

Factors Affecting Mothers' Satisfaction With Expressive And Creative Therapy Provided To Adolescents With Learning Disabilities: Self-Efficacy, Stress And Duration Of Therapy

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ABSTRACT

In view of the paucity of evidence on satisfaction with expressive and creative therapy among mothers to adolescents with learning disability in the context of special education schools, the present study examined the relationship between mothers' satisfaction with therapy and two psychological measures – self-efficacy and stress. Satisfaction was also examined in relation to duration of therapy. The sample comprised 54 mothers to adolescents with LD who were in therapy for at least one year. Data was collected via five structured questionnaires. The findings reveal that satisfaction with therapy in general was positively related to mothers' self-efficacy and negatively related to level of stress, whereas perceived effectiveness of therapy was not related to the two psychological measures. Duration of therapy, on the other hand, was positively related to perceived effectiveness of therapy but not related to satisfaction with therapy in general. 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 self-efficacy, parental stress, duration of therapy, adolescents, school children, learning disabilities.

INTRODUCTION

Expressive and creative therapy (E.C.T) is a therapeutic technique that began to develop in the 1940s. This therapeutic domain encompasses a variety of artistic specialties: art therapy, music therapy, drama therapy, movement therapy, psychodrama and bibliotherapy. Similar to any other mental therapy, the main purpose of the therapy is to improve the client's emotional, physical and functional state. Expressive and creative therapy (E.C.T) is utilised directly as a healing expressive tool and indirectly combines use of psychotherapeutic tools (Malchiodi, 2012; McNiff, 1992). Use of expressive tools enables the client to connect experiences in the internal world to those in the external world, experiences that often cannot be expressed in words.

The therapy uses the language of art, which serves as a tool for growth, personal progress, and further on insights (Amir & Or, 2005; Case & Dalley, 2014). E.C.T is common at present in a wide range of settings, from pre-schools and primary schools to hospitals and mental health centres, and

is applied as a therapeutic and diagnostic tool (Malchiodi, 2003). E.C.T is recommended for a variety of populations: both those who find it hard to express their feelings verbally and those with good verbal skills. The expressive therapeutic process bypasses the need for words and facilitates many insights (Rubin, 2016).

Due to the uniqueness of expressive and creative therapy (E.C.T), in recent decades efforts have been made to integrate it in a variety of educational settings. Children and adolescents coping with emotional and academic difficulties experience their world as one that suffers from a lack of order and organisation. As a result, their ability to express their experiences in words is diminished. E.C.T utilises additional communication and visual channels that can help them express their feelings (Safran, 2002). Educational systems around the world have identified the significance and range of benefits that E.C.T brings to the educational space and various schools have begun to use therapy as another support tool (Cortina & Fazel, 2015; Snir & Regev, 2018). E.C.T in the school lets school children with a variety of emotional, academic and functional difficulties connect with their creative side and express their experiences and difficulties in a different way, as not enabled by any other therapeutic process. The therapeutic interventions provide a response to emotional and academic needs aimed at support, rehabilitation and hope, by means of the creative tool (Abramovski & Fogel Simhony, 2019).

Within the school expanse, understanding and awareness of the significance of including parents in the therapeutic process have increased in recent years (Ishai-Karin, 2004). Parent attitudes to their child's treatment are directly related to their parental attitude, both at the basis of their self-concept as meaningful and main figures and consequently in the implications regarding their involvement in therapy (Abramovski, 2020; Oren, 2012). The parents' encounter with special education settings is complex and encompasses many varied difficulties. As a result, the emphasis on the encounter between the parent and adolescents on one hand and the educational therapeutic elements on the other has been expanded (Ishai-Karin, 2004; Greenbank, 2016). When a pupil is placed in special education, the parents naturally bear a sense of guilt about his or her condition. Sometimes others in the parents' environment also create guilt feelings and thus increase the parents' distress (Hagai & Hagai, 2014).

Parents' satisfaction with their children's school-based therapy depends on a variety of factors: the child's (client) features, the therapeutic method, the therapist's features and the parents' features. The current study focuses on two parent features: one is cognitive – parental efficacy, and the other mental – level of stress. In the following part these two topics shall be reviewed.

Parental Efficacy

Perceived self-efficacy refers to belief in one's ability to successfully perform a certain task. Parents' belief in their self-efficacy is their perceived ability to fulfil their role and confidence in performing parental tasks. High self-efficacy regarding spousal relations and parenting was found associated, respectively, with better adjustment to parenting and with the quality of the parent's functioning in the family (Bandura et al., 2011). According to the basic principles of Bandura's self-efficacy theory, the parent's self-efficacy includes the parent's knowledge of child rearing as well as the parent's confidence in his ability to maintain the behaviour expected of him or her (Bandura, 1977). Parents' coping with raising children with special needs is a process that requires a dialogue between the parents' abilities, conduct and recognition between the internal and external powers.

The parents have a need to constantly reduce and expand their resources according to the requirements and situations with which they must contend (Al-Kandari, 2005). Parental efficacy is a developmental, acquired and gradual process whereby any mission, challenge or fault in their parenting can contribute considerably to shaping their level of efficacy. The parent's encounter with adolescents who has learning disabilities and emotional difficulties might generate an experience of failure with regard to parenting.

A parent's encounter with an adolescent who has learning disabilities can shape the parent's efficacy either positively or negatively (Oren, 2012). Past experience with the therapeutic field has a considerable impact on parental efficacy. Positive past experiences associated with success raise parental efficacy and future expectations of therapy and of the therapist (Hoffman, 1984; Sutton & Hughes, 2005). In contrast, a succession of failures resulting from the encounter with the therapeutic world can reduce the parent's level of self-efficacy (Bandura, 1993).

Parental Stress

The medical term "stress" was coined by the endocrinologist Selye (1955, 1976). He claimed that a strain is formed between external situations and demands (pressure) and physical processes (tension). The parameters for assessing pressure and tension are based on the medical research approaches in the fields of physiology and psychobiology. The psychological theory surrounding stress was defined earlier by Lazarus (1966). He coined two major psychological variables: appraisal: i.e., one's ability to give meaning to an event experienced, and coping: the effort one puts into thinking or acting in order to deal with what is expected of him in an event. The most common definition of stress over the years refers to the result of an interaction between people and their environment when coping resources required are beyond those at their disposal (Lazarus, 1990). With regard to parental stress, the prevalent definition at present relates to the difficulty stemming from the requirements involved in being a parent (Anthony et al., 2005).

Any factor that leads to change in the balance within the family system might generate stress. When the complexity of the difficulty involved in being a parent is joined by the parameter of the birth of a child with special needs, the stress level might rise significantly. Degree of stress is assessed by the degree of threat brought to bear on the family (McCubbin, 1993). Measures of parental stress were examined with a variety of parents who have children with special needs (autism, cognitive difficulties and so on). Notably, each child is characterised by a different impairment directly related to his or her disability, and these have a direct relationship to intensifying parents' stress levels (Esdaile & Greenwood, 2003). In addition, it should be noted that external variables, i.e., cooperation with professionals and social support, have an impact on the level of stress (Scorgie et al., 1998).

Satisfaction With Therapy

In recent decades new trends are apparent in the health field, trends that focus on consumers' point of view and emphasise the significance of client satisfaction measures. These measures help shape the decision making of health suppliers (Kessler & Mroczek, 1995). There is almost no measuring of client (patient and family) satisfaction with mental health services, both in public systems and in private systems. Measuring consumer satisfaction is inexpensive, efficient, and usually provides a real good quality reflection of the service provider (Edlund et al., 2003). Mental health consumers are vague and disagreed as to the significance and meaning of satisfaction. The question is to what degree is satisfaction with treatment directly related to changes in clients' clinical symptoms or

functioning (Garland et al., 2003). Some studies indicate that satisfaction with treatment is not related to improvements in clinical functional measures (Garland et al., 2003; Kaplan et al., 2001). Then again, others contend that symptomatic functional change has crucial significance for measures of satisfaction with treatment (Fontana et al., 2003; Liao & Sukumar, 2005). Assessing satisfaction among adolescents is challenging due to the complexity characteristic of adolescence and its implications. There are few studies on satisfaction with the treatment of adolescents (Weisz et al., 2005).

It is usually the parents who urge their children to receive emotional therapy. Nevertheless, surprisingly, there are only a handful of studies on parent and adolescent satisfaction with mental health services. Since in most cases the parents are the factors involved in their children's therapy programs, measuring parent satisfaction is very important (Barber et al., 2006; Garland et al., 2000; Godley et al., 1998). Another aspect of satisfaction with therapy focuses on the parent's contact and communication with the therapist. When parents feel that they are not supported by their child's therapist and that there is no communication with the therapist, this increases parental frustration and as a result dissatisfaction with therapy and with the therapist (Baker-Ericzén et al., 2013). The parent's experience of the therapist's attitude as positive or negative often shapes the parent's satisfaction (Laszloffy, 2000). With regard to measuring parents' satisfaction with emotional therapy within the education system, no mention was found in the professional literature.

In view of the increasing use of E.C.T in general, and for children within of special education schools in particular, on one hand, and the paucity of empirical evidence concerning this phenomenon on the other, the present study aims to examine a major aspect of this therapy. The study focuses on the satisfaction of mothers whose children are adolescents in special education schools, with E.C.T. The mothers' satisfaction was predicted by a cognitive aspect - self-efficacy, a psychological aspect - stress level, and a therapy-related dimension - duration of therapy. The mothers' satisfaction was studied via two dimensions: satisfaction with therapy in general and satisfaction with the specific therapy provided to their children (perceived effectiveness). Two research questions were derived from this aim:

1. What is the relationship between self-efficacy, stress level and duration of therapy, and satisfaction with therapy in general?
2. What is the relationship between self-efficacy, stress level and duration of therapy, and perceived effectiveness of therapy?

Three hypotheses were derived from these questions:

The first hypothesis postulates that participants' higher levels of self-efficacy will be associated with higher levels of satisfaction with therapy as assessed by the two measures.

The second hypothesis postulates that participants' higher levels of stress will be associated with lower levels of satisfaction with therapy as assessed by the two measures.

The third hypothesis postulates that participants' satisfaction with therapy as assessed by the two measures will be positively related to therapy duration.

METHODOLOGY

Research Design

The research was conducted in a quantitative design, using a correlational approach, examining phenomena as they appear in nature with no interference by the researcher.

Participants

The sample was comprised of 54 Hebrew speaking mothers of children aged 14-18 (grades 9-12), 32 boys and 22 girls, whose children have learning disabilities and have been receiving expressive therapy for at least one year. The religiosity of the participants was mainly secular (59.3%) or traditional (37.0%), where only two participants (3.7%) referred to themselves as religious. Forty participants were married (74.1%) and the rest were living with no partner because they were either divorced (20.4%), single (3.7%) or widowed (1.9%). Additional characteristics of the participants are presented in Table 1.

Table 1: Characteristics of the participants (N=54)

	M	Med	SD	Min	Max
Education Years	14.06	12.5	2.65	10	22
Number of Children	3.09	3.00	.94	1	5
Years in Current School	3.65	4.00	1.05	2	6
Years in Treatment	2.91	3.00	1.15	1	5

The study was conducted at two large special education schools, one in central northern Israel and the second in northern Israel. (Special education schools are defined for adolescents with learning disabilities who face a variety of pedagogical difficulties such as: Reading, Writing, Speech, Mathematical reasoning.)

The two schools are located in areas characterized 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 Tools

Sociodemographic background questionnaire

The questionnaire included sociodemographic (SES) information related to the family and to the mother's level of education, profession, ethnicity and socioeconomic status. In addition, it included details related to the child (such as the child's age, gender, reason for referral, classification of learning disability, referring element, duration of expressive therapy within the school and more).

Early Intervention Parenting Self-Efficacy Scale (EIPSES)

The questionnaire was developed by Guimond, Wilcox and Lamorey (2008) and translated into Hebrew by Goldberg (2012). The questionnaire assesses to what degree mothers believe that they have the ability to influence the achievements of their children's intervention program and to advance their development. (e.g., "I feel that I can cooperate well with my child's therapists and be part of them"). The questionnaire was comprised of 16 items ranked on a 7-level scale ranging from 1 (strongly disagree) to 7 (strongly agree). The score on the questionnaire was generated by

calculating the mean of the items. Internal consistency of Cronbach's $\alpha = .80$ was found for the English language questionnaire (Guimond et al., 2008) and .86 in the current study.

Parenting Stress Index/Short Form - SF/PSI (Abidin, 1995)

The questionnaire was developed in English by Abidin (1995) and translated into Hebrew by Weisel, Most and Michel (2007). The questionnaire consists of 36 items, ranked on a five-point scale ranging from 1 (strongly disagree) to 5 (strongly agree) (e.g., "I often feel that I can't handle things well"). The questionnaire has internal consistency of Cronbach's $\alpha = .95$ in the current study.

Satisfaction and Estimation of Progress Questionnaire (Kopelman-Rubin et al., 2011, 2012); 'Perceived effectiveness'

In this questionnaire, parents were asked about different aspects of I.C.S = "I Can Succeed". (duration, frequency of session, the most important topic and most unimportant topic), whether they found I.C.S useful and whether they would recommend I.C.S to a friend considering such an intervention. The I.C.S questionnaire consists of 23 items ranked on a seven-point Likert-type scale ranging from 1 (very big deterioration) to 7 (very big improvement), (e.g., "As a result of my child's participation in expressive and creative therapy at school I think that changes are evident in his/her emotional functioning") and four yes/no questions (e.g., "Does your child receive additional therapies beyond that provided at school"). The questionnaire has internal consistency of Cronbach's $\alpha = .94$ in the current study. A general score was computed by averaging the responses to all the items.

Attitudes toward Seeking Professional Psychological Help - Short Form ATSPPH-SF (Fischer & Farina, 1995); 'satisfaction with therapy in general'

This questionnaire measures attitudes toward seeking professional psychological help. The questionnaire was developed by Fischer & Farina (1995). It was translated into Hebrew for the present study by the author, who is an art therapist, using the procedure of back-translation. It includes 10 items on a four-level scale ranging from 1' (disagree) to 4 (agree) (e.g., "I would want to get psychological help if I were worried or upset for a long period of time"). The ATSPPH-SF score yielded a coefficient Cronbach's alpha of .84.

Research Procedure

At first, the researcher approached the school principals to receive approval to conduct the study, as required by the procedures and by the customary ethics principles. After receiving approval, the researcher approached teachers at the school, 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. Mothers who gave their consent to participate in the study were sent an informed consent form by return e-mail, and then a meeting was held at the school at the parents' convenience. The meeting was attended by the researcher and the mother.

At the beginning of the meeting, each mother was assured that she is entitled to cease her participation in the study at any moment, and the issue of confidentiality and research ethics obligation was clarified. The mother was also assured that her identifying details would not be presented at any stage of the research. The researcher himself administered the self-completion questionnaires to the mothers. Each questionnaire included an explanation of the study's purpose

and contribution. Time for completion of the questionnaire was approximately 30 minutes. In some cases, questionnaires were distributed to mothers in hard copy by mail or were distributed to their children by the homeroom teacher. Additionally, the mothers were given the option of completing the questionnaires by means of a digital questionnaire prepared and distributed to them.

Data Analysis

Descriptive statistics yielded means and standard deviations. Relationships between the variables were investigated using Pearson's correlation coefficient. Regression analyses to model expectation levels were carried out with the SPSS program (version 25).

FINDINGS

Descriptive statistics

Means and standard deviations of the research variables were computed and the results are presented in Table 2.

Table 2: Descriptive statistics of the research variables

Research Variable	Range	M	SD
Parenting self-efficacy	1-7	4.80	1.01
PSI general	1-5	2.36	.73
Perceived effectiveness of therapy	1-7	4.96	.89
Satisfaction with therapy in general	0-3	2.28	.62

The results presented in Table 2 shows that the level of self-efficacy is moderately-high; the level of the different measures of stress are generally medium; the level of the two measures of satisfaction are moderately-high.

Testing Of The Hypotheses

The First Hypothesis

Postulated that participants' higher levels of self-efficacy would be associated with higher levels of satisfaction with therapy. To test this hypothesis, Pearson coefficients of correlations were computed between parental self-efficacy and the two measures of satisfaction with therapy. A medium-high positive correlation was found between self-efficacy and satisfaction with therapy in general ($r_{(52)} = .60, p < .01$). Thus, mothers with higher levels of self-efficacy tended to be more satisfied with the therapy. In addition, no significant correlation was found between self-efficacy and perceived effectiveness of therapy ($r_{(52)} = .25, p > .05$). The results show that the first hypothesis was partially supported.

The Second Hypothesis

Postulated that participants' higher levels of stress would be associated with lower levels of satisfaction with therapy as assessed by the two measures. To test this hypothesis, Pearson coefficients of correlations were computed between the four measures of stress and the two measures of satisfaction. Table 3 presents the results.

Table 3: Correlations between stress and the two measures of satisfaction (N=52)

	Perceived effectiveness of therapy	Satisfaction with therapy in general
PSI General	-.22	-.51**

* $p < .05$, ** $p < .01$

Table 3 reveals significant negative correlations between all the PSI stress levels and satisfaction with therapy in general. As can be seen in the table, all correlations are medium. Thus, as expected, mothers who reported higher levels of stress, exhibited lower levels of satisfaction with therapy in general. In addition, no significant correlations were found between the measures of stress and the perceived effectiveness of therapy. Thus, this part of the hypothesis was not supported.

The Third Hypothesis

Which postulated that participants' satisfaction with therapy as measured by perceived effectiveness of therapy and satisfaction with therapy in general, would be positively related to therapy duration. To test this hypothesis, Pearson coefficients of correlations were computed between the two measures of satisfaction and the duration of therapy. The results show that this hypothesis was partially supported. Duration of treatment was positively related to perceived effectiveness of therapy ($r_{(52)} = .33, p < .05$). Thus, mothers whose children were treated for a longer duration tended to be more satisfied with the progress of the treatment. In addition, no significant correlation was found between satisfaction with therapy in general and duration of therapy.

Quality Of Parenting

In addition to testing the research hypotheses, the relationship between parental self-efficacy, level of stress and the two measures of satisfaction, and perceived quality of parenting was also examined. Perceived quality of parenting was measured by the parental stress questionnaire: The mothers were requested to evaluate their quality as parents via a four-level scale (see Table 4). A one-way analysis of variance was conducted, comparing the four levels of perceived quality of parenting, with self-efficacy, level of stress and the two measures of satisfaction, as dependent variables. The results are presented in Table 4.

Table 4: Comparison of the study measures and quality of parenting

	Very good parent (n=16)		Above average parent (n=14)		Average parent (n=14)		Some difficulty at being parent (n=10)		F
	M	SD	M	SD	M	SD	M	SD	
Parenting self-efficacy	5.48	.54	5.22	.80	4.70	.60	3.25	.57	27.79***
PSI general	1.74	.32	2.17	.54	2.53	.55	3.37	.39	26.84***
Perceived effectiveness of therapy	4.97	.97	5.15	.92	5.08	.76	4.54	.91	1.02
Satisfaction with therapy in general	2.47	.46	2.59	.39	2.34	.56	1.45	.50	12.87***
*** $p < .001$									

The analysis yielded significant differences in three measures: Mothers who perceive a difficulty with being a parent had significantly lower parental self-efficacy, significantly higher levels of stress and significantly higher satisfaction with therapy in general. They were not significantly different from the other groups in their perceived effectiveness of therapy.

DISCUSSION

The purpose of the study was to examine the relationship between parental self-efficacy, stress levels, therapy duration and satisfaction with therapy in mothers of children with learning disabilities who receive expressive and creative therapy (E.C.T). Self-efficacy was positively related to satisfaction with therapy in general, indicating that higher levels of parental self-efficacy among

mothers who have children with learning disabilities were related to higher levels of satisfaction with therapy in general. However, their parental self-efficacy was not related to their perceived effectiveness of therapy. This finding was validated by the relationship of the two measures of satisfaction with another measure – quality of parenting. Mothers who reported some difficulty with being a parent showed a lower level of satisfaction with therapy in general, but were no lower than other mothers on perceived effectiveness of therapy. This finding is innovative because client and parent satisfaction has very rarely been measured in public mental health systems (Edlund et al., 2013). In Israel's educational system, and particularly in the therapeutic field, the satisfaction of adolescents and their parents with school-based E.C.T has not been measured.

The positive relationship between self-efficacy and satisfaction with therapy in general can be explained by the claim that mothers with high self-efficacy develop high expectations of therapy. This creates a dynamic that fundamentally motivates experiences of success and of satisfaction with therapy. When parents have high parental efficacy, their subjective experience facilitates the therapy's success and increases satisfaction with the process and with the outcomes of their child's therapy. It is possible to observe the finding brought in the context of the "Pygmalion" effect phenomenon (Jussim, 1986), where high parental efficacy is associated with high expectations of therapy and predicts the actual success of the therapy.

High parental efficacy, in addition to perceiving therapy as beneficial, positive and enabling mutual communication between the therapist and the parent, often shapes the parent's satisfaction with the therapy (Hart et al., 2007). With regard to the mother's therapeutic relationship with the therapist, it may be hypothesised that high parental efficacy is unconsciously projected on the therapist and thus ascribes to the therapist a higher potential ability to succeed than among mothers with low parental efficacy.

Another psychological aspect that should be noted may point to an association between high satisfaction of parents with therapy and parental efficacy. In order for parents to avoid experiencing a narcissistic wound (Engelhard, 2016), a defence mechanism is generated, where the parent expects high results from the therapy in advance in order to avoid encountering experiences and feelings of disappointment and frustration with regard to the child's therapy, which are projected on the parent's inner world.

The lack of the hypothesised association between parental efficacy and perceived effectiveness of therapy can be explained through the mother's internal reality and external reality (Casement, 2013). In the mother's subjective experience and in her internal world, in the case of positive prior experience with therapy this enhances satisfaction. In addition, when the perception is that emotional therapy can succeed and help the mother, this facilitates the capacity of affecting and controlling the success of the therapy. In contrast, in the external reality when the mother must assess her child's progress, she has very little influence.

The mother is unable to directly influence the child's responses or beliefs and, as a result, the therapeutic process. Parental efficacy can have a direct and personal effect on the parent but not necessarily on the child. The child's realistic difficulties with the learning disability significantly reduce the mother's satisfaction with the therapy, which is not under her control. A possible implication of the lack of association is evident in the parent's communication and relationship with

the child's therapist, considering the significance of the therapist-parent relationship and communication as stressed in the professional literature (Godley et al., 1998). When parents' experience includes no support or understanding of their situation by the therapist this has a negative effect on their attitude to the therapist and may even at times generate resistance to therapy. All these were found to be significant factors related to parents' satisfaction with therapy (Baker-Ericzén et al., 2013; Laszloffy, 2000).

The study of parental efficacy as related to satisfaction with therapy has practical significance. Various factors that affect parent satisfaction are unchangeable (the intensity of the child's disability, environmental factors, socioeconomic factors and others). In contrast, parental efficacy can be influenced. Mothers contending with their child's learning disability often experience frustration, lack of control, anger and more. All these might hamper their faith and parental efficacy. Creating and forming a space that facilitates high parental efficacy will strengthen the parental capacity to handle a variety of difficulties, which will lead to higher involvement in therapy and, as a result, to higher parent satisfaction with the therapy.

Stress level was positively related to satisfaction with therapy in general, indicating that mothers with a higher level of stress exhibit lower satisfaction with therapy in general. However, their level of stress was not related to their satisfaction with the perceived effectiveness of therapy. The research literature indicates the hardships that stem from the difficulty of being a parent, the consequences and demands that lead to many changes in the balance within the family system (Anthony et al., 2005). The higher the levels of stress, the lower the faith in therapy. Pressure weakens all the physical systems and does not allow the individual to utilise internal resources. Stress reduces the parent and makes him or her more vulnerable. High levels of stress lead to a continuous state of failure experiences.

The ability to hold optimistic views diminishes considerably, leading and shaping negative thinking. When these various difficulties are joined by the child's disability and the child's functional decline in a range of aspects, the stress level rises and as a result satisfaction with therapy might also drop considerably.

The lack of association between stress levels and perceived effectiveness of therapy can be explained by the mother's limited ability to directly affect the therapy's progress or the child's responses. The findings regarding mothers' level of stress are connected to the concept of "locus of control". Locus of control denotes the degree to which people feel that they have influence/control over the results of their behaviour (Phares, 1976). We suggest that in the process of shaping attitudes to therapy in general, an internal locus of control is in action.

The mother feels and acts in the understanding and belief that she has control over her inner world and that she has access to a variety of emotional, cognitive and behavioural tools. As a result, her satisfaction with the therapy is higher. In contrast, in the case of attitudes towards outcomes of the child's therapy the mother's ability to influence the child's various behavioural, emotional and intrapsychic functions is lower. In this state of affairs, the external locus of control is the main active mechanism.

Duration of therapy was not related to mothers' satisfaction with therapy in general. However, it was related to their satisfaction with the perceived effectiveness of therapy, such that the longer the duration the higher the satisfaction with the effectiveness of therapy. A possible explanation for the lack of association between the duration of therapy and satisfaction with therapy in general is that mothers' intrinsic attitude to therapy is part of their set of beliefs. These are stable conceptions that were forged over many years. In contrast, perceived effectiveness of therapy refers to the specific therapy provided to the child at school. The findings demonstrate that the duration of therapy is related to progress in the child's functioning from the mother's point of view.

The duration of therapy provided to the child, lengthy exposure to therapy, creates a change in the child's inner world, which leads to an external change (emotional, behavioural, academic and social) that is projected and affects the parent's well-being and inner world. All these affect the child's home, school and environmental systems and as a result raise mothers' satisfaction. The proposed process can be associated with the ecological model (Bronfenbrenner, 1979). According to this model the client develops and grows in an environment consisting of interrelated systems. Improvement in the child's inner world will affect his or her external world and functioning, which will affect the emotional climate of the parents and family. Of course, in wider circles there will also be an effect on the educational and environmental system.

The findings of the current study can illuminate the discussion of an essential topic in the field of mental therapy concerning the differences between short-term and long-term therapy. This topic has special meaning for treatment provided within the public health system (Lorentzen et al., 2018). The current study contains two conditions that make it hard to maintain changes that can affect parent satisfaction. The first condition is adolescence (Phinney, 1993), in itself is a complex developmental mission that demands much energy and resources from the adolescent and his or her surroundings. The second condition is the learning disability, which also contains quite a few emotional elements (Petti et al., 2003). These two components raise the need for a more lengthy therapeutic experience. The school environment facilitates maintenance and conditions for change that will begin with the child and consequently filter into wide circles.

Treatment of adolescents includes working with many elements of resistance and avoidance. Use of the medium of E.C.T helps circumvent the resistance that is particularly characteristic of verbal therapy. The very existence of long-term therapy facilitates deep processes and insights. E.C.T contains at times two stages: The first is a word-evading form of expression that provides room for processing feelings, sensations and thoughts (Malchiodi, 2012). The second enables reaching meanings and insights. Work within the school over several years can enable processing and process, which may explain mothers' satisfaction with therapy.

The study also indicated that long-term therapy has two other aspects pointing to high levels of maternal satisfaction with therapy. The first aspect relates to the point that when there is communication and connection between the therapist and the mother, she can share and consult with the therapist in routine times as well as in times of crisis, receiving counselling, direction and tools. This is compatible with the research literature in this field (Odhammar & Carlberg, 2015). The second aspect is related to, influenced by and dependent on the therapeutic alliance (Horvath & Luborsky, 1993) formed between the therapist and the client. The quality and depth of the client-therapist connection often project on the mother's satisfaction. In long-term therapy, when both the

above aspects exist, the mother feels that there is another figure who is taking part in “raising” the child. In this state of affairs satisfaction increases, the mother feels calmer and there is a sense of full partnership that raises the mother’s satisfaction with the therapy.

This finding is innovative because to date, the association between the duration of therapy and mothers’ satisfaction with the outcomes of expressive and creative therapy in the educational system and specifically in special education schools has not been explored. Israel’s Ministry of Education defines therapy in special education schools as short-term therapy for one year. In practice, expressive and creative therapy at special education schools can continue for many years based on the considerations of the school or considerations arising from the therapy, and of course the pupil’s desire to continue therapy. As a result, adolescents are given the option of long-term therapy lasting many years.

No reference was found in the research literature to mothers’ satisfaction with short- or long-term therapy. With regard to the literature’s reference to differences between short- and long-term therapy, long-term therapy was indeed found to be more efficient than short-term therapy. Nonetheless, compared to short-term therapy most measures indicate that the influence and differences between the two types of therapy are relatively small (Horn et al., 2015; Lorentzen et al., 2018).

Despite the disagreements in the research literature concerning the differences between satisfaction and the effectiveness of short-term therapy versus long-term therapy, it is clear that in the school the very existence of long-term therapy in adolescence increases mothers’ satisfaction with the therapy. In order to maximally adapt the therapy to the type of client and reach thorough insights, it is important to identify the causes of referral for therapy, the symptoms to be treated, to continue finding and improving the measures for which the client is in therapy in order to adjust the duration of therapy accordingly (Knekt et al., 2016).

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

1. The research population consisted of mothers with adolescents who have learning disabilities, and not fathers. It is to be assumed that differences would be found in the attitudes, intentions, expectations and perceptions of mothers and fathers towards therapy and the therapist. There is a difference between mothers and fathers in various psychological processes, i.e., levels of efficacy, stress and others. It would be desirable to hold a future study that would compare between mothers and fathers with regard to satisfaction with therapy in general and with the therapy provided to their child.
2. The current study focused on the expectations and perceptions of mothers with adolescents who have learning disabilities and who study in a special education school. The perceptions and expectations of mothers with adolescents who have other difficulties and are studying in a special education setting, such as emotional difficulties, cognitive difficulties, communication difficulties and so on, were not examined. It is desirable to expand the study to encompass a variety of disabilities, in order to inquire whether it is possible to reach generalisations and whether satisfaction depends on the type of disability.
3. The data were gathered from mothers only. The voice of the adolescents and of the therapists with regard to satisfaction with the therapy, the therapist, and the therapist’s relationship with

the parents, was not heard. It is suggested that satisfaction with therapy be explored from the point of view of all those involved.

APPLIED RECOMMENDATIONS

- The school should organize and initiate parent workshops in order to improve and enhance the conditions necessary for successful treatment. The purpose of the workshops: coordinating parent expectations, enhancing parental efficacy and reducing stress levels. This in order to promote internal self-encouragement resources and trust in the therapy and in the therapist role.
- It is necessary to maintain a mechanism for receiving written feedback from parents concerning satisfaction with the therapy and with the therapist and to adjust the duration of therapy according to parents' responses to this feedback.

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