally disturbing information and focus on the present in verbal interviews as Docherty and Sandelowski (1999) have pointed out. This can be explained partly by the fact that an interview setup, where a child is only met once, or on a few occasions at the most, offers limited opportunities to build trust.

The work of child psychologists, psychiatrists, psychoanalysts, or art/play-therapists with children uses, necessarily, an interview setting so they have had to develop ways of enabling children to express themselves, especially on sensitive issues like those related to mental health, for example. This has led to a long tradition of such practitioners’ use of play and drawings to understand children in psychotherapeutic consultations (Anzieu, 2008; Caldairou-Bessette et al., 2018; Dolto, 1948; Fabre, 1998; Marans et al., 1991; Winnicott, 1971). Clinical practitioners have developed a unique and deeply experience-based culture of trying to understand children through their drawings and play. Since there can be similarities between qualitative research interviews and clinical interviews (Thompson & Russo, 2012), knowledge derived from clinical settings can help researchers in relation to qualitative interviewing with children and can contribute to finding ethical strategies for including children in research, especially in the field of mental health.

Childhood Studies developed by “positioning itself against previous dominant modes in Developmental Psychology,” and is particularly influenced by sociology, anthropology and geography (Tisdall, 2012, p. 74). Until now, psychology has not engaged significantly in giving voice to children in research. Although there has been important work by some developmental psychology researchers (see Greene & Hogan, 2005) to adapt to this important turn in research (partly in response to criticism), clinical psychologists have not participated much in this movement. Thus, literature bringing together clinical interview knowledge and research methods aimed at giving a voice to children remains scarce.

Our objective in this article is to illustrate how clinical knowledge, combined with arts-based methodologies, can allow children to have a multidimensional voice in qualitative interview settings. Writing as researchers from two disciplinary areas, clinical practice (the first two authors) and arts-based research methodologies in childhood studies (the third author), we are interested in sharing knowledge that might expand the range of possibilities of including children in research and lead to critical reflection on how we understand and represent children’s voices. To do so, we present an account from a large study in Youth Mental Health in Montreal of qualitative interviews with a 9-year-old child using play and drawing.

**Children’s Voices: Transcending Verbal Language**

What should be considered as the voice of children? The notion of voice refers to the sounds produced by the vocal chords but also to the expression of thought, opinion, and emotion (Centre National de Ressources Textuelles et Lexicales, 2012). The
latter definition transcends verbal expression, so, as Jackson and Mazzei (2009) have noted, one can ask, “What should count as voice, and therefore as data?” (p. 20)? This question is relevant to both research and clinical settings. In the literature on research with children, the conceptualization of children’s voice is subject to debate (Spyrou, 2011). Similarly, in clinical settings, different types of input are considered—verbal and non-verbal, direct and more implicit—and the legitimacy and validity of interpretation is questioned since we need to ask who should interpret and how this should be done (Anzieu, 2008; Thomas & Jolley, 1998; Widløcher, 1984).

Drawing has been used in numerous ways in research with children. One way has been to see drawings as “facilitators of communication” according to the title of Driessnack’s (2005) article (see also, Driessnack, 2006; Linder et al., 2018). The aim here is to prevent producing adult-centered interpretations (Darbyshire et al., 2005; Driessnack, 2005). More recent work on participatory arts-based methodologies involving drawings has pointed to the inclusion of verbal interpretation by the child. As C. Mitchell et al. (2011) have observed, such approaches that have come to be called draw-write-tell and draw-tell, “encourage collaborative meaning-making that allows the drawer to give voice to what the drawing was intended to convey” (p. 20). This perspective points to the significance of verbal exchange, but also to the significance of the relationship between researcher and participant in arts-based participatory research—something that has received less attention.

Indeed, this relational dimension goes beyond verbal expression, and some researchers have highlighted the inadequacy of verbal language (Blaisdell et al., 2019; Koller & Juan, 2015), stressing, instead, the underpinning principle of how arts-based methods allow voice to be expressed in ways that do not rely on verbal competence. At the same time, some researchers have also pointed to the overvaluing of certain children’s voices and the lack of attention given to children with limited verbal communication skills (Gallacher & Gallagher, 2008; Lomax, 2012; Robinson & Gillies, 2012; Teachman & Gibson, 2018), a group that includes younger children.

The emphasis on the notion of voice can itself have an impact on inclusion/exclusion in research. As Blaisdell et al. (2019) has mentioned, “The ‘individualizing character’ of this notion of voice reproduces an understanding of the ideal subject as rational, articulate—an understanding which ‘marginalizes children’ (Tisdall, 2009, p. 214), particularly young children (Arneil, 2002)” (p. 27). Furthermore, imagining the child as “all-knowing and all-seeing” (Lomax, 2012, p. 106), and as necessarily able to express her or his views in an orderly manner, can also be problematic, although this does not mean that their view does not merit consideration (Spyrou, 2011). This raises the question of how we should represent children’s voices in research (Lane et al., 2019). The overvaluing of direct verbal representation of children’s voices—typically through quotes—can lead to inequalities and discrimination in the data collection and analysis processes. As Spyrou (2011) has said, What the child does not respond to, omits or ignores—the silent and the unsayable—might tell us more about the child’s voice and perspective than what she actually verbalizes. For the researcher this is an opportunity to go beyond verbal to examine other than surface meanings. (p. 157)

Following these different considerations, Teachman and Gibson (2018) proposed a reframing of the concept of voice as “always multiple and relational” (p. 2), allowing for the consideration of what is expressed non-verbally and through human contact. In the same vein, arts-based research values art as a way of working beyond logical verbal language to come to an understanding of voice.

In clinical psychology, even if some researchers have questioned the usefulness of children’s artistic productions and their interpretation (Thomas & Jolley, 1998), clinicians have valued play and drawing as therapeutic in themselves for the expression and elaboration space they allow (N. Rogers, 1993; Winnicott, 1971). For example, in the latest versions of mentalization-based psychotherapy treatment for children, play is central to the therapeutic process and is described as “providing a way to explore relationships, to learn about the world of feelings, and to find one’s own voice as a child” (Midgley et al., 2017, p. 134). As have researchers, clinicians have underscored the importance of interpreting artistic material in psychotherapy using the child’s words (Anzieu, 2008), but have also argued that the child’s artistic productions sometimes precisely express what the child cannot say (Dolto, 1948; Krymko-Bleton, 2015).

Toward a Clinical and Arts-Based Approach to Research With Children

In this section, we provide some clinical basis for understanding drawing and play and other arts-based activities in interviews.

Play and drawing have been used in clinical encounters since the early days of the practice of psychotherapy with children (Garcia-Fons, 2002). In the development of psychoanalytic therapy with children, drawings and play were used as a replacement for the free association technique (Anzieu & Chabert, 2004), used verbally with adults to explore the subject’s psychic life since spontaneous thoughts were understood to have an underlying meaning that needed to be discovered. Play and drawing were used as both material and method; they were considered the natural language of children (Dorfman, 2003). Having a multidimensional meaning, partly unconscious, they could also reveal wishes, as dreams could according to Freud (2016).

Artistic productions of children in clinical work can be understood as pictures of their emotional state or unconscious self-portraits (Dolto, 1948). This idea was also the basis of what are called projective methods in psychology, in which drawings and play (or story completion situations) are often used. For example, many clinicians showed how in drawing a family or a person, a child could project representations of his
own family or his own self (Abraham, 1999; Corman, 1978; Royer, 1977; Vinay, 2007). The narrative value of projection underpins the deep understanding of the child in psychotherapy as giving voice to non-verbal, implicit, or unconscious dimensions. However, the projections in the artistic productions of children can appear displaced and condensed (Widlöcher, 1984); emotions and representations can be displaced from one image to another, and one image can represent multiple projections.

A clinical perspective also suggests that we pay attention to the fact that the child identifies (consciously or unconsciously) with aspects of characters he or she plays or draws that reveal dynamics of identity. These identifications can be recognized through the investment the child puts into creating a character, like, for example, the quantity of details, the degree of noticeable attention given and the emotional engagement (Abraham, 1992; Bessette, 2012; Corman, 1976).

Finally, interpreting children’s artistic productions in psychotherapy relies on considering transference (for the patient) and counter-transference (for the psychotherapist) processes. Those processes refer to the relationship that develops in the psychotherapy frame (generally with an interview setting) and that is stuctured by the roles of psychotherapist and patient. The dynamic of this relationship is influenced by present and past relational experiences (that are “transferred”) and is considered partly unconscious (Chiland, 1983; Lapplanche et al., 2004). Children’s drawings in interviews are not created out of nowhere, but in a particular relationship and a particular context, as is their play. More broadly, these principles invite us to understand any production of the child in the interview as having a meaning in the context of that interview. However, to interpret that meaning, we must gather enough converging information from varied sources like, for example, behaviors, information given by people in the child’s environment, relational impressions, or contextual details (Bertrand et al., 2011).

Up to now, clinically based knowledge has been used in research, but in efforts to study personality and psychopathology, rather than to give voice to children. However, the perspective of arts-based research has much in common with the clinical use of drawing and play. The emphasis on the meaning that can be elicited through the arts and the relational value of artistic productions are converging, along with a posture of sensitive listening (see Bagnoli, 2009; Boydell et al., 2012; C. Mitchell et al., 2011; Vanner & Kimani, 2017). Arts-based methods have been used to give a voice to the experience of children, even very young ones, in relation to sensitive issues like inclusion, fear, life after trauma, and even on the very issue of having a voice or not, in healthcare settings and in education (see for example Akesson et al., 2014; Blaisdell et al., 2019; Clark, 2005; Coad, 2007; Driessnack, 2006). However, arts-based research understands artistic productions beyond the scope of individual expression and moves into broader concerns about the construction of knowledge (Boydell et al., 2012). Indeed, art-based research has argued for art as a “primary way of understanding and examining experience” (McNiff, 2008, p. 2), so as art being literally a method for building knowledge in research.

An Illustrative Example: Max

Background and Method

In this section we offer an account of 9-year-old Max from our work as part of a large mixed methods research project on Collaborative Youth Mental Health Care led by the second author. This example is meant to illustrate and explore the possibilities of a clinical and art-based approach to gathering data with children in an interview setting. This project took place in Montreal, Québec, Canada, in primary care settings called Community Local Service Centre (CLSC) (hereafter referred to as the clinic). These centers offer general social and health care, including Youth Mental Health (YMH) services, which are provided mainly by social workers, psycho-educators, psychologists, and art-therapists. Over 300 participants—parents, youth and mental health professionals (MHPs)—participated in the project. This mixed methods project looked at the process of care and the clinical outcome for children and youth receiving services in YMH care. Among the themes explored, those involved in the project were interested in understanding the ways in which children and young people (aged 6–18 years) experienced these mental health services.

The qualitative part of the project took place between 2015 and 2018 and included semi-structured qualitative interviews with 44 triads of youth, parent, and MHP. Qualitative interviews were conducted with each triad at two different times—6 months after the beginning of the services and 1 year after. Semi-structured interview protocols were developed for the three categories of participants (MHPs, parents, and young people) to explore the trajectory of care, representations of the difficulties, representations of the intervention and therapeutic relationship, cultural and socioeconomic issues, and the perception of clinical evolution and satisfaction. But the interview protocol intended for young people limited data collection for children under the age of 12 since their verbal input was minimal. An interview protocol was therefore formulated for younger children, based on clinical knowledge related to interviewing children, engaging them through talk, but also through play and drawing. This allowed 23 children aged 6 to 12 to be included in the project. A simplified version of the semi-structured interview was used (with a few questions instead of more than 20), followed by a play situation and an opportunity to draw.

This talk-play-draw protocol for the younger children included:

1. A “talk moment” based on simple questions about how the services were experienced (for example: Can you tell me a little about when you went to see (clinician’s name) at the clinic? Do you think it helped? How? Is
there a special moment you remember? What did you like most? What did you like least?)
2. A play situation in which the materials included figurines of different ages and cultural origins and three color sheets to represent spaces (one of the spaces suggested was the clinic, and the others could be as the participant wished, like, for example, home or school). The guideline was: “Let’s pretend it’s the story of a child who goes to the clinic to see someone like (the clinician’s name).” The creation of the story was encouraged by asking children simple questions such as: How would the story begin? Why does the child go to the clinic? With whom? How would the story end?)
3. A drawing for which the materials included one sheet of paper and a set of colored pencils. The guideline was: “If we were to draw a child who goes to the clinic to see (name of the clinician), what would it look like?” In a few open-ended follow-up questions the child was asked to talk about how the characters might feel.

The first author conducted both sessions in Max’s home with his mother present (sometimes in the same room, and at others in another room). Although the first author is also a clinical psychologist, she was introduced only in relation to her research function to minimize any dual role issues (see Allmark et al., 2009). All participants were told that they had no obligation to do any of the activities and could choose to stop at any time. The main character in the play situation or drawing could be a child of their choice (including themselves). The idea was to be as non-directive as possible in a child-centered posture inspired by humanistic psychology as advocated by C. R. Rogers (2003). We then followed the child’s spontaneous choices and movements, allowing indirect, mediated modes of expression. In this way, we sought to foster the most comfort possible for the child given that he or she was sharing intimate matters with an adult stranger.

We presented consent forms, approved by the institution’s ethics review board, to the parents for signing and assent forms to the children who were invited to sign them. Interviews were audio recorded and transcribed verbatim. Since the design did not include using videotapes to record the play, the interview included describing the child’s actions as clearly as possible in words. Qualitative analysis of the interview was conducted with consideration of the clinical principles described earlier (projection, identification, relational dynamic, and interview context) along with a consideration of the play and drawing productions as a kind of art work to be looked at from an arts-based enquiry stance (Kossak, 2012). From this exploratory position, following Schwandt’s (2014) definition of hermeneutics as “the art of interpreting the meaning of an object (a text, work of art, social action . . . etc.)” (p. 176), the analysis was guided by these principles. The interpretations process took the form of a “hermeneutical circle” (Schwandt, 2014, p. 173) in which back and forth movements were made from specific elements to the case as a whole, from this case to other cases in the project, and to a more general image of the mental health field as a social and cultural context. The first author listened to the recording of each interview as many times as was necessary to make sense of it, and of the case as a whole. She also read the verbatim transcripts and looked at the drawings and pictures of the play session many times. She listened to and/or read all the complementary data (interviews with parents and MHPs). She conducted a first qualitative analysis in collaboration with the second author for all 23 children in the study. Further analysis was conducted in collaboration with the third author in the specific case of Max, in an effort to enhance the arts-based perspective. The case is presented here in the form of a continuous story, in which Max’s words, those of his mother and the MHP appear along with pictures of the play session and drawings which have been integrated into the text. We can consider this work a form of creative reconstruction but one that is rooted in the data gathered.

**Working With Max**

At the time of the consultation, Max was described as experiencing insomnia, temper tantrums, and attention difficulties. He was often violent with his mother, was in constant conflict with his younger brother, and was, according to his mother and social worker, “seeking negative attention” and dramatizing or lying to make people “uncomfortable.” Max’s mother had been a victim of violence in the past and was depressed and suicidal and had been hospitalized for this. Relational problems were present in the nuclear and extended family; the MHP reported that there was a strong expression of “not feeling good in this family” throughout the follow-up. The (French) mother also reported being criticized by her family of origin and Max was criticized by his father’s (South American) family. The father participated in a few meetings at the beginning and then refused to take part in the intervention. During the intervention that lasted approximately 10 months with Max, his brother, and their mother, a referral was made to psychiatric services for Max and his mother. After the intervention ended, the social worker continued to see the mother for several months while she was waiting for services for herself.

**Session 1**

In the first interview, Max said that he went to the clinic because his mother “had difficulties” and because he “wasn’t sleeping.” When he was invited to talk about the intervention, he did not have much to say. He said that it had helped but could not really say more, but added, “You can ask my mom.” He reported that he liked to play and did not like to talk. In the play situation (Figure 1 and 2), Max told the story of a boy named Brad, who was the little brother in a separated family and who went to the clinic with his mom because he was “angry all the time.” The MHP, Albert, was happy to help. He gave advice to the mother. The mother was thinking, “It’s really Albert that I need.” They continued going to the clinic forever. Everybody got old, the mother and Albert died, and Brad
continued to go to the clinic and became “someone who helps.” Then Brad died, and everybody was sad.

In the drawing (Figure 3), Max drew himself and the real MHP, Jane, sitting at a table and “talking together” at the clinic, and “smiling.”

Our analysis draws on the information gathered from the mother and MHP. First, it was reported that Max found it difficult to go to the clinic because he felt that it was “his fault” that they had to go. Even though his younger brother participated in the meetings, Max was the “designated patient.” Perhaps he hoped that the situation was the opposite and that his little brother would be seen as the one needing an intervention, and that he, the “big brother,” would not have to go. This could be the reason why Max chose “the little brother” as the main character of his story. This could also mean that he was not that comfortable talking to us about his experience of going to the clinic. Perhaps choosing a character who did not correspond to him (since he would have been the big brother) was less threatening, even if there were some similarities (separated family and consulting with the mother). Upon further analysis, we came to think that Max did, in fact, project himself into the character by imagining the story of a boy who is “angry all the time,” since, in reality, Max was described as having behavioral and aggressivity problems.

We can also ask ourselves if Max would have preferred a male MHP since the story featured a male MHP while his real MHP was a woman since both Jane (the real MHP) and his mother reported that Max was in need of male role models because all the important role models around him were women and his relationship with his father was difficult. The fact that in the story Albert was really helping the mother (giving advice) also corresponds to reality (both his mother and the MHP reported that, in the end, the intervention helped the mother a great deal).

Additionally, we see that there was identification with the MHP as an idealized role model. The main character, Brad, becomes “someone who helps” like the MHP, and appears to have been appreciated until the end of his life, since people are “sad” that he is dead.

The fact that Brad continues to go to the clinic all his life might also point to the question of the end of the intervention. Indeed, when we met Max, there were only a few meetings left in the intervention. Perhaps he found it difficult to end the relationship, as is often the case for children and parents, as well as for MHPs. The drawing could also support this since Max drew himself “talking and smiling” with the MHP. Could the fact that he drew himself alone with her also mean that he would have preferred an individual intervention? Both the mother and the MHP reported wishing that Max could have an individual intervention while also feeling ambivalent because Max, in his behavior, seemed opposed to the services.

Session 2

At the time of the second interview, the intervention had ended with Max, but was still going on with his mother. We invited Max to talk about the intervention retrospectively, given that his condition or ideas may have evolved. In the talking moment, Max reported again that before the intervention, his mother had “more difficulty” but added that he and his brother were “more unpleasant,” which was why they “were sent to the clinic.” He also explained that he was both okay and not okay with going to the clinic because, at first, his mother said they were going to the doctor, and he would like to have known the truth. He clarified that if she had told the truth, his mother would have said, “I am bringing you to see somebody who is going to help you to solve your behaviour problems because it’s a little annoying.” Max thought the meetings were “fine” and that the intervention helped, even if it was sometimes “painful” because he was hungry (the interventions took place after school). He explained that they stopped going to the clinic because “things were better.” He thought it was okay to stop because he “also likes to be a normal student.”
This time, in the play situation (Figure 4), Max invented the story of “a little girl” who goes “to see the lady” at the clinic with her father. The reason for consultation is that this girl is a “little wild” and “insolent.” “Together,” with the lady, “they try to find solutions for helping her.” Then, they “lock her up in the house for three days.” The father goes to the school to talk with the teacher, the police, the “lady” from the clinic, and a remedial teacher. He says to the police that “his little girl has to be arrested” because she is a “little wild” and says to the teacher that his daughter needs better services in school. The remedial teacher says she is going to take care of it. The little girl remains “all alone” in the house for three days; the father sleeps at school because “she is not allowed to see anybody.” After that, the school people, the police officer and the MHP talk “with the father alone, and then with the little girl.” Afterward, “they discuss all together, about the solutions there can be.” Then, the little girl goes to prison, after which “the problem is solved.” She feels good, has 100% grades in school and behaves well. They go back to see “the lady... once in a while.” Max explains that the lady’s profession is to help “little insolent people” and that she is a “mental doctor,” someone who “helps people in their brains, to solve their mental problems”; she is a “psychotrist” (invented word). The reason why the little girl was “like that” was that “her mom died.”

Acknowledging that this last detail was a very important one, we risked asking Max if the “little girl” had things in common with him. Max said “no” because his mom was not dead; he was experiencing “problems in his head”, unlike the girl who had real life problems.

For the drawing of a child going to the clinic (Figure 5), Max represented his mother standing, and himself and his brother sitting at a table with Jane, their MHP. In bubbles, Max represented thoughts: mom being happy, himself being “intrigued” and his brother thinking about a football player.

It appears that the second interview revealed more sensitive content directly about Max than did the first one; Max seemed to be a little more comfortable, and this was probably linked to the fact that this was now our third time meeting. More relational trust was perhaps built, allowing Max to feel less defensive and less influenced by a desire to please.

This interview also took place in a context in which Max was referred for an evaluation in child psychiatry. This might shed light on the “mental doctor” profile of the MHP. While the “solutions” found by the adults in the story are not quite appropriate, the story still represents some collaboration between different important actors in the life of the child protagonist, which we could think is based on Max’s experience. Nevertheless, we cannot help but feel a certain anger toward the adults of the story for their complicity in unfairly punishing the child, which is even more interesting if we go back to the first story that features a child who was “angry all the time.”

The drawing shows Max’s experience of not understanding why he was there in the first place. The drawing may represent how Max experienced the intervention in giving the impression that it was intended for the children (they are sitting with Jane, and he reports that he and his brother were sent to the clinic), and to please the mother (who is happy). This is interesting since we know from the MHP that Max felt that it was “his fault” that they had to go to the clinic, even though he also said that they went to the clinic because his mother had “difficulties,” and we know that the intervention really helped the mother. This might illustrate the confusion children can experience in a mental health intervention, rationally “knowing” or being told something, but feeling confused, nonetheless.

Discussion

Our example gives a glimpse into how we can access many dimensions or layers of voice by using a combination of clinical and arts-based approaches. Some aspects were expressed
directly by Max, like his dissatisfaction with not knowing where he was going when he went to the clinic, but some content was subtler and required a higher degree of interpretation and an understanding of converging information. For instance, this applies to what we envisaged as a wish regarding his relationships with male figures. Even though this might be subject to debate, we think it might be of central interest since our clinical and research experience also often highlights gender-related issues, expressed through play or drawing rather than verbally, which is also important as we have argued. Perhaps this was the only way in which Max could express what he felt about his father and about his need for a male presence, since the relational context may have also played a role especially in an interview setting (see Morison et al., 2000) in that the interviewer was female and the mother was present.

While a general clinical perspective over the two sessions would underscore the positive process of Max’s going from wishing for the power to change things (“becoming someone who helps the mother”) unfortunately not achievable for now, to something closer to acceptance of a difficult reality (“living while mom is not always there as much as needed, and experiencing problems”), we can see more socio-cultural layers to Max’s voice. For instance, the first interview material (the story of Brad and the drawing at the CLSC, with this initialism in huge capital letters), might speak to the importance of the mental health institutions and workers for a child confronted with emotional and behavioral difficulties in our society. Furthermore, material from the second interview (the story of “the little girl,” the “psychotrist” character, the “confused” drawing and the claim Max makes that he has “problems in his head”), could be seen as an expression of how a child can feel in a culture in which human suffering is understood through knowledge and theories based on the notion of mental health.

This wider understanding is facilitated by the contribution of arts-based perspectives that allow us to look at the material as if it were artwork expressing human issues. This voice is neither exclusively verbal nor exclusively individual to the child or to the researcher since its intention is to transcend a subjective perspective. As McNiff (2008) has suggested, “Art is characterized by consistent formal patterns and structural elements that can be generalized beyond the experience of individuals” (p. 6). Furthermore, Gadamer (1996) has reminded us that the experience of art is truth revealing (on the side of the artist and of the viewer) since artwork detaches itself from its author to come into its own being. Hence, beyond the child expressing something personal in art activities, the world we live in expresses itself through art.

**Arts and Play as an Ethical Practice in Interview Settings**

At the end of the first interviews, we had this conversation with Max.

Researcher: How did you find participating in the research?
Max: Cool!
Researcher: What did you find cool?
Max: Playing and drawing.

This use of “cool” allows us to think that this other kind of what we might think of as voice space had a positive value for Max. Clinicians, as well as researchers working in the area of drawing in arts-based participatory visual research, have emphasized the importance of participants’ ability to represent visually what is difficult to put into words (Morison et al., 2000). Given the complexity of Max’s everyday world and the weight of the feelings that we can imagine he might experience, the idea of creating art and manipulating play objects seems crucial. He did mention that during the intervention, he liked to play and did not like to “just talk.” Another positive sign is that Max was evidently happy to participate in the second interview and shared more than he had in the first one.

Since an ethical posture involves questions about what is right in relationship to the other (Caldaïrou-Bessette et al., 2017; Ricoeur, 1990), an aspect of the ethical question about our approach is answered by what Max did not say directly, but showed, instead, through his participation.

The literature addressing ethical issues in research with children underlines the need to address the issues of power, confidentiality, and informed consent (Kirk, 2007). Yet, arts-based work and play, in a “transitional space” (Winnicott, 1971) between imagination and reality, allows us to navigate these issues in a way that is both empowering for the child and that does not artificially transform our respective positions as adult and child. With the arts-based research and play, the child has more power to shape the interview and could even have the power to invalidate our interpretation, which has its own ethical value (see Caldaïrou-Bessette et al., 2018).

In addition to generating insightful data, these creative activities during the intervention provided a simple and pleasant way for the MHP, Max and his mother to be together, thus creating a space in which a relational ethic could be realized.

**Figure 5.** Max, his brother, his MHP (sitting at the table) and his mother (standing) at the clinic.
The Necessary, Creative and Ethical Participation of the Researcher

Given that we were interested in exploring the usefulness of a clinical and arts-based approach in research with children, we need to think through the question, “So what does this add?” If our concern is about (re)conceptualizing the significance of children’s voices, what does an arts-based framework for looking at play and drawing add to the discussion? We think that one of the most important contributions is that it might engage the researcher reflexively, creatively, and ethically in research into the construction of knowledge (see Akesson et al., 2014; Boydell et al., 2012; Chamberlain et al., 2018; Higgs, 2008; McNiff, 1998; C. Mitchell et al., 2011).

As highlighted by Akesson et al. (2014) in their consideration of the ethics of working with children in arts-based research, the participation of the researcher is ever present in the interpretation and in the answers to the two questions: “Whose knowledge is this?” and “Whose truth is it?” both of which raise many ethical and methodological issues. Perhaps what has not been acknowledged sufficiently in the literature is the role the researcher plays.

Since children’s voices are by nature “messy, multilayered and non-normative” (Spyrou, 2011), in order to make children’s voices intelligible to the academic reader, the researcher has to go through a sort of translation and reconstitution process to interpret and present results given that the academic world is a verbal, logical, and linear one, which can be far removed from that of children. In the process of this translation and reconstitution, the researcher has no other choice but to participate with her or his own voice. We could compare this to the interpretation process of a piece of art, as a signer or an actor would interpret the work of another. The issue here is the imperative to represent well what we think the work tried to communicate (since we cannot ever know the intention of the creator) while drawing on a personal understanding that will lead to what might be thought of as a good interpretation. The question is this: “How can we represent children’s voices well enough?”

Literature on quality and trustworthiness in qualitative research argues for the researcher’s self-reflexivity (McPherson & Thorne, 2000; Spyrou, 2011), throughout the relationship (Goldstein, 2016). Interpretation of our findings entails a responsibility for these relationships and a humble recognition of our position as adults and as researchers. Rather than artificially trying to transform this relationship, taking responsibility is acknowledging the “subordinate role of children to adults in the research encounter” (Spyrou, 2011, p. 154) and using our powerful position by doing something worthwhile with what we heard and with who we are. As adults, we should defend children’s right to express their voice, to be heard and recognized as worthy. As McPherson and Thorne (2000) have argued, part of our ethical responsibility as researchers is to advocate for children’s voices.

Since we cannot help but participate in the construction of children’s voice in research, an ethical and reflexive posture of humility and respect for children is crucial, with real care for their condition and genuine engagement in defending and representing their perspectives as justly as we can.

Conclusions and Implications

In presenting the example of Max and our accompanying reflections, we have attempted to illustrate some avenues for generative and ethical qualitative research with children in an interview setting using a clinical and arts-based approach.

Generally, we recommend prudence in the interpretation of children’s voice, especially when less data is available; indirect or projective material may need more complementary data to be interpreted accurately. As we have seen, indirect artistic activities provide a non-intrusive method that is sensitive to the intricacies of the researcher-participant relationship, thus creating a more comfortable space for children to express themselves in an interview with an adult stranger (and sometimes in the presence of their parents).

We must also highlight the role of prior training and experience (Morison et al., 2000). Indeed, being trained and having experience with interviewing children can have a major influence on the capacity of the researcher to interpret and represent children’s voices. Also of central importance is the fact that we must take time to listen, reflect, and make sense of the data (Spyrou, 2011).

The voice of children has the power to touch and transform us, but we must make the effort to hear this voice. A clinical and arts-based approach seems to offer opportunities for children to express themselves and for researchers to listen both ethically in an interview setting. It also appears to provide sound ways to engage and include children in research and make their voice heard. However, this also requires a significant and personal engagement of the researcher to support and understand the participation of children. And finally, researchers responsibility should include advocating for children’s perspectives, as these perspectives are the most valuable source of information to improve children’s wellbeing, and contribute to a better human world.

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ORCID iD
Prudence Caldairou-Bessette https://orcid.org/0000-0003-4868-2066

Notes
1. For example, Human Figure Drawing (Skybo et al., 2007), Family Drawing (Corman, 1978), House-Tree-Person (Buck, 1947)
2. For example, Patte Noire [Black Paw] Test (Corman, 1976), Doll Play (Woolgar, 1999), Sand Play (Lacroix et al., 2007)
3. And more broadly, anything the child does
4. See the Funding section for more details
5. Max is not the only boy in the study who had a female MHP but drew a male one when he was drawing imaginary characters.
6. A first meeting took place before the interviews, as part of the quantitative segment of the larger project
7. Researchers who can sometimes also be clinicians, as was the case in this study.
8. This is always ethically preferable to playing the role of ventriloquist

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