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Art Therapy with Mentally Ill Children

Phyllis L. Childers

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Phyllis L. Childers

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Faculty Sponsor: Judith Simmons

Faculty Administrator: Craig Eisendrath

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Preface

This thesis is concerned with the applicability of art therapy for medically ill or injured children and adolescents. The majority of the bibliographic and experiential research comes from work with hospitalized young people, however a hypothesis could be made for the applicability of art therapy for non-hospitalized pediatric patients, as well. Due to the limited amount of available research, this second category can only be addressed briefly in this thesis.

Hospitalized pediatric patients refers here to children and adolescents who are hospitalized for physical illness, injury, or other medical problems. This thesis does not concern itself with patients who are hospitalized for psychiatric disorder.

Art therapy with medically ill patients in this country is a very new branch of a profession which has been formally organized for only the past ten years (American Art Therapy Association). Art therapists are beginning to work with medically ill patients in a variety of medical units, including oncology, kidney, leukemia, and burn units, as well as in pediatric and general medical units, as illustrated here.

Art therapists working with pediatric patients in hospital must have an understanding of psychological and emotional factors which affect children's reactions to hospitalization. There must also be understanding of the interrelationship between a patient's physical and emotional states.

Fortunately, the emotional needs of hospitalized children and adolescents have been well documented. General interest in this field began forty to fifty years ago, as the field of psychiatry grew and developed. It was found that the origins of mental illness frequently originate in an individual's childhood roots. This discovery has led to an increased interest in studying the emotional needs of children.

Prior to this time, it seems that children's emotional needs during hospitalization had gone virtually unrecognized. At one time, any hospitalization was considered serious and quite traumatic. For children it must have been, in many cases, terrorizing. Not only were they faced with a weakened physical condition, but they were placed in a totally strange and frightening environment. They often had to cope with painful, anxiety-provoking treatments and constant fear of the unknown.

Understanding the development of several interrelated fields is essential to the acceptance of art therapy in hospital pediatric programs. This thesis looks at the concurrent development and

interrelationship of child psychiatry, play therapy with children, interest in the emotional needs of hospitalized children, hospital play programs, and finally, art therapy and its applicability to medically ill patients. It shows, with illustrated descriptions, the effectiveness of art therapy in a hospital pediatric unit.

Symbolic expression occurs through the creative art experience, providing the patient with nonverbal release of unconscious, sometimes highly emotional, material. It provides the art therapist with an accurate, reliable, visual record of the patient's ongoing, developmental processes and emotional state. Such a record, with interpretive remarks by the art therapist, provides unique information about the hospitalized patient.

It appears that the 1980's may well be a critical period in the evolution of art therapy with medically ill patients. In order for this field to expand and develop, it is crucial that hospital administrators and patient care supervisors fully understand the value of art therapy. Only through the support of these administrators can art therapists become vital, interrelating members of the hospital team.

CHAPTER 1: HISTORY OF CHILDREN IN HOSPITAL

It is helpful to understand the history of a child's place in society in order to develop a clearer picture of how children within one particular setting--the hospital--were regarded and treated.

In a careful review and compilation of ancient literature, Lloyd deMause, editor of The History of Childhood, uncovers some startling truths about the cruelty, deprivation, and misunderstanding of childhood which has existed in many cultures, probably since the beginning of time.

"The history of childhood," deMause writes, "is a nightmare from which we have only recently begun to awaken. The further back in history one goes, the lower the level of child care, and the more likely children are to be killed, abandoned, beaten, terrorized, and sexually abused" (deMause 1975, 1).

Primitive people often supported and nourished only healthy babies. Weak, sickly or disfigured infants were left to die. Ruth Matheney and Mary Topalis, co-authors of Psychiatric Nursing, support this theory. They state, "Although evidence is available that peoples of ancient times and numerous cultures had concern for children and their welfare, no period in history has contributed so much to the understanding of children as has the twentieth century" (Matheney/ Topalis 1970, 287-288).

These authors state that, in the past, children were expected to serve and conform to adults. A child's individuality and personal

feelings were disregarded. They state,

> The will of the parents or guardians dominated the child's life. Rigid religious codes often determined the morality of right and wrong. Children were loved but were needed more. From a very early age, children were given specific chores essential to the vitality of family life. (Matheney/Topalis 1970, 288)

As children gradually came to be regarded as individuals in the late eighteenth and early nineteenth centuries, adults began to alter the ways in which they treated children. The authors go on to say,

> Psychiatry and pediatrics witnessed important changes in their knowledge and practice. In pediatrics, medical care became a planned routine for young children and preventive care became a household concern. Dynamic psychiatry recognized the need to understand the whole person--his early experiences and his life's experiences, as well as his symptoms. These are the threads that lead to the origins of mental illness. A biographic history is now an essential component of the patient's personal data. (Matheney/Topalis 1970, 289)

By reviewing medical literature, which tells the story of how children in hospitals of this country have been treated over the past fifty years or so, it is possible to see a correlation with our society's attitudes toward children in general.

If a child was expected to "speak only when spoken to" at home, and if a child's personal feelings and emotional needs were disregarded in the home setting, it is not surprising that the same adult attitudes would prevail in the hospital environment.

Innovative ideas were presented from time to time regarding the care of infants and children who were ill or hospitalized. It took many years, however, before the ideas were understood, accepted, and put into common practice.

Violet Broadribb, in Foundations of Pediatric Nursing, states that nearly fifty years ago, in 1932, Dr. Joseph Brenneman of the Children's Memorial Hospital in Chicago advocated that infant mortality rate in institutions might be connected with lack of stimulation. This was a revolutionary concept. Prior to this time a baby's physical and medical needs were attended to, but no consideration was given to the tiny being's emotional needs. Brenneman advised that each baby should be "mothered" several times a day, and that an infant should not be admitted to a hospital if care could possibly be obtained within the child's home, or in a foster home. He also advised that infants should be dismissed from hospital as soon as possible (Broadribb 1967, 14).

Pediatric Annals reported that not until the 1940's did adults begin to be concerned about the "traumatic emotional effect" on young children which resulted from hospitalization, primarily caused by the enforced separation from their parents (Levine 1972, 7). A number of studies were conducted in the 1940's and early 1950's dealing with the "short-term and long-term effects of maternal deprivation," especially on children between the ages of about one and four years, as a result of separation during hospitalization (Broadribb 1967, 15).

It was not considered sanitary to have a daily flow of visitors coming into the hospital. Infection spread too easily, and diseases were not controlled at that time by the vaccines and antibiotics which are available today. However, what was not recognized was the detrimental effect which this very limited visitation had on the already isolated young patients.

In pediatric units, parents were the only visitors permitted. Their visitation rights were restricted to one or two hours a week, on Sunday afternoons. "Children used to be isolated, even from each other, in hospital 'cubicles' so diseases would not spread from one patient to another" (Levine 1972, 7). Gradually the use of new vaccines against contagious diseases allowed for less rigid visitation codes, but the old fears lingered and hospital personnel were reluctant to accept these changes.

Further attention was given in the 1950's to the matter of child-mother separation during hospitalization. Dr. John Bowlby initiated the idea "of allowing the mother to be admitted to the hospital with her child and to participate in the child's care" (Broadribb 1967, 15). Bowlby's studies, as well as other studies on the subject, led to many changes. Child care in orphanages and foundling homes was gradually replaced by the use of foster homes.

Margaret Stacey, in Hospitals, Children and their Families, states that a report from the "Platt Committee on the Welfare of Children in Hospital" (1959), made a number of recommendations for "improving the non-medical aspects of the treatment of children in hospital" (Stacey 1970, 1).

> The Committee considered children of all ages and many aspects of their welfare, but their attention became centered on the psychological evidence that the separation in hospital of young children from their parents results in some emotional disturbance, which in some cases may be long lasting and which may sometimes affect the rate of physical recovery of the child patients. (Stacey 1970, 1)

Stacey adds that the most radical recommendation of the report from this committee, also the one which received the most attention, was the one connected with "unrestricted visiting and mothers-in units" (Stacey 1970, 1).

Again, this was a revolutionary concept. It would be many years before mothers-in programs would be at all encouraged, let alone commonly practiced in hospitals throughout this country. Nearly ten years later Eva Noble, author of Play and The Sick Child, stated that "the Platt Committee Report with its recommendations of unrestricted visiting by parents is slowly being implemented" (Noble 1967, 13).

During the same years that visitation regulations were being questioned, other aspects of child care were beginning to receive attention. Interest in children was not contained to this country alone. The OMEP (Organisation Mondiale pour l'Education Préscolaire), "an international, non-governmental educational organization," open to people of all nationalities was founded in 1948, "to promote greater understanding of children under eight years of age and to share between different countries the experience and knowledge gained through the study of young children during their formative years" (Harvey/Hales-Tooke 1972, 192).

A symposium on "The Emotional Reactions of Children to Tonsillectomy and Adenoidectomy" by psychiatrists, pediatricians, and psychologists, was held during the 1940's to discuss ideas on how to lessen the trauma involved in this common surgical procedure and hospitalization (A.Freud 1952, 75).

Anna Freud was one of the early contributors to the research of children's emotional needs, and most particularly to the subject of child-mother separation. Her studies of children removed from their families

during bombings in London supported the hypothesis that "emotional deprivation caused potential physical damage as well as irreversible psychological harm" (Broadribb 1967, 14).

In 1952, Freud made reference to two physicians whom she termed "enlightened pediatricians" for their innovative positions in the 1940's of encouraging children to be treated for illnesses without enforcing bed rest, or at the very least, in allowing unrestricted movement within the crib during the child's confinement (Freud 1952, 72).

Hospitalized children in this country, during the first half of this century, faced a fairly bleak outlook. They were admitted to hospital and immediately separated from, what Anna Freud termed, the "rightful owner" of their bodies, at the very moment when their bodies were "threatened by dangers from inside as well as from the environment" (Freud 1952, 80).

They were placed in beds, isolated from other children, and were allowed few, if any, randomly selected toys or playthings. Confinement to bed was mandatory, and it was not uncommon for restraints to be used to assure the prescribed "complete bed rest" for the anxious, restless, fretful child.

Medical and nursing procedures were carried out, forcibly if necessary, without explanation to the child. Little consideration was given to the child's feelings or concerns. "Children of all ages were taken to the operating room, unaware of what was going to happen to them," wrote Thesi Bergmann, author of Children In The Hospital (1965, 43). This was thought by adults to be kinder to the child.

Hospitalized children saw their parents, if at all, only once a week. Following a brief visit, they were then torn again from their loved ones for a prolonged separation. Their losses were innumerable: loss of loved one, of familiar surroundings and comforting objects, of freedom, of interesting activities, of security, and of their own self-esteem. For some "enlightened pediatricians" and other innovative child care workers to begin to see the hospitalized child's plight, was a giant step for children everywhere.

"The hospital of today should no longer be for the child an experience of terror, anxiety, fear or even dreariness and rejection," wrote Dr. Milton Levine in a 1972 issue of Pediatric Annals. He added that in most respects it can even be "rewarding and pleasurable as well as beneficial" (Levine 1972, 9).

Perhaps compared to the terrors of hospitalized children in the past this was true, but is it true that today a hospitalized child does not experience "terror, anxiety, fear, dreariness or rejection"? Is today's child emotionally prepared to make a smooth transition into the hospital world? Are today's hospitals truly equipped to deal with the child's diverse emotional needs in a collective and unified way? These are questions which will be examined in the next chapter, "Working with Children in Hospital: Psychological and Emotional Factors."

CHAPTER 2: WORKING WITH CHILDREN IN HOSPITAL: PSYCHOLOGICAL AND EMOTIONAL FACTORS

From this brief historic review, it has been demonstrated that gradually an interest in the psychological welfare of sick and hospitalized children did develop in this country, along with an interest in, and an understanding of, children in general. These changes occurred simultaneously with the development of psychiatry's interest in an individual's childhood roots, and along with the development of child psychiatry. Matheney and Topalis state,

> Today child psychiatry is accepted as a special and important field of psychiatry to be included in medical, nursing, and teacher education. Child psychiatrists are partners with pediatricians in the care of children in hospitals and clinics.... And most importantly, the public and parents or guardians of children are being educated with respect to children's behavior problems and the various means available to help them to help their youngsters. (Matheney/Topalis 1970, 290)

The questions then arise: What are the emotional disturbances which may occur in sick or hospitalized children? What defense mechanisms are likely to be employed? How will children at different age levels and stages of development perceive their illness and the hospitalization experience? What will be the lingering aftereffects? Will children differ in their responses to acute versus chronic illness? To long-term versus short-term physical impairment? To hospitalization requiring surgery versus hospitalization with no surgical intervention?

What factors are involved in children's reactions to, and fears of, pain? How do children perceive the experience of being nursed by

adults? What are the symptoms of hospitalized children in distress? How can the symptoms be recognized? And, finally, what can professional child care workers do to help the sick, injured, or hospitalized child overcome these emotional obstacles, and how can the ill effects of hospitalization be minimized?

Although this thesis is concerned with medically ill children, in general, this chapter will focus primarily on hospitalized children. A child who is in need of hospitalization is facing physical impairments which require professional medical services, facilities, and/or equipment which cannot easily be obtained in the home environment. The child may be the victim of physical injury requiring surgery or specialized equipment for traction. Hospitalization may be necessary during an acute illness of an emergency nature, or during an acute phase of a chronic illness. Not only must the hospitalized child cope with the strains of illness or serious bodily injury, but at the same time must also put forth effort to adjust to a totally new and strange environment and role.

Eva Plank, author of Working With Children in Hospitals, views the basic problems of hospitalized children as "grief at separation from home, anxiety about mutilation,...immobility, and the many other adjustments that the child has to make to illness and to the hospital regime" (Plank 1962, 1-2).

Harold Geist, in his studies of the psychological apsects of hospitalized children, emphasizes the importance of understanding the intimate relation between a child's emotional and physical states.

Geist states, "The child who is to be, is, or has been hospitalized must be especially understood with particular respect to the nature of his emotional needs, the feelings of his parents, and the attitudes, concepts and emotions of the professional people with whom this child comes into contact" (Geist 1965, vii).

The question of how a given child will react to the hospitalization experience is a complex one. Several different factors need to be considered individually in order to gain a better understanding of the complexity of the child's reactions and adjustments. The factors of age, family support, constitutional endowment, and the reason for hospitalization will all be discussed. It will then be possible to see how each of these factors affects a child's reactions to various restrictions and impositions which hospitalization requires.

Factors Affecting Children's Reactions to Hospitalization

Age

Age is a prime factor in understanding the meaning of hospitalization to a child. Dr. Herman S. Belmont, in a 1970 issue of Clinical Pediatrics, discusses the common reactions of children to hospitalization according to the following breakdown of age groups: (1) early postnatal (first six months), (2) six to eighteen months, (3) latter part of second year into third year, (4) three to six years, (5) school age and early latency, and (6) adolescence (Belmont 1970, 473-476).

For the infant in early postnatal development, no verbal communication can occur, nor can the infant comprehend what is happening in the surrounding environment. Belmont points out that adults may not recognize and fulfill the infant's needs, even though it is well known that the consequences of the child's experiences depend on the fulfillment of needs arising in earliest infancy.

During the second half of the first year, hospitalization can interrupt the development of the child-mother relationship. Belmont states that the baby's fears of desertion or separation will be felt strongly from this age until approximately three years of age, when the child achieves object constancy.

The child of two to three years has gained a fuller sense of self, and is therefore less vulnerable to feelings of complete helplessness. At this time the child may acquire a distorted interpretation of the reason for the hospitalization. The two- or three-year-old hospitalized child is likely to react in one of two opposing ways, either by rigidly reinforcing controls of all impulses, or by yielding to these same pleasurable impulses.

The child of three to six years still feels separation anxiety, although to a lesser degree than before, says Belmont. The focus for the hospitalized child of this age is on maintaining physical integrity, fears of mutilation, and coping with various fantasies, some of which can be simultaneously gratifying and threatening.

When the child reaches school age and the period of early latency, the separation anxiety is lessened further, yet the child is far from

feeling securely independent. Efforts to achieve independence and master the many new skills of latency are interrupted during hospitalization by a restricted, dependent confinement. The child of this age frequently interprets medical procedures as punishment for misdeeds.

Susan Harvey and Ann Hales-Tooke, authors of Play in Hospital, add that older children, who have a more realistic interpretation of their environment, are apt to feel anxiety regarding treatment procedures. They may become pre-occupied by fantasies over bodily damage or total destruction (Harvey/Hales-Tooke 1972, 29).

The last age group discussed by Belmont is adolescence. The teenager is involved with ongoing life problems of sexual identity, dependence-independence conflicts, occupational choice, and special concerns about physical changes and disparities, physical integrity and adequacy, and masturbation anxieties. Hospitalization at this age is likely to interfere directly with more than one of these concerns, creating further anxiety in those areas.

Family

Age is not the only factor which influences how a child will react to the traumas involved in illness or injury resulting in hospitalization. Another highly influential factor is the emotional climate of the home.

There are probably as many different degrees of family reaction and interreaction to a child's illness and hospitalization as there are members who make up the families. Certain prevailing moods of family groupings, however, have been observed within the hospital environment.

A child is strongly influenced by the attitudes, reactions, and moods of close family members, and it is a factor worthy of consideration.

Madeline Petrillo and Dr. Sirgay Sanger, in Emotional Care of Hospitalized Children, identified eight basic family types, as they were observed in the hospital environment (Petrillo/Sanger 1972, 38-48).

The "emotional family" is one which exhibits histrionics and gross mood swings. Members mill about the hospital room and corridor with a worried pall hanging over the entire group. Often there are so many relatives involved that the hospital staff finds it difficult to cope with them effectively. The family keeps close tabs on the hospitalized patient, for there is a general distrust of the hospital environment.

The "deceptive family" makes untrue statements to the patient about the illness, physical condition, or prognosis. Often they make impossible promises to the child. Their deception may be so strong that they hide the true facts from even themselves. They are experienced by the hospital staff as provocative, alienating, and quite difficult to deal with openly.

The "punitive-depriving family" commonly uses threatened or actual physical abuse for discipline. They view sickness as punishment. Parents usually view hospital staff members as indulgent and permissive. They may become jealous of the young patient's attachment to a sensitive, caring staff member. Hospital workers may need to use caution not to over-react or pre-judge this type of seemingly over-strict guardian.

The "magical-thinking family" sees sickness as an omen of bad things to come. It may be viewed as a signal of God's displeasure, or as fate. The child often craves emblems and objects to provide

protection from further damage. Parents in these families are often docile and childlike, bowing to hospital personnel, and following detailed instructions for the child's care, so as to not upset the precarious balance of the family's fate.

The "culture-of-poverty family" is fatalistic and authoritarian in its outlook. The parents are present-oriented, with a strong distrust of outsiders. Parents have clear male-female roles, and they usually exhibit signs of very low levels of self-esteem. There is little verbal communication between parents, but one or both of the parents may often have a volatile temper.

The "overprotective family" is ambitious and achievement-oriented. The child is overprotected and usually feels entitled to extreme gratification. Parents may exhibit signs of latent hostility toward the child for being ill and for causing a disruption in the life goal toward achievement.

There are also families whose religion interferes with medical treatment. These parents should be informed, in a gentle but firm manner, of the child's physical and medical needs. Care should be taken on the part of the hospital staff members to interact with these parents without belittling or stripping away their strongly-entrenched values and beliefs.

The "best-adapted family" is a joy to behold within the hospital. The parents are able to deal with the infirmed child in a mild, but firm, manner. Their discipline measures are consistent. They are rational, objective, evidence-oriented, self-confident, and trustful. They thrive on new experiences. Usually the children in these families are creative and full of energy.

Some families which operate in one of these eight modes may have difficulties accepting a child's hospitalization. The illness or hospitalization may create changes within the emotional climate of the family. The basic family constitution is likely to remain constant, however, and it will have considerable effect on the child's adjustment to this challenging situation.

The child will often be the first to notice, at some level, a change of emotional climate during an illness or convalescence. "There are few parents who do not, imperceptibly or grossly, change their own attitude to the ill child," writes Anna Freud. "Mood swings, changes in the relationship to parents and siblings, loss of self-confidence, temper tantrums often appear for the first time during convalescence after a severe illness" (Freud 1952, 70).

The type of family from which a child comes and the degree of change in the emotional climate within the home, both have their effects on how the child will react to hospitalization. Margaret Stacey supports this theory. She writes,

> The emotional atmosphere of the home affects the child's ability to adjust to hospitalization. This is widely considered to be one of the main determinants of child behavior....It can be expected that a child who is in a state of emotional equilibrium with his environment will be able to adjust satisfactorily to the trauma of hospitalization without showing disturbed behavior. (Stacey 1970, 77)

Stacey adds that, at the other extreme, a child who is in a state of anxiety or a "high degree of arousal" prior to the hospitalization, is likely to display maladaptive behavioral changes, some of which may be prolonged.

Constitutional Endowment and Libidinal Demands

In addition to the child's age and the emotional climate of the family, a third factor must be considered, that of a child's constitutional endowment. A hospitalized child's age is apparent immediately upon admission. The prevailing mood and interactions of the child's family members can be observed shortly after admission. The factor of a child's constitutional endowment, however, remains elusive. It is difficult to distinguish or define. It has, nevertheless, a powerful influence on the child's ability to adjust to the hospital experience.

Anna Freud has demonstrated how children differ from each other in their levels of frustration tolerance and sublimation potential, in their abilities to cope with anxiety, and in their tendencies toward using defensive measures in the face of stress (Freud 1965b, 134-45).

In addition, Freud addresses this differentiating factor in her discussion of "changes in libido distribution," or "the heightened demand of the ill body for libidinal cathexis" (Freud 1952, 77-78). Freud discribes two very different ways in which sick children instinctively react to libidinal demands.

> Many children who, when healthy, are in good contact with their surroundings, full of interest in their toys and occupations, and in the happenings of everyday life, begin their sicknesses by withdrawing from the environment, lying down on the floor or curling up in a corner, listless and bored.... Anxious mothers are terrified by this complete reversal in their child's behavior and feel him to be in grave danger. In reality the manifestation is not a physiological but a psychological one and not commensurate with the severity of the illness. It is a change in libido distribution during which cathexis is withdrawn from the object world and concentrated on the body and its needs. Despite its frightening suggestion of malignancy this process is a beneficial one, serving the purpose of recovery. (Freud 1952, 77-78)

The child who reacts in this way is viewed by adults as totally withdrawn and undemanding. Other children experience the changes in libido distribution in quite the opposite manner.

> Unable to give their own ill body the additional narcissistic cathexis which it demands from them, they claim this surplus of love and attention from the mothers who nurse them through the illness, i.e., they become demanding, exacting, clinging far beyond their years. In doing so they make use of a natural process dating back to the first year of life, when the mother's libidinal cathexis of the infant's body is the main influence in protecting it from harm, destruction and self-injury. (Freud 1952, 78)

Reason for Hospitalization

In addition to age, family types, and constitutional factors, children differ from each other in their reactions to hospitalization depending on the reason for their hospitalization. Thesi Bergmann, who worked for twenty years with chronically ill children, compiled her observations (in collaboration with Anna Freud) in her 1965 publication of Children in the Hospital. Bergmann noted typical reactions to a number of different illnesses or conditions. Two highly contrasting reactions existed within the two conditions to be discussed here, orthopedic patients and cardiac patients.

Bergmann observed that, with few exceptions, orthopedic patients accepted confinement and motor restrictions in a positive manner. Her theory for this was that orthopedic patients could deal with a tangible condition. Orthopedic equipment is visible. There is no mystery about

the physical ailment. A bone is broken; it has to be positioned, perhaps in traction, for a definite length of time until it is healed. The apparatus can be seen, examined, and observed in action. The treatment procedure, degree of improvement, and the time needed for recovery can usually be discussed specifically. "Somehow it seemed as if the stark and uncompromising reality of the situation, i.e., its very concreteness, served as reassurance and helped to keep fantasies and unrealistic anxieties in check" (Bergmann 1965, 60).

Interestingly, Bergmann observed a common revolt during the recovery period of orthopedic patients. When ambulation began, the patients suddenly experienced impatience and extreme sensitivity toward even the slightest further restriction. Treatments were viewed as insurmountable tasks. The patients complained and were filled with self pity. It was as if these patients had endured such hardship that they suddenly felt entitled to freedom, and they became unwilling to accept further impositions.

Bergmann also noted that, in many cases, "a distinct inhibition of verbal expression went parallel with immobilization, as if the restraint enforced on children's limbs spread further and affected more highly differentiated motor functions" (Bergmann 1965, 67).

Cardiac patients, in contrast to those with orthopedic problems, reacted with depression and discouragement. Often their reactions seemed hypochondriachal. Bergmann theorized that, for children with heart disease, nothing external is visibly wrong. The ailment is internal and remains mysterious. There is no easy explanation for these children. They experience vagueness from physicians and parents. This naturally results in increased fears and fantasies.

In contrast to orthopedic patients who thrived on the support of group members, those with cardiac conditions did not appear to benefit from group situations. When one child improved, others so afflicted became envious and asked why it was not true of them; if a relapse occurred in another child, they expected the same fate. Bergmann explains further,

> Most of our cardiac children were compliant, sad patients, who did not exhibit their discomforts but insisted, on the contrary, that everything was fine with them. If not handled very carefully, their tendency was to withdraw from emotional contacts and to turn their interests inward, with body and heartbeat assuming the place which normally in a child's life is held by the important people in the outside world. (Bergmann 1965, 69-71)

Cardiac and orthopedic conditions are only two of the many illnesses or conditions observed in hospitalized children by Bergmann. Other chronic conditions possess their own individual characteristics, as observable in the afflicted child's behavior. It is helpful to understand the unique characteristics of different illnesses or conditions, and to have knowledge of the behavior trends which are usually apparent in these conditions, in order to better understand each child's individual reactions to the hospitalization experience. (See Bergmann 1965, Ch. 8, "Typical Reactions to Specific Illnesses.")

Experiences Commonly Faced by Hospitalized Children

Age, family disposition, constitutional endowment, and the condition under which the child is suffering all contribute significantly to a child's reactions to being a hospital patient, and all that this new role entails. Belmont states,

> As a result of the interplay of such factors as past experiences, age, constitutional endowment and developmental history, one child may undergo a major surgical procedure and convalesce with minimal disruption of his future development, whereas another may show many disturbing sequelae to a relatively minor office procedure. (Belmont 1970, 472)

The factors discussed in the previous section affect how the child reacts to such experiences as being nursed by adults, as well as to various restrictions. They affect the child's reaction to pain, surgery, and anesthesia. They explain why some children view the hospital experience as punishment. They also affect the child's reaction to the duration of the illness or confinement. All of these are experiences which are commonly faced by hospitalized children.

The Role of Patient

Any person, child or adult, who enters the hospital must immediately assume a new role, that of a patient. Often the person, at the same time, must cope with the loss of old roles. Effler and Sestak, in their article, "The Chronically Ill Patient in a Medical Setting," describe how the patient is suddenly submerged into a strange and unfamiliar world of "new faces, unfamiliar language, painful and noxious stimuli, and separation from loved ones" (Effler/Sestak 1979, 56-60).

> Once the person becomes a 'patient' he is met with an entirely different set of roles, expectations and patterns of behavior. The person must temporarily regress from his station of independence, and allow others to care for him and to meet his needs. The patient temporarily gives up many things including freedom of choice and mobility. This 'sick role' is a normal and necessary adaptive process characterized by a marked dependence on others, a focus on bodily processes, an egocentricity or lack of interest in the social world, and certain affective symptoms. (Effler/Sestak 1979, 57)

These authors state that the patient suffers a number of losses due to the sick role, including a loss of self-image; a feeling of loss as the result of separation from loved-ones, and from familiar surroundings and objects; loss of mobility, recreation, and re-energizing acitivities; loss of privacy, loss of choices, and sometimes loss of bodily functions, or even of body parts.

There is simultaneously a need to be subjected to stressful stimuli in the form of examinations, medical procedures, pain, fear of strangers and of the unknown, and of anxiety-provoking medical equipment.

The natural consequences in adapting to losses is grief. Patients, particularly those with chronic illness, may experience grief at different levels of intensity. Effler and Sestak note that there may also be different stages to the grief process, not unlike the stages of grief noted in dying patients as described by Elisabeth Kubler-Ross in On Death and Dying (1970).

The patient is likely to experience grief first by denying that the illness exists, or by denying that it exists at the level which has been communicated to the patient, or by denying that the prognosis is as severe as it appears to be.

This stage might be followed by anger, and a "why me?" attitude. Bargaining is a third stage, at which point the patient might attempt what is termed "trade-offs." At this stage, too, the patient may feign a less severe reaction to the illness than is actually being experienced. Depression is likely to follow, and hopefully, acceptance will soon be evidenced.

As with dying patients, those grieving over their ill state and their numerable losses, may stop at any stage along the way for a considerable period of time. The nature of the illness and the prognosis are likely to affect the patient's grieving process.

Both children and adults suffer losses, face stress and experience grief. It is possible that a child's grief is felt at a more intense level than an adult's, primarily due to the child's lack of ability to incorporate the total hospital experience at a rational level. This, of course, depends largely on the child's age, developmental level, family support, and on the child's innate ability to cope with life's challenges.

Being Nursed by Adults

The experience of being nursed is perceived by older children as a potential interference with their personality development. Children struggle in their attempts to achieve independence from the adult world and to have control over their bodies. To suddenly have nursing care thrust upon them by adults may be perceived as an indignity.

Some illnesses require that the patient be dressed, undressed, fed, cleaned, bathed, turned from side to side, and helped with urination and

defecation. The patient's nakedness is exposed to nurses and doctors of either sex. Even an adult patient often finds that such intensive nursing care feels as though one is "being treated like a baby."

Children, who have only recently achieved a state of autonomy in the matters of bodily care and personal hygiene, may find this kind of care to be intolerable. They may react to this situation with behavior which obstructs progress and appears contrary and uncooperative. Other children, unable to maintain a mature status of autonomy in the face of illness, may regress into passive compliance, allowing the nursing care to procede without resistance. Neither reaction is welcomed nor helpful, either as an aid to physical recovery, or in the progress of mental development (A. Freud 1952, 71; 1965a, 143).

Restrictions

Motor restriction is experienced to some degree by all sick or injured children. It may vary from as little as confinement to house or hospital unit, to the extreme limitations of orthopedic traction. Anna Freud states, "In contrast to the comparative ease with which ego skills and abilities are renounced under the impact of being 'nursed,' children defend their freedom of movement in the same situation to the utmost wherever they are not defeated by the type or intensity of the illness itself" (Freud 1952, 72).

Aggressive behavior may surface as a direct result of motor restraint, particularly when restraint is lifted only partially, or when the restraining measures have to be increased or endured for a longer period of time than originally estimated.

Food restrictions imposed on ill children are of lesser importance than restrictions on mobility. Still, these restrictions are not to be overlooked in the whole picture of a child's reaction to illness and hospitalization. The taking of medicines is another factor which often presents difficulty for the already restrained, confined child. Freud states that analytically there are overtones behind the child's resistance to taking medicines of "repressed ideas of being attacked by the mother" (Freud 1952, 74).

Freud notes the correlation between the hospitalized child's limitations of mobility, food restrictions, and confinement, to the common punitive restrictions used by many parents in their disciplinary measures. Children are commonly disciplined by being sent to bed, confined to their rooms, or deprived of favorite foods. In certain societies, more common in the past, even enforced administrations of laxatives was used in a punitive fashion (Freud 1952, 74). It is not surprising that many children come to view the entire hospitalization experience as punishment.

Hospitalization as Punishment

The observation of children's common reactions to hospitalization as punishment has been noted by a number of writers (Freud 1965, Geist 1965, Bergmann 1965, and others). Bergmann writes, "There is in many children's minds, a firmly fixed belief that illnesses are self-induced, the well-deserved punishment for all sorts of badness, disobedience, disregard of rules, neglect of prohibitions, bodily abuse" (Bergmann 1965, 80).

How does this viewpoint come about? Harold Geist, author of A Child Goes to the Hospital, states, "Many youngsters interpret illness as punishment, particularly punishment for misdeeds, if their parents have been over-demanding. Parental admonitions merely intensify any latent fears the child may have that his illness comes as punishment" (Geist 1965, 13).

Geist explains further that when parents fail to take sick children into their confidence, the result is often mistrust and insecurity. "If this mistrust has been furthered by oft-repeated threats of hospitalization, the stage is then set for the child's reaction to the hospital as an actual (rather than feared) place of punishment and to the routine hospital examination as sharp retribution for his misdemeanors" (Geist 1965, 15).

Lesser parental admonitions may also intensify a child's latent fears of illness as punishment. Memories of such misdemeanors as going out in the rain, walking through puddles, refusing to wear coat, hat or mittens, in the face of parental prohibition are all revived at some level of consciousness. Children often hold the belief that wrongdoings, even those accomplished secretely, or not accomplished at all but perceived merely at a fantasy level, are all subject to punishment. Further, these children will strongly suspect that other still undetected misdeeds will likewise be followed by retribution, resulting in increased fears and fantasies (Freud 1965a, 137-38).

The consequences of children's viewing hospitalization as punishment can be severe. Geist notes that a child who interprets the hospitalization as punishment becomes vulnerable to fearing injury within the hospital environment, thus increasing anxiety.

Freud also states that children do not differentiate between severe illnesses and less severe medical conditions as consequences to their misbehavior or "badness." The retribution of hospitalization intensifies all of the fears which are experienced in the course of child development. The idea of hospitalization as punishment "...arouses intolerable pangs of conscience...." regardless of the nature of the physical affliction (Freud 1965a, 138).

It is not likely that children of any age will willingly express these fears or this commonly-held viewpoint at a conscious, verbal level. Therefore, it is the responsibility of all hospital child care workers to be aware of its possible existence in order to understand the consequences in the child's behavior patterns.

Pain and Physical Discomfort

Children, like adults, differ widely in their reactions to actual pain or discomfort, as well as to their prognostication of the pain, and to the lingering emotional aftereffects of the pain. All of the factors mentioned earlier contribute to the individual's reaction to pain and physical discomfort.

Different ages and stages of development certainly have different levels of tolerance to disagreeable stimuli. In general, older children can approach the subject more intellectually or rationally than younger ones. Even so, wide variances occur within each age group.

One young child, known to this writer, went through the entire series of infant inoculations and finger-prick blood tests between the ages of three months and five years, a total of eight or ten needle-pricks,

without shedding a single tear or uttering a whimper. These occurrences drew amazed reactions from nurses, physicians, and laboratory workers at more than one medical clinic.

Suddenly, at age six, the child exhibited extreme signs of anxiety just prior to a simple blood test. His parents were bewildered and unprepared for the abrupt onset of prognosticated fear as a stress reaction to what had heretofore seemed inconsequential to this child.

The family's support and attitude toward the child's discomfort, as well as the child's repeated observations of how older family members generally react to pain, are also contributing factors to a child's ability to tolerate pain. Certainly, the elusive factor of an individual's constitutional endowment will contribute to the way in which pain is perceived and experienced.

More basic than any of these factors, however, is the compilation of an individual's total life experiences with pain from birth on. Dr. S. A. Szurek, in his article entitled, "Comments on the Psychopathology of Children with Somatic Illness," concludes that children and adults differ in their total reactions to pain and illness. They also differ in their reactions of anticipating pain, as well as in their lingering reactions following the experience of pain (Szurek 1951, 844-49).

In explaining this, Szurek emphasizes that all experiences with respect to pain, from birth on, when the individual remains incapable of relieving the pain, may lead the person toward further attacks of severe tension, anxiety, and panic when faced with painful stimuli.

Anna Freud underscores Szurek's conclusions. She explains that

pain or discomfort, when experienced early in life, "...upsets the delicate balance between pleasure and unpleasure, which lies at the basis of mental development and determines the infant's positive or negative attitude to life" (Freud 1965a, 142). The infant's ability to resolve the initial conflict of "trust versus mistrust," as described by Erik Erikson (1950), depends largely upon the environment's willingness to withhold, remove, or lessen the helpless infant's exposure to pain or discomfort.

Surgery and Anesthesia

Children differ in their reactions to surgery, but it seems safe to say that most child patients, and probably the majority of adult patients, as well, experience some level of anxiety during the anticipatory period prior to surgery. Here again, factors of age, family support, and constitutional endowment all have their bearings on the child's feelings and reactions concerning surgery.

Young children primarily experience the anxiety of having to be separated from mother during the surgical procedure. Older children may experience surgery as a fear of mutilation.

Anna Freud states, "...any interference with the child's body, whether major or minor, is likely to arouse his fantasies and fears with regard to being attacked, mutilated, deprived of a valuable part of his own self" (Freud 1965a, 136). Freud adds that this reaction occurs regardless of the severity of the physical intervention.

From an analytical point of view, Freud is able to elaborate on this point further.

> Ever since the discovery of the castration complex analysts have had ample opportunity in their therapeutic work to study the impact of surgical operations on normal and abnormal development. By now it is common knowledge among analysts that any surgical interference with the child's body may serve as a focal point for the activation, reactivation, grouping and rationalization of ideas of being attacked, overwhelmed and (or) castrated. The surgeon's action from minor surgery to major operations, is interpreted by the child in terms of his level of instinct development, or in regressive terms. What the experience means in his life, therefore, does not depend on the type or seriousness of the operation which has actually been performed, but on the type and depth of the fantasies aroused by it. (Freud 1952, 74)

One part of surgery which can be the most disturbing to children is anesthesia. It is not uncommon for children to experience anesthesia as a loss of control. Geist explains that there may be hidden, unexpressed fears of what is going to be done to their bodies while they are under anesthesia (Geist 1965, 89).

Duration of Hospitalization

Children's reactions to the duration of their illness or hospitalization differ widely from that of adults. Freud explains how a child's sense of time is perceived differently at young ages than in later years. Adults view the passage of time objectively. Young children view time purely subjectively. Children's time measurement "is carried out not by their ego, i.e., the sensible and rational part of their personalities,

but by the strength and urgency of their wishes which turn all periods of time into waiting times, namely, waiting for gratification of their impulses" (Freud 1965a, 138-39).

All periods of illness or of physical confinement are experienced by the child as painfully long, regardless of the objective length as viewed by adults. Thus, a chronically ill child's complaints may be shared empathetically by parents and hospital staff members, whereas complaints by a short-term ill child are likely to be dismissed as unreasonable (Freud 1965a, 139). In fact, however, they are quite reasonable from the point of view of the child whose time sense is not yet fully developed.

In this chapter it has been shown that children differ in their reactions to the experience of being nursed, to restrictions, to the notion of hospitalization as punishment, as well as to pain, surgery, anesthesia, and to the duration of illness or hospitalization.

In each of these situations the factors of age or stage of development, the family type and family support system, and the child's constitutional endowment all contribute to the child's reactions. The reason for the child's hospitalization and whether the medical condition is chronic or acute, short-term or long-term, are also contributing factors in how the child reacts to the hospital experience.

It is essential that hospital child care workers have a firm grasp on child psychology in order to function effectively with many different

children, from different families and backgrounds, with their widely varying reactions to common, everyday hospital procedures. Bergmann states,

> [In the child's mind], ... where the dividing line between conscious and unconscious, reality and fantasy, reason and affect, are less firmly established than they will be in later life, archaic fears and primitive anxieties from all levels of development merge only too readily with the real dangers and obscure the issue by confusing corrective surgery with punishment, operation with castration, and therapeutic procedures and manipulations with attack. (Bergmann 1965, 44)

Bergmann observed how personality development could, in some cases be altered or even quite devastated by impairments to the body. In other cases, a strong ego would prevail with a positive influence over the progression, recuperation, and final outcome of the illness. There were also children who remained "helplessly exposed to their illnesses" as a result of earlier life experiences which "had deprived them of the chance of building up healthy and effective personalities" (Bergmann 1965, 100).

Multiple factors are involved in the psychological processes which govern how a child reacts to various procedures and hospitalization experiences. Anna Freud states that, for the most part, children view their life's experiences from a "subjective, irrational, emotional approach." This is true of younger children more than of older children who are beginning to assimilate their experience from a more mature vantagepoint. Adults, in contrast, are accustomed to an "objective and wholly realistic appraisal of events" (Freud 1965a, 137).

Adults who do not comprehend this important difference are likely to remain perplexed when they see one child react with acquiescence to a major event, such as surgery, while another child reacts with extreme anxiety to a non-painful treatment, such as an electrocardiogram.

Belmont provides a conclusive statement for this length discussion of children's reactions to hospitalization:

> Let us say here that when a child is subjected to stimuli which come in such abundance and concentration or intensity that with his own particular constitutional endowments and personality development he cannot assimilate, digest and master them, periods of recurrent anxiety then follow the trauma. (Belmont 1970, 473)

Anxiety and Defense Mechanisms

"Admission to hospital must necessarily increase tension and anxiety in children,..." writes Eva Noble (Noble 1967, 157). There are a number of ways in which a hospitalized child can cope with anxiety. Where anxiety is acute, or where no reasonable action for eliminating the anxiety is apparent, or in cases where the source of the anxiety remains at an unconscious level, the child is likely to employ defense mechanisms as protection from the anxiety.

The chronically ill child's defenses have been enumerated by Thesi Bergmann during her lengthy associations with hospitalized children. Some children experience nightmares, a sure sign of repression. Others engage in fantasy as a way of showing denial of the source of anxiety. Withdrawal is another signal that denial, or some other defense mechanism is being employed by the child. Bergmann identifies regression as the most

damaging defense mechanism in chronically ill children. Children have been known to regress to infantlike behavior, a condition which can be harmful, both psychologically and physically (Bergmann 1965, 94).

Two more defense mechanisms, not outlined by Bergmann, but known by this author to be witnessed repeatedly in pediatric units, are displacement and intellectualization. The child who displaces feelings does so out of fear of directing the feelings toward the original source of anxiety. Open hostility toward hospital workers, family members, nursing procedures, or even toward routine hospital care, is an indication of displacement.

Older children may use intellectualization in a way which is not unfamiliar to many adults. Here, the repressed, unacceptable feelings are replaced with abstract, intellectual analysis of the problem.

One additional defense mechanism, which will be discussed at greater length in a later section on art therapy, is that of sublimation. This is where the child uses socially acceptable outlets (such as art) for re-channeling impulses away from forbidden outlets.

Adult understanding of children's emotional reactions to illness and hospitalization, as explained by Freud and others, will come more readily when the child's fears stem from "unquestionably serious situations." As Freud elaborates,

> ... so far as fantasies, anxieties, and affects are concerned, the piercing of a boil, the taking of a blood sample, or the extraction of a tooth may loom as large as the actual removal of an eye or the amputation of a limb. What needs to be understood is the fact that in both instances, whether objectively justified or not, the patient's emotions are very real and the child is in need of help. [Emphasis added.] (Freud 1965a, 137)

CHAPTER 3: THE MEDICALLY ILL CHILD'S NEED FOR SUPPORT

"In hospital the aim is to support the child through a crisis and to handle the experience as humanely as possible," write Harvey and Hales-Tooke (1972, 144). These authors point out that going to a hospital is often the first major crisis that a child experiences. The child needs support from all of the people encountered during the illness or hospital experience.

In this section, the following questions will be addressed: Who are the people within the child's hospital environment who can offer support? What kind of support can each of them give? Also, who are the "information gatherers" about the infirmed child's emotional state? What kind of information can be gathered about each child, and how can the information be pooled to be used collectively by a unified, interacting hospital team?

The answers fall into one or more of four categories: (1) the family, (2) the nurse, (3) the physician, and (4) the hospital therapists.

The Family

The family is the source of support which is generally the closest and most readily accessible to the child. It is likely to be the source that the child turns to initially for comfort and emotional support. If support is received from the family and if it remains constantly available during the hospitalization, the child may not need to turn elsewhere for support.

Some families can offer support to a child who remains emotionally stable throughout the duration of the hospitalization, but they become perplexed when faced with the child's abnormal behavior, such as hostility, withdrawal, or regression. They may lack not only an understanding of the psychological processes at work, but also the skills required to help the child overcome the emotional obstacles.

The family is likely to be the first source to notice significant changes in the child's attitude or behavior. Some families may communicate these changes to the nursing staff. Others may try to hide the facts, either by secretly threatening the child or by pretending that the behavioral changes are insignificant, or do not exist at all. In any event, nurses and other staff members cannot consistently rely on families to provide complete and honest feedback of the child's emotional condition.

The Nurse

Nurses are in constant contact with the hospitalized child. Like the family, they may be quick to detect changes in the child's behavior, attitudes, or reactions to daily procedures. The importance of the nurse's role to aid and relieve a child's emotional distress has long been recognized.

Mildred Wallace and Violet Feinauer published an article in the American Journal of Nursing in 1948. It was entitled, "Understanding a Sick Child's Behavior: How to recognize and relieve emotional distress and disturbance in the child ill in the hospital." These authors emphasized

the pediatric nurse's responsibility in preventing and alleviating a child's emotional distress as medical treatment and hospital care are being carried out (August 1948, 518).

However, even as much as thirty years ago, the authors recognized that nurses, no matter how well-meaning or well-equipped in understanding developmental processes which underlie children's behavior, could not realistically do the job alone. The authors state, "With the assistance of child care specialists to help her evaluate behavior and plan guidance, the well-prepared nurse is able not only to prevent and alleviate emotional distress but to make the hospital experience a vital learning situation for the child and his family" (Wallace/Feinauer 1948, 521).

The nurse is the member of the hospital team who makes frequent, progressive, reliable notes about the child's behavior patterns. The nurse's notes in the patient's chart not only record the child's vital signs and provide a record of medical and nursing procedures which are being carried out, but they provide the physician and hospital therapists with valuable clues about the patient's emotional welfare. The nurse, then, is likely to be the primary information-gatherer about the patient's behavior.

In turn, the nurse utilizes the valuable information which is recorded by the hospital therapists, in order to better understand each patient, and to provide the kind of support each individual child requires. It is only through this unified team effort that each professional child care worker can perform his/her job effectively and efficiently.

The Physician

The physician is an important figure in the life of a sick or hospitalized child. In the hospital environment, the child usually sees the physician briefly nearly every day. In the case of long-term care, particularly in those cases where nursing care is not likely to require daily monitoring, the physician may be seen less frequently. The frequency of visitation and the extent of actual medical contact by the physician, however, remain quite separate from the child's ongoing fantasies about this person.

Most sick children are highly invested emotionally in the physician. Often the child views the physician as awesome, or god-like. This reaction is not surprising when one considers that, from the child's point of view, the physician seems capable of doing anything to, or for, the child as a means toward furthering recovery. The physician orders procedures, recommends diet and prescribes medication. The physician's wishes seem to have priority over all of the other people whom the child observes, including his or her own parents.

A child's wildest and most secret fantasies may well center around the physician as a result of the power and control which this person seems to hold. It is for this reason alone that the physician is not likely to have direct access to the child's inner world of fears, fantasies, anxieties, and dreams. Naturally, relationships between children and their physicians vary considerably, depending on many factors. Some children who receive regular medical care from multi-physician clinics may not even know their physician well enough to have a significant relationship. Others, who have had the same pediatrician since birth,

particularly where physical care has had to be monitored carefully and frequently as in the case of long-term illnesses, may have a very close and supportive relationship with the physician.

In either event, however, the physician does stand in a position of power and authority, and this cannot help but affect the child's relationship to this important figure. The child's high level of emotional investment in the doctor may leave the patient feeling vulnerable and somewhat cautious.

In the hospital setting, the physician primarily gathers information about the child's physical condition. In some cases, the physician may provide information about the child's emotional state prior to hospitalization, if the child's family was seen previously. Nurses and hospital therapists will find it helpful to know the kinds of distress a child may have faced in the past, in order to continue with appropriate means of support within the hospital environment.

In return, the physician, knowing that the child's complete physical recovery is dependent upon a healthy emotional foundation, watches for significant behavioral changes as recorded in the daily nursing log. It is fortunate that today's physicians are increasing in their awareness of the interrelationship between an individual's emotional and physical states.

Norman Cousins, author of Anatomy of an Illness, is a former patient who describes the recuperative effects of humor on the restoration of his physical health. The accounting of Cousins' intense and prolonged efforts

has received wide-spread attention, not the least of which has come from physicians. Cousins writes,

> The thousands of letters I have received from doctors have demolished any notion that physicians are universally resistant to psychological, moral, or spiritual factors in the healing process. Most doctors recognize that medicine is just as much an art as it is a science and that the most important knowledge in medicine to be learned or taught is the way the human mind and body can summon innermost resources to meet extraordinary challenges. (Cousins 1979, 159)

In cases where a hospitalized child's attitudes or behavior seem to be impeding physical progress, the physician may gain valuable insight about the reasons for the behavioral changes from the diagnostic or interpretive remarks recorded by the specialized hospital therapists. Again, it is the interrelating and cooperation of the entire hospital team which creates the most favorable environment in which each member may work.

Hospital Therapists

For the purposes of this thesis, the term "hospital therapists" refers collectively to art therapists and play therapists. It is recognized that these are not the only categories of therapists who work in hospitals.

Play therapists have been recognized as important contributors to hospitalized children's emotional welfare since the 1950's. Art therapists' work with medically ill children progressed during the late 1970's. Both of these therapists are professional child care workers.

The art therapist provides much more for the hospitalized child than art materials, just as the play therapist does much more than provide playthings. In both situations, these specialized workers are keen observers, not only of a child's behavior, but of the symbolic content of the child's expressions.

Most hospitalized children, unless severely restricted by the nature of the illness, itself, are very enthusiastic about the materials and services which hospital therapists offer. Regardless of whether a few art materials have been supplied to the child by parents or friends, the art therapist's tray of paints, pastels, markers, and clay usually look inviting to a confined child. And regardless of how many toys a child has been allowed to bring from home, some new plaything from the play therapist usually holds a certain amount of appeal.

While observing the process of the child's creating--either creating art products through art materials, or creating a fantasy world through playthings--the hospital therapists gather significant information about the child's emotional state. The art therapist has an additional advantage of being able to study the end product of the art session, which remains available for futher observation and interpretation beyond the completion of the therapy session.

Hospital therapists report their observations of the therapy session, and offer interpretive comments about the child's expressions and the child's emotional state in their hospital report. The report remains in the patient's chart, available to nurses, physicians, and others responsible for the child's hospital care.

Hospital therapists are guided by the reports and expressed concerns about the child's behavior from nurses and physicians. In addition to the written reports, which, of necessity, must usually remain brief, hospital therapists frequently find that informal verbal exchanges with nurses and physicians help to clarify the areas of concern, and to provide direction for future therapy sessions.

Thesi Bergmann states, "It speaks for the normal child's versatility and adaptability that even severely upsetting experiences can be weathered provided that an adequate measure of support, understanding, and comfort is forthcoming from the environment" (Bergmann 1965, 30). This kind of total understanding and support can only come from a hospital environment in which a collective and unified team of professionals work together to meet the individual child's emotional and physical needs.

CHAPTER 4: DEVELOPMENT OF HOSPITAL PLAY PROGRAMS

By the 1960's, children in hospitals were faring much better than they had at any time in history. Most pediatric units had relaxed their visitation regulations in order for children to have a variety of visitors, at least throughout the afternoon and evening hours of every day.

Many hospitals allowed rooming-in by a parent. Cots and linens were provided for the parent. Later, changes in architectural design of hospitals made it possible for the overnight visitor to sleep on built-in, cushioned benches in the patient's room.

Children's emotional needs were being recognized. One specific need emerged as the next major area of concern, that of the child's need for play activities. Eva Noble, in 1967, while stating that unrestricted visiting was slowly being implemented in pediatric units, admonished that "...one very important aspect, that of emotional outlet through play, is not being given sufficient attention" (Noble 1967, 19).

"Anna Freud conceived the theory that children seek self-expression through play. Not only was this a means of providing an acceptable method for the child to express hostility, anxiety, and insecurity, but it also afforded the child a therapeutic emotional release" (Matheney/Topalis 1970, 290). Freud's use of play therapy, which grew out of the development of child psychiatry, was psychodynamic in origin.

Later on, others used this psychoanalytic model to develop a humanistic-existential perspective, with play therapy as the preferred mode of treatment. Virginia Axline (1947, 1964, 1969) and Clark E. Moustakas (1959) were leaders of this development. Axline emphasized that the play, itself, was therapy (not merely symbolic expression). Moustakas emphasized the importance of the patient-therapist relationship as a healing power (Calhoun 1977, 424).

Play therapy advanced as an effective means of helping emotionally disturbed children to cope with their feelings. Play came to be regarded as crucial to the normal development of all children, in all cultures. Eventually, play therapy programs were to make their way into pediatric hospital units.

Harold Geist, in A Child Goes to the Hospital, states,

> Play is the language of children, the medium through which children communicate with adults and with other children. Play is therapeutic because it provides a natural outlet for feelings of hostility and aggression, and also permits release of feelings resulting from unpleasant experiences through the medium of role taking. (Geist 1965, 50-51)

According to a 1972 issue of Pediatric Annals, progressive hospitals began to develop play programs around the early 1950's. They were known by a variety of names, e.g., child life, play therapy, recreational therapy, child care, and child activity (Landsman 1972, 66).

Throughout the 1960's and early 1970's, writers and prominent leaders in the movement to introduce play therapy programs to pediatric units published limited results of some of the early, innovative play programs. Smith (1961), Plank (1962), Geist (1965), Noble (1967),

Belmont (1970), Stacey (1970), Landsman (1972), Harvey/Hales-Tooke (1972), and Oakeshott (1972) were all proponents of the principle that play therapy programs were vital to the success of a well-integrated, smoothly-functioning pediatric unit.

Harvey/Hales-Tooke reported, "In 1966 the U K National Committee of the World Organization for Early Childhood Education (OMEP) sponsored a working party to consider the value of play for children in hospital" (Harvey/Hales-Tooke 1972, 11). The book which these authors published, Play In Hospital, was the resulting report of that project.

Eleanor Landsman, in writing about "The Function of a Play Program in Pediatrics," published in a 1972 issue of Pediatric Annals, states,

> In the therapeutic sense, play provides an opportunity to place the patient's hospital experiences--of pain, separation, immobility, defenselessness, frightening medical and surgical procedures--in a more understandable and tolerable context. And it is through his play that the child communicates his concerns and fears, facilitating our treatment of them. (Landsman 1972, 65)

Violet Broadribb states the need for a trained leader of a hospital play program. In her chapter, "The Play Program in the Pediatric Area," she writes,

> The time the child spends in the hospital should not remain empty. He does not live in a vacuum, but continues to grow and to develop. We can help or hinder this growth by the opportunities that we provide for him. A play program needs thought and planning if it is to be anthing more than a means of keeping the children quiet. A trained recreation leader appears to be an essential part of the pediatric staff, and the nurse can learn much from her. (Broadribb 1967, 40)

These writers seem to be in basic agreement on the major issues, that hospitalized children have a great need to play out their experiences through therapeutic, symbolic expression, and that a professional, trained person is required to facilitate and supervise a smoothly functioning, meaningful, hospital play program. Also, that this person must be an integral part of the hospital team, with access to the child's complete medical records.

In summarizing Harvey's Play In Hospital, Edna Oakeshott states that where no play therapy program exists, it has been found that children often become aggressive, uncooperative, unruly, demanding, and deprived. When children's needs are not met, Oakeshott states, the "healthy open revolt is only too likely to be replaced by withdrawal into the fears and threats of lonely fantasy" (Oakeshott 1972, 124).

Most of what has been written about pediatric play therapists applies equally to pediatric art therapists. The goals in working with infirmed children are basically the same. Where it has been stated that hospitalized children have a need to play out their experiences, it can be stated, rather, that these children have a need to express their experiences symbolically. This symbolic expression can occur through play; it can also occur through art.

CHAPTER 5: ART THERAPY

The Growth of a Profession

> Art Therapy is a human service profession. Art Therapy offers an opportunity to explore personal problems and potentials through verbal and nonverbal expression and to develop physical, emotional, and/or learning skills through therapeutic art experiences....Therapy through art recognizes art processes, forms, content, and associations as reflections of an individual's development, abilities, personality, interests, and concerns. The use of art as therapy implies that the creative process can be a means both of reconciling emotional conflicts and of fostering self awareness and personal growth. The benefits of art therapy experiences are applicable to populations with special needs. Art therapy may be primary, parallel, or adjunctive therapy in psychiatric centers, clinics, community centers, nursing homes, drug and alcohol treatment clinics, schools, institutions, half-way houses, prisons, developmental centers, residential treatment centers, general hospitals, and other clinical, educational and rehabilitative settings.
>
> Statement by the American Art Therapy Association, Inc., 1979

The art therapy profession grew out of psychoanalytic origins in the 1930's and 1940's. Its growth parallels the development of psychiatry. "Training for art therapy is a recent development. The field came into existence through the pioneering efforts of independent practitioners, most of whom remain active today" (Statement by AATA, 1979).

The Association is ten years old, with annual conferences held since its conception. The American Journal of Art Therapy, originally entitled Bulletin of Art Therapy, has been published for nearly twenty years. Today (1980) there are approximately 800 active members in the American Art Therapy Association (AATA), with an additional 300 student members. Eighty per cent of employed art therapists have masters degrees; four per cent have doctorates; seventy per cent are supervised by psychiatrists or psychologists. Art therapists must meet strict certification requirements, and they are governed by a professional code of ethics. (AATA information brochure, 1979.)

Art therapists work with people of all ages, as individuals or in groups, in many different kinds of settings and with different areas of emphasis. Some art therapists emphasize psychotherapy. Others emphasize art as therapy, and they see the role of art therapist as combination artist-therapist-teacher. Still others place much of their emphasis on diagnostic and evaluative art therapy. In the last fifty years, a great many people have contributed to the growth of this emerging profession.

Margaret Naumburg was the first art therapist to publish her work and research. She spent nine years developing art therapy at New York State Psychiatric Institute. Her first publication on art therapy in 1947 was a compilation of six studies from her early research, now included in her book, An Introduction to Art Therapy (1973).

Naumburg's development of art therapy was as a "primary therapeutic method." She worked intensively with individual behavior-problem children and adolescents. Her emphasis was on the use of art in

psychotherapy. She used fundamental psychoanalytic tools, such as release of unconscious material by way of "spontaneous art expression," transference between patient and art therapist, and free association (Ulman/Kramer/Kwiatkowska 1977, 7).

Edith Kramer developed her theory and methods of art therapy approximately one decade later than Naumburg. Like Naumburg, Kramer's orientation to art therapy was psychoanalytic. "The basic aim of the art therapist," writes Kramer, "is to make available to disturbed persons the pleasures and satisfaction which creative work can give, and by his insight and therapeutic skill to make such experiences meaningful and valuable to the total personality" (Kramer 1958, 5-6).

Kramer considers the art therapist role to be a combination of three roles: artist, therapist, and teacher. "We may say that the art therapist is a specialist who combines the general qualification of being a competent artist with specialized skills in the field of psychotherapy and education" (Kramer 1958, 7).

Kramer puts much emphasis on the process of sublimation through the use of art materials. She describes sublimation as "a process wherein drive energy is deflected from its original goal and displaced onto achievement, which is highly valued by the ego, and is, in most instances, socially productive" (Kramer 1971, 68).

Kramer's interpretations of patients' art work frequently indicate a strong trend toward Freudian psychoanalytic concepts, however she does not advocate therapist interpretation of the sublimated material to the patient. Her orientation to art therapy differs from Naumburg's in that the emphasis is on "the idea of art as therapy rather than on psychotherapy which uses art as a tool" (Kramer 1971, xiii).

Dr. Mala Betensky, a clinical psychologist and art therapist in private practice, developed a humanistic approach to art therapy. Like Naumburg, Betensky considers psychotherapy to be of utmost importance in the art therapy experience. In the preface of her book, Self-Discovery Through Self-Expression (1973), Betensky states, "The use of art media afforded ... patients authentic experiential sources of awareness and thereby enabled them to find understandable and viable patterns and meanings in their lives" (Betensky 1973, x).

"All psychological events," explains Betensky, "are anchored in awareness. Awareness is a conscious psychological experience." It arises "at a moment of the present, between subject and environment," and is a combination of feelings and thinking (Betensky 1973, 334). Betensky discovered that art expression is a viable avenue through which awareness may be discovered.

Betensky emphasizes the "interdependence between cognition and emotion." She states, "Such interdependence takes place through art expression in the fine arts as well as in psychotherapeutic art work.... [it] pervades human life in general. Perhaps this is the meeting point of personality and art" (Betensky 1973, 339).

Janie Rhyne is another humanistic art therapist, whose personal emphasis is on a "gestalt art experience." Gestalt art experience, as defined by Rhyne in her book, The Gestalt Art Experience (1973), is "the complex personal you making art forms, being involved in the forms you are creating as events, observing what you do, and hopefully perceiving through your graphic productions not only yourself as you are now, but also alternate ways that are available to you for creating yourself as you would like to be" (Rhyne 1973, 9).

Throughout the 1970's, numerous books on art therapy emerged. Kramer (1971), Lyddiatt (1971), Betensky (1973), Harris/Joseph (1973), Naumburg (1973), Rhyne (1973), Ulman/Dachinger (1975), Robbins/Sibley (1976), Williams/Wood (1977), Anderson (1978), Kwiatkowska (1978), Roth (1978), Rubin (1978), Silver (1978), Virshup (1978), and Uhlin (1979) are all recent contributors to art therapy literature. Two of these, Ulman and Kwiatkowska, stand out as having contributed valuable work in the area of art therapy for patient diagnosis and evaluation.

Elinor Ulman, editor of American Journal of Art Therapy and co-editor of Art Therapy in Theory and Practice (1975), is another pioneer in the art therapy profession. Ulman considers that art expression is a power which comes from within the personality. "It is a way of bringing order out of chaos.... a means to discover both the self and the world, and to establish a relation between the two" (Ulman 1975a, 13).

One of Ulman's primary contributions to art therapy is centered on her diagnostic work with psychiatric patients. Ulman's diagnostic series of pastel drawings has been used extensively by art therapists, some of whom work in adjunctive positions with psychiatrists and psychologists where a great deal of emphasis is placed on patient diagnosis and evaluation (Ulman 1975b, 361-86).

Hanna Yaxa Kwiatkowska, another pioneer, is also well-known for her diagnostic work. Kwiatkowska's emphasis is on the evaluation of family groups for family therapy work. Like Ulman, Kwiatkowska developed a very specific procedure for family art evaluation, as described in her

book, Family Therapy and Evaluation Through Art (1978). Her developments grew out of working with families of schizophrenic patients, but the techniques are now applicable for a wide variety of family counseling and diagnostic work.

Many art therapists have centered their work around children and adolescents, not only emotionally disturbed children, but also those with behavioral problems, physical disabilities, and learning disabilities. The fine line between art therapy and the teaching of art in schools is one of constant debate between art therapists and art teachers. Many years ago, Viktor Lowenfeld paved the way for art therapists working with children by publishing his research on children's developmental stages and how development is clearly reflected in children's art work. His book, Creative and Mental Growth, originally published in 1947, has been revised six times and is still a valuable resource to those interested in children's art work.

Judith Rubin stands out as an art therapist who offers both sensible and sensitive advice, not only to art therapists, but to all professional adults who use art with children. In her book, Child Art Therapy, Rubin emphasizes the balance between rigidity and chaos, neither of which she considers to be conducive to creative function. Rubin states, "... in creative expression there can be no true order without some experience of genuine freedom; ... the provider of art for children must make possible a productive and integrated relationship between the two" (Rubin 1978, 22).

Regardless of the setting in which a child works with art materials, Rubin emphasizes the need for an adult "to provide him with the physical

and psychological setting in which he can freely struggle to order and control." She states that the child needs "an adult to provide empathic support, accepting understanding, a reflective mirror ... a vessel into which he can freely pour his feelings and fantasies; and a reflective, articulate voice which can help him to clarify, explain, and make sense out of them" (Rubin 1978, 30).

Art Therapy in a Medical Setting

Rubin's words precisely define the role of an art therapist working with children in a hospital setting. Here, where children struggle mightily with numerous stress factors, affecting both psychological and physiological processes, the need for sensitive guidance and support from a trained art therapist is readily apparent.

The use of art materials with ailing children is hardly a new concept. Parents have always been quick to reach for the crayons, plasticine, or paint box at the first sign that a child is to be confined to bed for any length of time.

Therapeutic use of art materials in an institutional medical setting also goes back many years. One of the earliest documented accounts of art therapy in a medical setting is a book entitled Art Versus Illness, A Story of Art Therapy by Adrian Hill. It was published in 1945, two years before Naumburg's earliest publication on art therapy.

Hill was a noted English artist who was confined to a sanitarium with tuberculosis for four years in the late 1930's. In order to face

the inextricably slow passage of time during his extensive convalescence period, Hill naturally turned to his art materials and discovered, what he termed "art therapy," for himself.

Following his release from the sanitarium, with the encouragement of his doctor and the supervisor of the institution, Hill returned to share the art therapy experience with many other patients. Hill's advice to the tuberculosis patients, during his introductory talk, was that "the art germ when once it becomes firmly planted in the mind and heart, is far more difficult to dislodge than another germ with which you are all more familiar. Indeed the former germ can help enormously in banishing the latter bug" (Hill 1945, 30).

Many of Hill's personal discoveries about using art therapy with medically ill patients provide sound advice for today's art therapists working in medical settings. The technique Hill developed and referred to as "doodling" is now known as the combination of "scribbling" and "projection." His observations about patients and their art work, and his skills in being able to reach the wide assortment of adults who became patients in the sanitarium, are both admirable and inspirational. Hill created, as well as documented, the therapeutic use of art in a medical setting, and yet many years were to pass before this specialized field would be recognized as an important avenue for art therapists to pursue.

Until recently, nearly all art therapy work centered around patients with mental disturbances. Initial exceptions to this were art therapists working in schools or clinics, usually with handicapped youngsters. A review of the quarterly publication of American Journal of Art Therapy reveals that, during the 1960's and 1970's, art therapy was discussed

solely in terms of psychiatric, rehabilitative, or educational uses. Art therapy in a medical setting was not presented at AATA annual conferences until the latter part of the seventies.

Today, interest in the use of art therapy with medically ill patients is increasing and, depending on economic situations, is likely to witness rapid growth in coming years. It is applied to both children and adults, with long-term and short-term illnesses.

Hanna Kwiatkowska, in introducing a panel on art therapy with medically ill patients at the 1978 AATA Conference, stated,

> The preliminary observations of this newly revised application of art therapy are surprisingly impressive and have roused considerable interest. The use of art therapy with patients whose strong, troubled feelings related to their illnesses were otherwise suppressed and therefore verbally incommunicable, proved to be of great help in their treatment. It soon became evident to the staff of hospitals where these experiments were conducted that this approach opened a unique avenue for the expression of stress, fear, grief, anger, and despair experienced by patients. (Kwiatkowska 1979, 117)

At the tenth annual AATA Conference, in November 1979, art therapists presented illustrated work on: "Art Therapy and Anger, The Common Denominator in Children's Diseases" (V. Austin), "Applications of Art Therapy with End Stage Renal Patients" (B. Bruck), "Art Therapy and the Trauma of Cardiac Care" (T. Cady), "Art Therapy in the Field of Oncology," (E. Dreifuss), "Art Psychotherapy as an Adjunct in the Medical Management of Cancer Patients (C. Wolf), and "Art Therapy with Life-Threatened Medically Ill Children" (Bruhn, Datel, Jensch, Sims). The conference was attended by 1100 art therapists, students, or persons in related fields of interest, and it was quite obvious that interest in the uses of art therapy with medically ill patients is increasing.

One reason why art therapy is proving to be such an effective means of reaching patients with physical ailments is the therapeutic value of the art media. For some patients, the process of working with art materials offers the most satisfying element in the art therapy experience.

Mala Betensky states that some art materials, "by virtue of their kinship with universal forces, ... when we willingly work them with our hands can reach and stir deep emotional levels in us" (Betensky 1973, 308-09). This experiential part of the art therapy session is, in and of itself, therapeutic.

Patients confined to bed for extensive periods of time are particularly attuned to the therapeutic qualities of art materials. Their world has shrunk to a disturbingly shallow array of visual and tactile senses. "I know it sounds silly," confessed one young-adult patient following spinal surgery, "but it just feels good to be coloring."

The hospitalized child's appeal for the therapeutic manipulation of art materials arises from a source which is quite different from an adult's. It is the young child's desire to mess. The child in the hospital is quick to notice the emphasis which is placed on cleanliness. The hospital room is cleaned daily; clean linens are provided freely; there are frequent (often fruitless) attempts by adults to keep the child's playthings and belongings tidy. Wounds, of course, are kept scrupulously clean. In most hospitals, the child is even expected to bathe daily.

Some children balk at all of this unnatural cleanliness. These children soon discover that art materials not only feel good, but they provide an appropriate means for creating, sometimes, a rather large mess.

For this reason, the pediatric art therapist provides plasticine and modeling clay, in addition to drawing and painting materials. Clay has the additional advantage of providing the child with activity requiring exercise and manual dexterity.

Another reason why art therapy is valuable for medically ill patients is that it provides an avenue for creative expression and emotional release. Effler and Sestak point out that art therapy in a hospital is never the primary intervention. Hospital patients remain medical patients throughout their hospital stay. The primary goal is to reverse the physical disorder.

Nevertheless, these authors state that art therapy may become a potent catalyst in the recuperative, re-adaptive processes. They write,

> We [art therapists] begin to alter our goals, much as the patient must, to focus on the issues of successful adaptation; regression in the service of recovery (through regression with art materials), maintenance of adequate defenses against stress (through art education or an art as therapy approach), and access to feelings, fantasies and the ability to communicate (through free expressive work and the communicative value of art therapy). And, perhaps most basically, trust. (Effler/Sestak 1979, 56-60)

Pat Levinson, art therapist in the burn unit of St. Francis Hospital, San Francisco, conducted a pilot project with pediatric burn patients. The preliminary results of her study were presented at the 1978 AATA Conference. Levinson states that the goals of the program are "to provide severely burned children the opportunity to

ventilate feeling through the use of creative media, to bridge the gap between home and hospital, and to clear up misconceptions regarding hospital procedures." The results of her project are positive. "The children eat better, have fewer nightmares, and, on the whole, are more responsive. As their moods improve, the children are more cooperative, less manipulative, and regressions prior to discharge decrease" (Levinson 1979, 20-21).

Ruth Obernbreit, an art therapist who travels to chronically ill homebound patients, also reported the results of her work at the 1978 conference. She concludes,

> The physically disabled have to give up certain controls due to physical limitations but they still can have control over the emotional aspects of their lives. With the conventional ways of getting feedback about themselves missing, they must have some other means of getting this information. Art can address these problems by serving to reflect and mirror apsects of the healthy self--its emotion, ideas, perceptions and energy. (Obernbreit 1979, 60-62)

One way in which creative art expression plays an especially important role in the lives of medically ill patients is when sublimation occurs. Sublimation provides the patient with an acceptable and desireable avenue for defenses against the stress of anxieties.

In her article, "Art Therapy and Play," Edith Kramer discusses the way in which art activities invite "extensive sublimation" at a level which play activities rarely attain. Although Kramer sees art as resembling play, "inasmuch as it also enjoys sanctuary from the laws of time, place, and causality," she points out that "art demands the creation of symbolic equivalents for experience and this links it to work" (Kramer 1977, 8).

According to Kramer, play helps the child to maintain equilibrium between gratifying physical and emotional needs, and to neutralize the frustrations imposed by the surrounding environment. "To a limited extent, elements of sublimation are present in play as well as in art," explains Kramer, however she believes that play activities respond primarily to the "pleasure principle," and therefore do not present "a whole picture of the great contradictions of human existence." She explains further with the following example:

> Both play and art afford reassurance by providing the opportunity to take the active role in reliving experience that actually had to be endured passively. But even at an early stage, art is likely to encompass a broader truth. For example, after a painful medical examination a child will often play the part of the doctor. The child who makes a picture of himself in the doctor's hands usually shows himself as helpless before a terrifyingly powerful figure.
>
> Unlike play, art has the means to present truthful images of the conflicting realities of man's experience. At its highest level art establishes within the confines of its symbolic world states of harmony between antagonistic forces. This harmony is achieved without recourse to radically repressive measures that would obliterate the conflicting components.
>
> To create such images it is necessary to face difficulties and dangers far beyond the enticing obstacles of play. The child-artist must face unwelcome truth, make far-reaching decisions, renounce easy gratifications. In psychoanalytic terminology he must become capable of extensive sublimations. (Kramer 1977, 8)

Sublimation is not always the goal of the art therapist working with a hospitalized child, but the opportunity for sublimation to be achieved must remain constantly available to the child.

The relationship between art and play is one which must be considered by art therapists, particularly those working with children. Mala Betensky talks about it in her chapter, "Roles of Art and Play in Psychotherapy." She states,

> ...soon enough the child senses and discovers that by the stroke of the hand, things happen on paper that will not happen with toys and playthings. On paper or with clay, something is made that was not there before. This something is new and akin to a small act of creation. The little child who cannot play will benefit from an opportunity to experience such acts of creation. He is the child who was not given the experience of play, or the child too full of fantasies to play; he is the naturally slow child, the child stricken by perseveration, the child whose deep angers are threatened by play, and the child for whom nothing works at play. (Betensky 1973, 332)

Betensky's descriptions are primarily of child patients in art psychotherapy sessions, but such children--those who "cannot play"--are seen frequently in the hospital environment, as well. They have become deeply unhappy, withdrawn, fearful, anxious children. For the child who cannot play, art materials may hold a special appeal.

There are no rules of how the materials must be used, and no preconceived notion of what has to emerge from the therapy session. No play-acting is expected, and verbalization is not required. Any amount of creating is encouraged, no matter how small. If art sessions are made available on a frequent enough basis, the child who cannot play may gradually re-discover the life energies which are essential to his or her emotional well-being.

Some children, on the contrary, choose to play with the art materials or art products. Kramer states that art therapists "must encourage

playfulness to stimulate imagination, yet intercede when art threatens to dissipate into play; must tolerate regression from art to play or assist in the transition from play to art, according to the exigencies of the various situations they encounter" (Kramer 1977, 3).

Art therapy provides the hospitalized child with an opportunity to experience visual and tactile sensations, providing therapeutic release of energy. Art therapy also allows opportunity for sublimation to occur. Art materials may be experienced playfully at times, and may be used for serious, introspective expressions at others. When a patient faces severe disabilities and losses of the physical self, art therapy serves as reinforcement of the emotional self.

CHAPTER 6: DEVELOPING A PEDIATRIC ART THERAPY PROGRAM

The reader is requested to make an abrupt leap into this author's personal life, for the next two chapters are based on personal experiences from art therapy sessions with medically ill or injured children. The hospital experience is based on eight months of practicum work as partial fulfillment of a masters degree in art therapy.

The Hospital

My personal awareness of, and interest in, using art therapy with medically ill children grew out of a totally different practicum experience, that of working with adult psychiatric patients. The psychiatric unit in which I was placed was located within a small private hospital. My supervisor, who was hired solely for art therapy work in the psychiatric unit, saw a need for art therapy in some of the medical units, as well. Funds were not available for extending her hours to include this additional work, but she did receive permission to place students in these positions, under her supervision.

The Patient Care Supervisor (head nurse) of the Pediatric/Young Adult Unit was a young woman who was interested in art therapy, and who became very supportive of our efforts to introduce art therapy to her unit. At the time I came to the hospital, the art therapy program

had been in existence for about one year. In the pediatric unit, the program remained virtually unstructured. A few art materials were stored in a tiny cabinet which, to my dismay, was located approximately two feet above the top of my head. There was very little structure in the way of working hours, staff contacts, or communication between those students who had worked in the program before and members of the pediatric staff.

Unfortunately, I was only able to work in the hospital one day a week. Five to six hours of that day were spent in the psychiatric unit. That left only two to four hours for my work in pediatrics. My limited hours on the unit gave me very little exposure to staff members, and a number of weeks passed before I began to gain a solid sense of how the unit operated. Some of the nurses and other hospital workers were vaguely aware of the occasional art activities, but introductions had occurred only haphazardly, and most staff members had not been introduced to me or to art therapy directly.

At first, it was not made clear to me which staff person should be contacted in order to know which patients could be contacted for participation in the art therapy program. One corner of a small chalk board had been designated as the place to list patients' names for art therapy, but it was located behind a bulky ice cream freezer and was rather awkward to reach. I discovered that it was rarely kept up-to-date.

Although my art therapy work and notes were shown to, discussed with, and signed by my art therapist supervisor, and the art therapy program was supported by the Pediatric Patient Care Supervisor,

neither of these people were available to me for direct supervision during my hours on the pediatric unit. I remained, so to speak, "on my own."

I formed an alliance with one nurse who was, from the onset, always willing to stop what she was doing long enough to check the patient list and offer a few suggestions of patients to contact. This alliance was important in helping me through my initial months of trial-and-error. It would not, however, have been sufficient to sustain my interest in the work, in spite of numerous obstacles along the way.

Yet my interest was far more than merely sustained. It mounted, week by week. I felt pulled, gripped, by the array of young medical patients I was meeting. Long before I knew how to interpret or explain it, I sensed that something very exciting, very powerful, and very important was happening between the patients, the art materials, and myself. It started and is best illustrated with Teri,* my first pediatric patient.

Teri: A First Step

Teri was a ten-year-old girl who had fallen off the "monkey bars" at school, resulting in a fracture of her left arm. I found her, on my first day of work in the pediatric unit, lying in bed, rather uncomfortably, with her left arm in traction. She was staring mindlessly at television cartoons.

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*All names have been changed to protect patient confidentiality.

Teri was pleased to be able to use the art materials. She began by drawing a stereotype picture of house-tree-flowers-sun. I noted that no people or animals had been included. She set this aside, with no comment, and proceeded to draw a picture of a small person, lying in a huge hospital bed. "I don't know what else to add," she commented, looking around the room. "I guess I could draw the curtain." She added the privacy curtain which enclosed her corner of the room. The drawing was boxed in with a line, containing it to the lower right one-fourth of the paper.

Although Teri was friendly, chatty, and self-sufficient (she insisted on pulling the marker caps off with her teeth, rather than ask for my help), the pictures told me that she was feeling isolated and lonely in her corner of the big room. The room contained three other beds, only one of which was occupied by a tiny, very sick infant. Except when Teri had visitors, she had no one to talk with and very little to occupy her thoughts.

The following week I was informed that Teri had a roommate--eight-year-old Marie, who had met a fate similar to Teri's when she fell out of a tree. As I entered the room, Teri whooped for joy, exclaiming to Marie, "There she is! I told you she would come today!" I was amazed at the difference in atmosphere from the previous week.

Teri and Marie chatted amiably back and forth, including me in their conversation as they busied themselves first with clay, then with drawing materials. Teri created a small bed out of clay, in which she placed a tiny, clay-modeled doll. It told me about her concerns of being nurtured during her convalescence. With crayons, she repeated the

house-flowers-sun picture, but this time Teri added her dog, Boots. As she described Boots and his humorous antics, Teri was allowed an opportunity to focus, both visually and verbally, on her important ties to home.

In the middle of the art session, Teri's doctor entered for a brief visit, during which time he released her arm from traction and informed his patient that she would be discharged that evening or the next day. When he left, Teri drew a "big, beautiful butterfly," with a comment about how "free" butterflies seem. Being released from the weight of traction, and soon to be discharged from the hospital environment, Teri quickly focused on a symbol which, to her, meant freedom.

"I know what I'll do! Don't look," she ordered. Teri completed the next picture and handed it to me to keep. She called it "Art Therapy Time." (SLIDES 1-4) As in the previous week's hospital picture, Teri drew herself lying in bed in one corner of the room. The bed did not appear as large, in comparison to the patient, as it had in the previous week's picture. Additions of closet, bedside stand, and rolling tray table were included, but the privacy curtain was not added.

Teri drew Marie below herself, similarly lying in bed with her arm in traction. Each of the two bed areas are sectioned off with a line, dividing the paper into two quarters.

On the opposite side of the page, coming toward the beds, Teri drew me. I am walking in the door, carrying a tray of art materials and saying, "Hi, I'm Phyllis Childers. I'm an art therapist."

Teri's answer to me in the picture is, "Hurray, Yippee, Yahoo, All right." Marie is shown answering, "Great, Super, Yahooe, Terrific. When do we start?"

No words could have thanked me more completely for my participation in Teri's hospital care than the images in that picture. As a final farewell and thank-you message, Teri drew one more delightful, fantasy-like picture of tree, flowers, birds, a big beautiful butterfly, and other assorted creatures of nature. She added a message which said, "Have a Happy Day, Phyllis." (SLIDE 5)

The art therapy session was highly beneficial to both Teri and myself. Teri was happily on her way out of the hospital and, with Teri for inspiration, I was on my way to create a pediatric art therapy program which would benefit as many children in need as possible.

Changes

I felt hampered by some of the problems in pediatrics, not the least of which was the limited number of patients I was contacting. An enlarged and more structured program seemed vital to the eventual success of the pediatric art therapy program. Several changes were made which helped in this structuring process.

First, I requested that my working hours be confined entirely to the pediatric unit. Additional students placed in the hospital at that time allowed for expansion of the hospital art therapy program in all of its locations. Besides my one full day per week, another art therapy student worked two mornings per week in pediatrics.

Second, art therapy sessions were offered to pediatric patients in a group setting twice a week. Afternoon hours were reserved for individual sessions with patients who could not be moved from their rooms.

Third, larger and more accessible space for storage of art materials was found. Unfortunately, because of the new cabinet's location in the pediatric playroom, the materials were sometimes used by others outside of the art therapy program. The materials were often found in disarray or they disappeared altogether. Art therapy relies on the use of art materials. Eventually, we had to insist on exclusive use of these materials.

Fourth, communication with other members of the hospital team was improved. A meeting was held to explain the purpose of the art therapy program to nurses, and to get their feedback of the program. I drafted two memos, one to nursing staff, explaining the art therapy program and specifying details of hours and communications. (Appendix I.) The other was an illustrated letter to "Families of Patients in Pediatric Unit." (Appendix II.) In less technical language, it describes the benefits of the art therapy program.

It was agreed that I would meet with the nurse who was working as Shift Coordinator each day in order to determine which patients could participate in the program. The Shift Coordinator would contact the nurses responsible for patients who needed assistance being brought to the group. As a student, I was not covered by hospital insurance and could not move patients from bed to wheel chair or stretcher and back.

We also agreed that an effort would be made to maintain two-way communication between nurse and art therapist as to a patient's daily schedule. Some patients would occasionally have to be brought to the art therapy group after it had started or would have to leave early, but it was helpful for patient, nurse, and art therapist to understand the schedule in advance.

Once these changes were put into effect, the art therapy program was able to include many more patients. Communication improved immeasureably. Nurses read the progress notes of their patients' art therapy sessions, came to me with questions and clarification, and willingly answered questions in return. They noticed direct results of their patients' participation in the program, and were quick to disclose these behavioral or attitudinal changes. They offered suggestions and we were able to interact more freely.

Sometimes suggestions for improvements came directly or indirectly from patients. One little boy in an art therapy group kept looking up anxiously whenever he heard footsteps coming down the hall. Finally he confessed that he was expecting his mother that morning, and he was afraid she would not know where to find him.

I offered to leave a large note on his bed telling where he could be found. A few minutes after I had done that, his nurse came to the group setting, exclaiming how nice it was to have found the directive note on his bed, so she knew right where to look for him when it was time for his medication.

After that, we made a dozen colorful signs stating, "I'm at ART THERAPY in the lounge at the end of the hall." These were routinely

distributed to patients' rooms when they attended one of the groups. It was a very simple solution to a communication problem which had formerly evoked stress in both patients and staff.

Art Therapy Group

Our art therapy groups met in an open lounge area at the end of the hall. It was a spacious, well-lit, fairly attractive area which had a long table, chairs, and enough room for wheel chairs or stretchers. One wall was floor-to-ceiling windows, overlooking a beautiful river inlet with sailboats, docks, and a weeping willow tree. Some patients found it therapeutic just to look out of that window!

Like any other randomly-selected, flexible gathering of people, our groups met with varying degrees of success. I was pleased to discover that patients could remain supportive of each other, regardless of their ages and other differences.

Eva Plank, in Working With Children in Hospitals, explains why this occurs. She states,

> The common denominator in the hospital is not primarily age or sex, nor the socio-cultural background: it is the anxious uncertainty through separation and pain which creates a strong bond. The support children give each other works in both directions: older children can function as protectors and playmates for younger ones, while the helplessness of the very young, and the delight in seeing developmental changes in an infant or toddler, can act as a morale-builder for children slightly older and up to adolescence. (Plank 1962, 9)

The age range for patients participating in our groups was four to twenty years. Some of the groups happened to form with same-sex, close-in-age patients, but this did not always assure success for the group interactions as a whole.

The most cohesive feeling of "groupness" existed in one group which consisted of four boys and two girls: a non-verbal but highly energetic four-year-old boy; a six-year-old boy who had become alternately hostile and withdrawn during his hospital stay; an eleven-year-old boy who was extremely creative and talented; a fourteen-year-old boy who was very reluctant to join the art activities, and who only came after much coaxing from his nurse; a fourteen-year-old diabetic girl, who was hospitalized for about the fifteenth time in her life; and an eighteen-year-old highly athletic girl, who stopped by to watch and ended up being a participant. The interaction and support between these participants was a joy to watch. Several of these young people will be discussed individually in the next chapter.

That particular group enjoyed the morning activities so much, they requested art therapy group again in the afternoon. The child who pleaded the most was the six-year-old who had previously been so difficult to manage. Even the fourteen-year-old boy, who had been so wary of joining the earlier activities, returned voluntarily after lunch and worked on a clay head for an hour. Not all of the groups were that dynamic, but most of them held some positive aspects.

I was repeatedly surprised at the interactions which occurred between patients who appeared to have the least in common. I could never predict the mood of a group. For the most part, patients met each

other for the first time when they came to the art therapy group. It was not uncommon to observe shyness and reservation during the first awkward moments as patients adjusted to each other and "sized up" the situation.

Art materials were already spread out on the long table so patients could feel free to start as soon as they arrived. Keeping their hands busy and having a place to focus their attention helped in allowing patients to adjust to this new situation at their own pace.

No formal structuring of the therapy hour occurred. Even the ending time for the group had to remain flexible, depending on each patient's physical and emotional states. Patients were encouraged to talk about their art work, but this was done informally and spontaneously.

As patients worked, verbal sharing was invited. With gentle, probing questions or comments while passing around art materials, I found that conversation was not difficult to get started. Soon patients were comparing different apsects of their hospital experience and lives. Those who needed to work quietly or peripherally did so, but feelings of sharing the separation, losses, and pain of hospitalization occurred, regardless of the participation level. The art activities allowed for a central focus of interest while tentative verbal exchanges took place.

Individual Patients

The majority of the long-stay patients in a general hospital pediatric unit--the patients most likely to be referred to art therapy--are those with orthopedic problems resulting in several weeks of traction. All of these patients need to be visited individually in their rooms. Other patients who need individual contact are those with illnesses requiring isolation or complete bed rest. Often these young people are too sick to have much interest in art activities or visitors. Toward the end of their hospitalization, as they are feeling more energetic, they might be visited once or twice by the art therapist before their discharge.

Individual art therapy with pediatric patients is quite different from the group setting. All of the interaction takes place between patient and art therapist. There is generally a stronger focus on the art materials and products than with youngsters in the group. No comparison (even subconscious) can be made between one individual's art products and another's. The individual patients seem outwardly more appreciative of the art therapist's contacts than those in the groups. They are more confined, and their pictures frequently show signs of loneliness, isolation, and desolation. The amount of verbalization that takes place during an art session varies from one patient to another, just as it does in the group setting, but there is greater opportunity for sharing with only one other person in the room.

Orthopedic patients are often positioned rather awkwardly in their beds. To provide a viable way of working with art materials amidst the

orthopedic equipment sometimes requires ingenuity. I found that large, disposable, styrofoam trays from the kitchen were ideal for a work surface. The art paper can be taped onto the tray and the patient can hold the tray easily without placing weight on the abdominal area. In the case of arm traction or I.V.'s, it is sometimes necessary to help support the tray while the patient works.

The most incessant problem which exists while working with individual patients is the ever-present, droning television set. The effects of television during a child's hospitalization is probably worthy of an entire masters thesis, itself. This discussion will be confined to the effects of television during an art therapy session.

Stated very simply, television interferes. It matters little what kind of program is being shown, whether the patient is interested in the program or not, whether the television is right next to the bed or hanging from the ceiling across the room, how loud the sound is, or whether the sound is turned on at all.

When a television is left on, it interferes with concentration and with conversation between art therapist and patient. I insist that television be turned off during art therapy sessions, even though I risk a few patients choosing television over art.

Another problem which occurs while conducting art therapy sessions individually is visitors in the room. This, too, causes interference with the creative art process, concentration, and patient-art therapist verbal exchanges.

Privacy during individual art therapy sessions is necessary to insure that the patient will maintain freedom of expression, an unbroken flow of

expressive material, and unrestricted use of art materials. Privacy also aids in a more rapid development of patient-art therapy relationship. Also, even a silent visitor in the room may create an unspoken feeling of pressure about when the session will end and when the art therapist will leave.

When two or more patients share a room, it is preferable to form a semi-group, with all roommates participating at the same time, exclusive of other visitors. When only one patient in a double room is participating in art therapy, the other patient becomes a silent visitor. It is helpful to visitors if a sign is placed on the patient's door stating the ending time for the art therapy session.

As I developed a larger and more structured pediatric art therapy program, I worked through problems of communication, scheduling, storage, group versus individual art therapy, television, and visitors. I conducted art therapy sessions with a wide variety of children and adolescents. I remained constantly impressed by the art expressions which emerged from the pediatric art therapy program, many of which will be illustrated and discussed in the following chapter.

CHAPTER 7: ART EXPRESSIONS FROM THERAPY WITH MEDICALLY ILL CHILDREN

The art expressions which emerged from therapy sessions with my pediatric clientele will be discussed according to four age groups: Preschool Age (three to five years); Elementary School Age (six to twelve years); Early Adolescence (thirteen to fifteen years); and Late Adolescence (sixteen to nineteen years).

Preschool Age (Three to Five Years)

Unless they remain severely hampered by their reason for hospitalization, three- to five-year-olds are almost totally in favor of art therapy. It is more challenging to bring the session to a close than it is to get it started.

When I work with preschoolers, I offer a very limited choice of art materials, preferably not more than three different items (plus paper). I provide fragrant water color markers, paint-markers, and crayons. When the child chooses to work with plasticine or clay, I leave out one of the first three choices.

I do not tell the very young patient about the art session until it is time to begin. At this age they quite literally "can't wait." If scheduling needs to be confirmed early in the day, I speak to the parents and/or nurse about it, not to the child.

I use a simple, basic pattern for the entire art session. First, I name and demonstrate each art medium. The purpose for this is two-fold. First, it provides the child with a working vocabulary for the remainder of the session, and second, it allows the child to observe me for a few minutes at the beginning of the session, in order to develop security and confidence.

I then ask the child to choose which material to use first. This choice is placed closer to the child, but the other choices remain visible. For two-dimensional work, I ask, "What color would you like to start with?" I praise them warmly for being able to identify colors correctly, and I help them when they get the names of the colors confused. Color identification and choice becomes important to children at this developmental level, and they are often proud of this recent accomplishment.

I watch carefully, and if the child seems unsure of what to do next, I simply ask, "Is your picture finished, or does it need something else?" If the child answers, "It needs something else," I repeat, "What does it need next?" or "What color does it need next?"

These questions are repeated, with little variation, as many times as necessary until the child answers, "It is finished." Sometimes they answer, "It's almost finished." I never assume that the child is finished until she or he states that it is.

Some small children require more prompting than others, but this limited, almost rhythmic flow of questions and answers provides the small patient with a sense of security and does not interfere with the art process.

I have a fresh sheet of paper ready, and the entire process begins anew. Children of this age generally work quickly. They may produce a series of six to ten pictures within one session. As they finish, I ask them to name their picture. I write the picture title, child's name, date, and number of the series on each picture as it is finished for easy identification later.

With children confined to their beds, I provide disposable, water-proof, sheet-protector pads, plus a fresh wash cloth for clean up. The pads not only encourage the child to use the materials freely, but they keep me in good standing with the nurse who probably just changed the linens. Parents appreciate not having to use the child's clean wash cloth for wiping off the remains of clay, markers, and paint.

The expressions of three- to five-year-olds are always very meaningful, even if I am not able to accurately interpret the meaning. Sometimes the child gives me verbal clues, and sometimes I am left guessing.

At one time, I believed that most pre-representational art was experimental and random. My thinking on this matter has changed considerably as I have begun to watch, from an art therapist's perspective, two- and three-year-olds' earliest attempts at drawing.

One recent visitor to my home who had just turned three became irate with his older sibling and two of her peers when they refused to include him in a game which was intended for older children. To distract his attention, I settled him into a different room with paper and markers. Then I watched in fascination as he produced one drawing after another on the same theme.

He drew a long horizontal line down the length of the paper. Perpendicular to this line, he added a cluster of three smaller straight lines. Separated from the three lines, he added one tiny line toward the edge of the paper. Some of the pictures had the smaller line omitted altogether, just as he had felt omitted and separated from the three larger children. Had I not been an observer of the entire process which led up to these drawings, they would probably have appeared experimental and random.

It is not always possible to know what is uppermost on the minds of the very young hospital patient, but I believe that their expressions are as important to their growth and development as the more advanced representations of older children.

One little girl presented a repeated configuration of circular lines which made no sense to me until she began to verbalize her thoughts. Debbie, three-and-one-half, was hospitalized for tests to rule out mononucleosis, following a prolonged viral infection and fever. She was confined to bed except for bathroom privileges. Debbie's first three pictures repeated the theme and title of "circles." She drew multi-colored, concentric rings around the page, some of them closely adhering to the edge of the paper.

I puzzled over the meaning of her visual statement until, halfway through the session, her mother left the room for a coffee break. While we were alone, Debbie began to talk about her doll Victoria, about Vicky's having her own crib at home, and about how Debbie's baby brother sometimes climbs into the doll crib and breaks it. She continued to make rings around the paper as she talked.

I became aware that the art expression might have to do with Debbie's concerns about why she had been placed in a crib in the pediatric nursery. She was in one of the large, high cribs, covered with a plastic dome-like lid. The side rail was down as we worked, but there was no disguising the fact that Debbie was in, what looked like, a "baby's crib" and in a room being shared with an infant.

If Debbie had already graduated from a crib to bed at home, to make room for her own infant brother, it was understandable why she would be concerned about her crib status in the hospital. Although the bed and room assignment would remain the same until her discharge, art therapy at least allowed Debbie an opportunity to work through some of her feelings about being placed in a hospital crib.

Some small patients leave me with very few hints about where they have come from emotionally, what is going on during the session, or how they are feeling when it is over. Fortunately, the effectiveness of art therapy does not depend on the therapist's personal awareness and complete understanding of the art process or product.

Rosco was one such patient. Rosco, four years old, was admitted for observation following a car accident resulting in a possible concussion. He was the tiny, energetic, non-verbal member of the dynamic art therapy group which requested therapy time twice in a single day.

Rosco scooted down the hall at full speed on the playroom's Tyke Bike, pulled up to a halt at the art table, climbed into one of the big chairs, and proceeded to make one glorified mess as he produced multiple drawings and non-representational paintings. (SLIDES 6-7)

He disappeared occasionally for excursions on his bike, but reappeared just as suddenly, and continued where he had left off.

Rosco expressed his needs with monosyllables or by pointing. He was well accepted and looked after by the group members. Regardless of what Rosco's pictures meant to him symbolically, the therapeutic process of working with art materials was obviously important, and I was left with the feeling that Rosco appeared non-threatened and well adjusted to his hospital stay.

A child's developmental level does not always correspond with the normal level for that age. Brian was a child whose intelligence and sensory-motor coordination were notably lower than average for his age of five. He was barely able to represent objects in his environment through art. Some speech impediment (stuttering) was noted, and I was told he attended a special school.

Brian was hospitalized for several weeks with a fractured femur in traction. Another art therapy student visited him on his second and fourth days in the hospital; I met with him on his eighth day. I had been cautioned that he was becoming very withdrawn, quiet, bored, and often difficult for the nurses to manage.

Although Brian was resistant to participating in any activity initially, he gradually began to develop rapport with me as I visited with him. He became interested in using the new fragrant markers which I had brought with me, but he stated he did not know what to draw with them.

I noticed an elephant pictured on the front of his pajama top. We spent some time discussing elephants, and Brian said he would like to

draw an elephant. We verbally broke an elephant down into its major visual parts (i.e., "great big body, big ears, long trunk, eyes, four legs, tail"). In spite of Brian's low developmental level, he drew "an elephant eating lots of peanuts." (SLIDE 8) This was followed by "an elephant eating four bananas." (SLIDE 9)

Brian continued to draw elephants for over a week. The elephant is frequently viewed as a symbol for power. It was not surprising that this child who was unwillingly locked into a totally powerless position chose to focus on this powerful creature in his art work. Although I had brought the subject of elephants to his attention, Brian was the one who chose to use this art symbol in many of his pictures during his hospital stay.

On his fifteenth hospital day, Brian announced that he would draw (yet) another elephant. As he drew, we shared together the fantasy of an elephant with a broken leg. "It's too big for a hospital bed," he stated. "It would have to lie on the grass."

In spite of the elephant's enormous size and awesome power, Brian finally realized that even an elephant with a broken leg would remain incapacitated and would "have to lie down" until the leg had healed. That was Brian's last elephant picture.

Brian told me he would soon be going home. He drew a zig-zag diagonal line and stated, "This is stairs going up to the top." He enclosed the stairs in a circle, calling it "a house." (SLIDE 10) Brian's next picture was also of "a house, with lots of windows." (SLIDE 11)

Young children who are separated from home for a number of days have difficulty remembering what their home looks like. Art therapy allowed Brian to focus on his house, and on his concerns about what life would be like when he returned to his home and family. His low developmental level for his age did not hamper the effectiveness of the art therapy experiences. His nurses noticed a considerable improvement in his attitude on the days that he participated in the art therapy program.

Sometimes art activities are valuable to the young patient as diversion from painful or threatening hospital experiences. Skipper, five, was called away from the art group session to receive a painful injection in his thigh muscle. He limped back down the hall, complaining of the soreness in his leg. His attention was diverted to the clay figure he had begun, which was to go in his already completed clay "wagon."

With effort, still complaining of his sore leg, Skipper added arms to the figure, but he remained incapable of making satisfactory legs. He pulled the legs off and placed the legless figure into the wagon as it was. Skipper's own leg hurt too much to put his creative energies into making legs.

The following week I found Skipper confined to a closed croupette tent for two hours with nothing to do but watch television. He was a victim of enforced inactivity and I willingly came to his rescue. During the art session he was again interrupted for medication, this time a small container of red liquid medicine to swallow. He balked

at having to swallow the medicine (whining, complaining, pleading, frowning, finally choking it down, followed by a glass of water and a chocolate kiss candy).

Skipper's next picture was done entirely with a red paint-marker. It began as a large, round linear shape identified as "choo-choo track." He added a red train with windows, and red "wild animals" inside the track. Then Skipper began to smear the red paint, first with his fingertips, then with the palm of one hand. Most of the picture was covered with red before he decided to quit, wash his hands, and go on to something else. The picture was an obvious reaction to Skipper's distaste of the red medicine and all that the enforced taking of medications implied to him.

Jeannie was a patient who used the art activities as diversion from frightening admittance procedures, as well as for symbolic expression of her anxiety. She was three-and-one-half, and was hospitalized for tests to rule out rheumatic fever as a cause of leg pains.

Throughout the lengthy art therapy session, various interruptions occurred for standard hospital procedures and prescribed tests. The interruptions caused changes to occur in Jeannie's behavior, and the changes were reflected in her series of seven pictures.

The first picture was entitled, "Dots." (SLIDE 12) It is a typical, tentative exploration of the fragrant markers and paint markers. As she began to draw, Jeannie also began to relate to me verbally.

The second picture began as "three smiley faces with teeth." (SLIDE 13) The first face is at bottom center, the second at lower left, and the third at upper left. Before Jeannie had time to complete the picture, her nurse came in with a request to do a throat culture and to obtain a mid-stream urine sample. These were rather complex processes for a three-year-old, but both were accomplished successfully. Jeannie returned to the picture and stated she would add a "big, bad witch" (upper right). She also added a little face with big eyes but no other features. I could see that this tiny, perceptive child was already perceiving the hospital environment as nameless, smiling faces, behind which lurked possible dangers.

Just as Jeannie completed the second picture, two blood technicians entered the room (with "smiley faces"!) and chatted with her amiably for a minute or two. They might as well have entered costumed as witches, for as soon as Jeannie realized their intentions of obtaining a blood sample, she was immediately distraught. I left the room during the procedure, but I could tell that it was painful from her cries.

Before the blood technicians had gathered their equipment together, I returned and quickly re-focused Jeannie's attention onto the art activities. With no hesitation, she selected the red paint-marker and drew a large face, which she identified as "A Bear." (SLIDE 14) The mouth was enlarged and carefully, slowly filled in with bright red paint. While she was doing this, she began to tell me how much her arm hurt where they took her blood out. She stated very firmly, "I don't want no more needles!" As if for punctuation, she added two red dots below the eyes, calling them "cheeks."

The fourth picture was a second red "bear" face, similar to the previous "bear," but less agitated in appearance. (SLIDE 15) She continued to talk about the needle and her arm hurting.

Enough time had passed since the blood technicians' visit, and Jeannie appeared to be calming down. She selected a black magic marker and drew a large rectangle, completely filling the page. Adding only eyes, nose, and mouth, she entitled it, "A Pumpkin." (SLIDE 16) She spent several minutes returning to the previous two pictures to practice signing her name.

As Jeannie completed the signatures, another lab-coated technician entered the room, this time wheeling in an ominous-looking machine. She stated she was there to do an electrocardiogram.

Jeannie immediately displayed signs of extreme anxiety: panicky look on her face, fretting, whining, calling her mother, backing away from the technician, and assuming a rigid body posture. The technician, oblivious to the preceding events, repeatedly assured the child that it would not hurt (and it did not), but Jeannie remained extremely tense, restless, and anxious throughout the entire procedure.

Anna Freud, in a discussion of the "mental interpretation of pain," states,

> For the observer of children under the conditions of medical treatment it is interesting to note that older infants (two to three years) may react with almost identical distress to the experience of injections or inoculations and to the experience of sunlight treatment, although the former involves pain (plus anxiety) whereas the latter is merely anxiety-raising without any pain involved. (Freud 1952, 77)

For Jeannie, the EKG was as anxiety-provoking as the blood withdrawal had been. Following the EKG, she drew a large black box with paint-marker, adding a confusion of lines, dots, and scribbles inside it. She titled it, "Scribble." (SLIDE 17) It was a clear symbolic expression of the black EKG machine with its confusing jumble of wires, dials, and electrodes. It was also an expression of Jeannie's feelings of anxiousness about what would occur next in her hospital room. The threat of that big machine filled her entire world at that moment, just as the black box filled the entire page of her picture.

Just as she was ready to start on her seventh picture, Jeannie's lunch tray arrived. Earlier when some mention about lunch had been made, Jeannie declared, "I don't want no lunch." I assured her that she would not have to eat lunch if she did not want to. "How do you know?" she demanded, with an inquiring, intense look. (After all, she had been made to do a lot of other things she did not want to do.) I told her I worked in the hospital, and I knew that children were not forced to eat foods they did not want. This answer satisfied her. By the time her lunch actually arrived, she looked at it invitingly.

Her mother asked where she could obtain a straw for Jeannie's milk. Instead of getting it for her, I offered to show her where the pediatric kitchen was located. We told Jeannie she could work on one more picture while we were out of the room for two or three minutes.

When we returned, we found our little patient carefully squeezing drops of red and black paint out of the paint-markers and quickly smearing them across the paper before they dried. She looked up at us, delighted, and exclaimed, "Look! I'm finger painting!" (SLIDE 18)

Two important processes occurred simultaneously during this art therapy session. One was the art expression, and the other was the art activity. Both were invaluable to this small patient during the initial frightening hours of her hospital stay. She was placed in a fragile, helpless position, and her ability to adjust and cope with this difficult situation was taxed to its limit.

Wallace and Feinauer, in their article, "Understanding a Sick Child's Behavior: How to recognize and relieve emotional distress and disturbance in the child ill in the hospital," state,

> A pediatric nurse observing children in the hospital situation is confronted daily with signs of emotional distress precipitated by the child's illness and his hospital experience. She can see from the responses of many children that they are being called upon to make difficult emotional adjustments to unpleasant or frankly painful experiences which are a necessary part of their care. (Wallace/Feinauer 1948, 517)

Art therapy helped Jeannie to make these "difficult emotional adjustments." The colors she selected and the way in which she used the art materials indicated that symbolic representation was occurring. The bright red paint followed the traumatic and painful blood withdrawal. The confusing black "Scribble" followed the scary "black box" EKG machine. "Bears" and "witches" are creatures about which one should remain wary and fearful. All of the colors were explored and presented in Jeannie's first experimental picture, but by the end of the session she had regressed to smearing red and black paint.

Equally important as the expressions, themselves, was the fact that the art activity was ongoing. Rather than allowing this patient to focus on her pain, fears, and concerns, she was able to return to the art activities after each interruption. It is highly likely that without the aid of art therapy, Jeannie's fears following the blood withdrawal would have escalated to a much higher level.

Also, the fact that one hospital person could remain beside her and offer a pleasurable, engaging activity was undoubtedly reassuring. Jeannie's first morning in the hospital was not "all bad." The series of pictures hung on the bulletin board in her hospital room as proof of that fact.

Elementary School Age (Six to Twelve Years)

Children in elementary school years range from early latency to pre-adolescence. This is a rather wide range, but I group them together because their reaction to art therapy during hospitalization is very similar. Younger children in this age range may tend to react with the uninhibited freedom of their earlier preschool years, whereas those approaching adolescence usually tend to be more reserved. Generally speaking, however, children from six to twelve, unless severely hampered by their illnesses, react very favorably to art therapy.

The primary reason for this is that children of this age still use art materials as a regular part of their lives, so art feels comfortable to them. Art is still considered a non-threatening, pleasurable activity.

Most of the art work from this age group is representational. The children usually do not have difficulty thinking of something to make. Often their art relates directly to the hospital situation.

Children toward the younger end of this range still do not require more than three or four choices of art materials: markers, paint-markers, and clay are the overwhelming favorites. When offered, pastels or oil pastels may be attempted, but usually they are soon discarded as being "too messy." Water colors are very difficult to use properly. I do encourage children of this age group to paint their dried clay pieces with brushes and small jars of poster or acrylic paints if they wish. The finished clay products will not remain very durable in their unfired condition, but often the children proudly carry them home, nevertheless.

Six- to twelve-year-olds have many concerns while they are hospitalized. They often feel self-conscious about verbalizing their worries to hospital workers. It may be easier to invite conversation when the child introduces the anxiety-provoking material through the art expressions.

Bud, twelve, was hospitalized for removal of his spleen. Art therapy allowed Bud an opportunity to focus on his avid interest in horses. (SLIDES 19-20) He talked about wanting to be a horse trainer when he grows up. He also expressed concerns about when (and an implied "if") he would be able to ride horses again.

Jon, also twelve, used experimental colors, shapes, and designs for "free association." He looked at his picture and said, "It looks like my grandmother's barn." (SLIDE 21) He was then able to talk about the barn, farm, and apple orchards, focusing his thoughts on a far-away place which he associated with pleasure.

Sometimes in art therapy with six- to twelve-year-olds, symbolic expression occurs even when no verbalization about the expression takes place. Steve, ten, was hospitalized for an emergency appendectomy. Twelve days later he was still experiencing abdominal discomfort, although he was ambulatory and came to one of the art therapy groups.

Steve created a clay creature which he identified as a "Chinese animal called a Wong." It had a cylindrical shape and its facial features were carved on top of its head. The appendages, like flat feet or flippers, made the creature look amphibious. This clay figure

had an extremely constricted mid-section, not unlike an hourglass. Its gnashing teeth and pinched middle led me to believe that it was a possible expression of Steve's painful surgery and slow convalescence.

Another child who did not directly verbalize about his symbolic art expressions was Allen, also ten. Allen was hospitalized with a severe cough and fever, with the threat of pneumonia. By his fifth day in the hospital, he was out of the Croupette Tent, but he had to remain in his room for use of the vaporizor.

With paint-markers, Allen made some experimental, multi-colored, linear, maze-like shapes. He did not title the drawing. Allen then worked on clay for a long time, creating a "King Kong" ape, which later turned into a huge "shark." The shark had an opened mouth, two sharp teeth, pointed fins and tail. After stating that it was finished, Allen said, "Wait a minute. It needs side gils for breathing." He added three slashes on each side of the head.

Again Allen returned to the drawing materials. He created a very complex maze of multi-colors. (SLIDE 22) He asked me to work the maze when it was finished. He seemed pleased that I found it so challenging. As a last request, he asked to paint his clay shark.

Allen's last-moment interest in providing the big shark with breathing apparatus was possibly a reflection of his unspoken concerns about his own breathing problems. The mazes may have been expressions of his inner confusion, implying, "How did I get here?" and "Can you help me get out?"

Sometimes anxiety or stress are noticeable in young children at a level which appears more intense or exaggerated than the hospitalization, itself, would seem to warrant. One example is eleven-year-old Scott.

Scott was hospitalized with a dislocated hip resulting from a football injury. He was in traction for about two weeks. Scott's early art work, accomplished with another student, indicated signs of strong oral aggression, anger, and fierce protective or defensive measures.

I met with Scott on his tenth day in the hospital, when he was allowed to be out of traction for art therapy group. He was a very friendly, attractive boy who participated openly in the group and appeared will adjusted to his hospital stay.

Scott began by drawing a brown boat and a yellow corner-sun. (SLIDE 23) He added a blue, wavy water line right through the center of the boat. He stated, "It's not right. The boat is too far into the water." He tried to fix the problem by adding more boat to the part showing above the water line, but before coloring it in, he shook his head and again declared that it was not right.

On a second paper, Scott began again, coloring the boat and its big sail brown, and adding a bright orange cloud behind the yellow corner-sun. (SLIDE 24) The blue wavy line was initially drawn at the level of the lowest edge of the boat. Scott added three brown "hammer-head sharks" in the water just below the boat. He filled the remainder of water in with dark blue.

Next Scott added and colored in two more wavy lines to the left of the boat, so that the water appears to be above the top of the boat, like a huge wave ready to wash over it. More wavy lines were added to the right, but they were not filled in with solid blue. Scott appeared more and more disturbed as he worked on the picture. Eventually he abandoned it, saying it was "not any good."

I was struck by the repeated problems of Scott's sinking boats into waters filled with dangerous creatures. The word "engulfment" came to my mind as I studied the pictures. I wondered if this corresponded with Scott's innermost feelings, something he had not been able to share verbally.

Later that day, I learned that Scott was reacting to a very complex and difficult home situation. As the pictures indicated, Scott was feeling engulfed and helpless in a tormenting, conflicting family situation over which he had no control.

Thesi Bergmann cautions the hospital therapist to remember the "limits which the conditions of the work automatically impose." She goes on to state,

> Foremost among these is the fact that contact ceases when the set goal of physical improvement is reached and the patient leaves the hospital, whatever his emotional needs may be at that moment.... emotional first aid in the hospital is an adjunct to the total hospital experience and not as aim or a method which exists independently and in its own right. (Bergmann 1965, 14)

For Scott, the most that I could do was to bring the matter to the attention of the hospital social worker. She met individually with Scott and his father before Scott left the hospital, in order to inform them of community mental health services which could be contacted following Scott's discharge from the hospital.

Sometimes dramatic changes in behavior are seen in children after they begin to participate in the art therapy program. One example was six-year-old Eric, the child who pleaded for his art therapy group to meet twice in the same day.

Eric had come to the hospital for an emergency appendectomy. For some reason he was not recommended to the art therapy program until his eleventh day in the hospital. By then he had become very difficult for the nurses to manage, remaining extremely withdrawn most of the time.

Eric was seen by another art therapy student individually on his eleventh day. Initially he was very withdrawn, but the therapist encouraged him to express himself physically with clay, even to the point of having Eric repeatedly throw the clay onto the floor as hard as he could in order to "smash it." Eric began to open up to the therapist, and later that morning he joined the art therapy group. His art work indicated that he had developed strong feelings of anger and hostility.

I worked with Eric the following day. He began with a picture which was colored one-third horizontal blue at the top, one third horizontal green at the bottom, and the remaining middle one-third left blank. (SLIDE 25) "There's sky and grass and that's all," Eric commented, laying the picture aside. He seemed incapable of allowing any forms of life to "live" in his barren world.

Eric made a clay egg with a bird hatching out of it. He painted the bird, and spent a long time fixing the bird's head when it broke off. Another patient carefully made a nest for Eric's egg, so it would not roll off the table. Eric painted the nest, too.

Eric participated well in the group setting. His conversation was limited, but he exchanged comments with several other patients and he seemed mildly interested in others' art work.

After lunch, Eric pleaded with his nurse to have art therapy again. I was able to arrange my schedule to meet with the group in the afternoon. All of the others were pleased with this arrangement, too, but it was Eric's initiation which had caused it to occur. He worked primarily on a clay "smiley face," which he kept. He was much more relaxed and conversational than he had been in the morning.

Following these two sessions, Eric's nurses noticed a remarkable change in his attitude. He had broken out of his own "shell," and emerged with a "smiley face."

Twelve-year-old Derek is another example of a child whose attitude toward the hospitalization changed dramatically as a result of his participation in the art therapy program.

Derek was hospitalized with a fractured femur, result of a football accident. He was in a private room for wound isolation, due to an infection on his leg. Unfortunately, Derek did not participate in art therapy until he had been in the hospital for nearly one month. I met with him on his twenty-ninth day in the hospital. The session took place just one hour prior to his return to surgery for removal of traction and application of a waist-high cast.

In spite of the fact that his right hand was incapacitated with an I.V. and we had to work around orthopedic equipment, Derek drew a magnificent picture, left-handed, of himself lying in the hospital bed,

his huge leg in traction. He included many details such as the I.V. equipment, his call button plugged into a wall socket, and the complex orthopedic equipment.

Derek's second picture was of a desert scene with a huge yellow sun setting in a dark blue sky. As he started the third picture, Derek's nurse came in to give him a pre-operative injection. He began an ocean scene. The water rose higher and higher in deep blue tones until Derek was too drowsy to finish.

The following week Derek appeared noticeably depressed. He told me he had had his thirteenth birthday a few days before. "I became a teenager," he said sadly. The implication was, "I became a teenager while lying in a hospital bed." His picture that day began with a dark blue sky and three white clouds. He did not know what to put below the sky. He finally added a light tan field, "not where anything is growing, ---just a plowed field." Like Erik, Derek was unable to complete the picture with any other life forms.

The start barrenness, emptiness, and lifelessness of Derek's picture seemed to reflect the emptiness of his own life. He had been lying in traction for one month, and in a waist-high cast for the past week. He was taken to physical therapy each day to practice walking, but his progress was excruciatingly slow and he was growing increasingly unhappy with the situation. His thirteenth birthday was a painful reminder that life should have been moving along at a much faster pace than he was experiencing.

The following week, on Derek's forty-third day in the hospital, he appeared more depressed and withdrawn than I had ever seen him. At

first he would not even make eye contact, and he rejected the idea of having art therapy. I stayed to talk with him for a few minutes. In a voice which was barely audible, Derek told me they had "done something" to his leg the previous weekend. He had been returned to surgery for the third time. He said he didn't feel well, and just wanted to rest.

I contacted his nurse, telling her Derek's depression concerned me, and I would like to have him join the group. Just as the group was beginning, Derek's nurse wheeled him out on a stretcher. She had coaxed him into trying it, with a promise that she would put him back whenever he was ready.

At first Derek just lightly fondled a chunk of clay. Another boy who had been injured in a football accident was also participating in the group from a stretcher. With gentle questions to each of the boys, I gradually led them into revealing the sources of their injuries. Within a few minutes they were questioning each other about the injuries, football, schools, and other experiences. Derek continued to handle the clay, and as he did so he began to tell about favorite summertime activities such as "crabbing" and "catching turtles in the creek."

Derek created a small monster head, which he called a "Gorgone," his own version of a "Gargoyle Monster." (SLIDE 26) It has huge, pointed eye sockets, fangs and horns, but no eyes. There is no body or base upon which to rest the head.

The monstrous, bodyless head seems to indicate Derek's inner rage at the physical injustices caused by his totally useless body. Later he drew a picture of a brilliant, erupting volcano, with the earth cracking open and hot, red lava spilling down its sides.

Allowing the anger to spill out through his art work, Derek was able to cope with his unfortunate situation a little better. He not only stayed for the duration of the morning art therapy group, but he chose to remain in the lounge area with another patient and myself throughout lunch. Shortly after lunch he was taken to physical therapy, but he requested to use art materials on his own time in the afternoon. He no longer seemed as depressed, and he left the hospital a few days later.

Art therapists working with medically ill children need to watch for signs other than emotional or behavioral. Uppermost, it must be remembered that these are patients with physical problems. Often the child's concerns about the physical problem are reflected in the art work.

Kenny, eleven, was formerly a very healthy child who suddenly experienced bloody stools. He was brought to the hospital for tests, and eventually for exploratory surgery. During the time that the cause of his rectal bleeding remained unknown, Kenny's art work appeared very disturbed and distorted. He verbalized very little about it, although he remained pleasant to work with.

On his tenth hospital day, Kenny learned that his physical problem was not as severe as had formerly been indicated. He came to the art therapy group and drew two pictures, "The Circus" (SLIDE 27) and "The Hole." (SLIDE 28) In his circus picture, Kenny shows a

fairly complex perspective of three figures facing away from the foreground as though walking toward the circus tents in the background.

"The Hole," he said, is "sort of like a hole into another dimension." Kenny's art work appeared creative and well-advanced for his age, yet his mother commented that it was "not nearly as good" as his usual style.

Kenny's concerns about his unknown physical ailment left him incapable of his usual creative, artistic expressions. Following the diagnosis, when his convalescence could be more clearly anticipated, Kenny was able to return to more creative expressions, even though his artistic skills remained moderately regressed from their usual level.

Early Adolescence (Thirteen to Fifteen Years)

I can never guess whether young teenagers will enjoy working with art materials, or whether they will consider it childish. Some of them have reservations about it initially, but will participate after seeing other young people their age using the materials. Others enjoy art very much, and they seem quite pleased when they hear about the art therapy program. Long-stay patients of this age may require several contacts by the art therapist before they become willing to try it. They may arrive at this stage out of sheer boredom. Once they have experienced the low-keyed, non-threatening, pleasant experience of an art therapy session, however, they usually remain in the program.

The budding teenager often has a strong need for privacy. One fifteen-year-old girl kept trying to cover up her picture as she worked. I set up a barricade tray in front of her. I told her it would help to keep the sun's glare off of her paper, but it was actually meant to give her the needed privacy.

She seemed embarrassed, as many teenagers, do, that she could not "draw better." Often formal art instruction in school has ended by the time the young person reaches fourteen or fifteen. Their ability to represent the surrounding environment has developed very little since they quit drawing at about the age of twelve. They often feel, however, that they "should" be able to create something at a more advanced level.

With the privacy tray in front of her, Tina drew a picture of an apple tree. (SLIDE 29) She noted that it was "crooked," but she made no attempt to straighten it or to complete the picture with any other forms.

On a second paper, Tina tried to draw some boats which she could see from the window, but she remained dissatisfied with her inability to draw them well. She returned to a theme with which she felt more secure: Snoopy and Halloween. (SLIDE 30)

Tina talked about not being allowed to have candy on Halloween this year, as a result of her recently-diagnosed ulcer. Snoopy faces, but remains walled off from, the viscious-looking Halloween Jack-O-Lantern. Behind him, his "dog house" is colored with black and white stripes. The picture contains signs of agitation, as though this patient is wrestling with many more concerns than those she was able to verbalize.

As with all other age groups, symbolic expression of the patient's emotional state is of primary importance in art therapy. It is not always necessary for the therapist (or the patient) to gain clear understanding about the expression for its therapeutic value to prevail.

Teresa, fifteen, was in the hospital following an appendectomy with complications. Her appendicitis had originally been diagnosed as a mild ulcer, and she was sent home. Later, when the appendix erupted, Teresa was admitted for an emergency appendectomy. A few days later she was returned to surgery for "abdominal abscess."

Teresa did not seem to be coping with these complications at all well. She remained in a highly emotional state, bordering on hysteria. She cried easily and complained bitterly about the uncomfortable abdominal pain.

She began the art therapy session by drawing the petals of a flower (no stem or leaves), encircling it with a blue scalloped line. She stated she did not like it. On the same paper she began to copy a wall plaque of a cartoon duck. She drew the head fairly well, but she ran out of room at the bottom of the page. She added little wings, started to draw the body, then suddenly quit, scratching a quick mark across the duck which cut off the head from the body. She apologized for not being able to draw more. Whether she recognized it or not, Teresa's drawing seemed to be symbolic of her desire to separate her own head from her mutilated, painful, poorly-functioning body.

Patients who reproduce one theme repeatedly throughout their art work are of special interest to art therapists. This is often an indication that the patient is trying to work through some area of conflict in his or her life.

Emily, fourteen, was a diabetic who was hospitalized for the fifteenth time. She was hospitalized twice during my eight months at the hospital.

Emily repeated, in numerous drawings, the theme of a house. Many of Emily's houses are drawn almost translucent, blending in with the background color of the picture. In one picture Emily did not notice, until she was finished, that she had drawn her white-on-white house with "the grass at the top and the sky at the bottom." (SLIDE 31) She just laughed and shrugged her shoulders when she noticed it.

Emily's life seemed to be as "topsy-turvy" as her picture. The nurses were very concerned about Emily's unwillingness to take care of

herself when she was out of the hospital, resulting in many more hospitalizations than should have been required for her diabetic condition. While in the hospital, Emily displayed overt signs of neediness. She insisted on wearing an over-sized, wrinkled, hospital gown, and her physical appearance was usually pathetic. She used various methods to gain attention.

Emily's life style of recurring hospitalizations are clearly reflected in one of her drawings. (SLIDE 32) "The mother," according to Emily, is walking through the doorway of the (translucent, incomplete) house, carrying her handbag. "The girl" is sitting on a bench outside, waiting to be driven to "the hospital" by her mother. "The father" is shown in the background, milking a cow. He is not actively participating in his daughter's trip to the hospital. Following the path from father to mother to child to car to hospital and back to father, it is possible to see the cyclical nature of the picture, which echoed the cyclical nature of Emily's life style.

Emily made a little clay animal that same day, which she tried naming after her natural father. (She said her father had died when she was a baby.) She was unable to recall his name. She said, "That's what happens when you have a diabetic coma. You lose your memory."

In her picture, only Father has facial features. Mother and the girl remain faceless. Emily's clay animal also lacked identification. "He just likes to sit all the time," she explained. Then she asked, "Should I make a baby for it? Later on in the same session, she looked at it again and asked, "Should I make a mother for it?" She did neither.

Emily complained of abdominal discomfort. "It feels like before I came in here," she stated. "Maybe I'll have to go through all of that stuff in Intensive Care again,...or maybe they'll just do it all up here."

Away from the art therapy group, on her own time, Emily made herself a get well picture. (SLIDE 33) As in most of her pictures, a house dominates the scene and it is colored the same shade of green as the grass surrounding it. A swing set and tent are shown in the yard, but there are no people. The house has windows which are appropriately decorated with curtains, but the door remains impossibly tiny. On the trunk of a small tree near the house, Emily wrote, "Love You." The message is almost obscured by the dark brown trunk. At the bottom of the picture she wrote, "Get Well Soon Today."

Dr. Herman Belmont states that sometimes "...hospitalization can be a positive experience. We have seen children for whom their hospital experience has been an improvement over that at home" (Belmont 1970, 482).

I knew nothing about Emily's actual home situation, but from her art work I gathered that she was experiencing an ongoing struggle to develop a clearer sense of house, family, and home. It was a struggle which continued throughout the duration of her many hospitalizations. Emily returned to the hospital eleven weeks later. The theme of her pictures had not changed. (SLIDE 34) It may have been no accident that Emily required frequent visits to the hospital for her diabetic condition.

Art therapy is valuable to many patients who, for a variety of reasons, are unable to communicate verbally. Sometimes verbalization is blocked for physical reasons. Clarisse, fourteen, was admitted to the hospital with a fractured jaw following a car accident. I found her alone, lying in bed in a darkened single room. Black stitches etched her face, and one hand lay incapacitated from an I.V. She nodded her interest in using art materials.

Clarisse selected a black marker and slowly, painstakingly wrote, "I CANT TALK OR SPEAK." (SLIDE 35) Then she pulled back her lips to show me the crisscross of stitches over her teeth which were wiring her jaw shut. She seemed unable to do any more than that.

Three days later I returned. Clarisse was ambulatory, but she refused to join the group art therapy session. I arranged to meet with her individually later in the day. She appeared very withdrawn and depressed. I had been told that she was waiting to be discharged, and that she was upset because she had not been allowed to see her boyfriend since she had been in the hospital.

She began the session by drawing a small, single-branch plant with several green leaves. It was growing out of a small container of water. (SLIDE 36) I commented that the drawing appeared very delicate, like a Japanese brush painting. She looked at me gratefully. I complimented her artistic ability saying, "You like to draw, don't you Clarisse?" She nodded with a look of appreciation.

Clarisse's surgeon entered the room. He removed her facial stitches, checked the stitches for her jaw, and announced that she could be discharged as soon as her mother came. When he left, Clarisse

reached for a mirror and closely inspected her scars. Then she indicated her desire to make a second drawing.

This time Clarisse's drawing fills the entire page. It is a female face, with long, curly hair and enormously exaggerated facial features. (SLIDE 37) It seemed to be an expression of Clarisse's unspoken anxiety about how the accident would affect her own appearance in the future. I suspected that the first picture of the small fragile plant had been her acknowledgment of being alive. Regardless of the severity of her injuries or the fact that she may have been feeling very fragile, herself, Clarisse was at least alive and was capable of receiving nourishment as she slowly grew back to her former healthy state.

Another young adolescent patient who had difficulty with verbal communication was Rita, fifteen, a deaf girl who was hospitalized for Sickle Cell Crisis. I was told that Rita could read lips. When I explained the art therapy program to her, however, Rita just looked puzzled and shook her head.

I was not convinced that Rita had understood who I was or what I wanted. I assembled a tray of art materials and wrote a note before I entered the room a second time. The note said, "Rita, I am an art therapist. I bring art materials to patients on this floor. I have time this afternoon to stay with you while you draw pictures." She read the note, then looked up with a big smile, ready to begin immediately.

I directed Rita's attention to the fragrant markers. She appeared delighted with the discovery of bright colors and pleasant fragrances.

She carefully inspected each marker, then she began to draw what the fragrances represented. Her picture was a glorious display of colorful fruits. (SLIDE 38) Other patients had attempted to do similar pictures when first introduced to the "smelly markers," but none had accomplished it with the proficiency which Rita showed. The careful attention to details told me that Rita was making the statement, "I may not be able to talk or hear, but I can see and smell, and I am a careful observer of my environment."

Rita's next picture, drawn more hastily with pastels, was a scene with a large, yellow sun reflected on a body of water. (SLIDE 39) Her mother commented that Rita's bus crosses a large bridge on the way to school each day. One day a new driver became lost. Rita was able to point the correct route to all of the children's homes. This story confirmed my interpretation of Rita's first picture. She was very observant.

Rita's speech and hearing losses left her feeling even more isolated and confined than other hospitalized children. Art therapy became an important avenue in which she could express her capabilities. It also offered Rita valuable sensory, visual, and olfactory stimulation.

Early adolescence is a time for changes, growth, introspection, and questioning one's self-identity. Hospitalization at this time may cause the young teenager to feel a loss of self. Some young patients show their need for expressing self-identity in their art work.

Jack, fourteen, felt very tentative about joining an art group. He participated only peripherally with the art materials. I urged

him to try clay, but he shook his head saying, "I can't make anything with clay." When Jack noticed another child's clay egg about to roll off of the table, however, he picked up some clay and made a little "nest" for the egg. He tried markers, but said, "I can't draw." Jack did, however, make his initials in large, decorative, three-color letters. (SLIDE 40) It was one way of asserting his self-identity, even though he remained very unsure of himself and of his capabilities.

Mark was another boy who showed a need for expressing statements of self-identity. He was fifteen, and had received a fractured femur following a motorcycle accident. Mark informed me that his "art form" was model cars and sports. He said he was not interested in using art materials.

I returned a week later, and Mark agreed to have me stay. He wrote his full formal name in big, bold, colorful letters. He had been hospitalized for several weeks in a private room at the end of the hall. Mark's name-picture indicated possible anxiety about losing his self-identity in this lonely and rather isolated place.

The next week Mark wrote his nickname twice, crossing the two names at the center letter. The effect was like a colorful flag. His leg was out of traction and casted, so I did not expect to see him again. The following week the leg was back in traction again. Mark had visitors, so he declined the art session, but asked me to return the following week. He appeared rather withdrawn and depressed.

I met with Mark one more time, on his sixth week in the hospital, shortly before he returned to surgery to again have the traction pin

replaced with a leg cast. He had been moved to a four-bed room, and his attitude seemed much more positive. He wrote the word "YAMAHAS" both vertically and horizontally, crossing the words at the middle "A." It was all in red and black, the colors of the motorcycle which had caused his accident.

Mark's sense of self was somewhat restored and he was once more able to focus not only on the source of his accident, but on his future life. He said he was even looking forward to getting onto "that old cycle" again as soon as he could.

Joe was a fourteen-year-old who used the art therapy time as an opportunity for expressing his anxieties about the future and to help him begin the process of changing his former identification.

Joe drew a detailed picture of a racing car, entitled "The Barricuda." (SLIDE 41) He talked avidly about his life-long interest in cars. Toward the end of the session, Joe said, "I just about died Friday night when the doctor told me I couldn't work on cars anymore."

I questioned him further and learned that the physician's warning had come as a result of Joe's asthmatic condition. Joe stated that he had always loved cars, and his dream was to design and build racing cars. He could not envision his future as not including the racing car interest.

Art therapy allowed Joe to begin a complex, lengthy process of values clarification and compromise, as he maintained visual and verbal expressions centering around this important area of his life.

Don, fifteen, spent the entire art therapy group session creating a small, smooth, cylindrical clay pot. As he made it, he shared with others in the group the complex series of events which had led to his hospitalization.

Don had teased another boy at school, resulting in a fight. Don was pushed down a long flight of stairs, then kicked in the back several times. In a routine urine test to check kidney function following the fight, it was discovered that Don was a diabetic.

Don's ambiguity about his odd set of circumstances showed as he talked. He was furious with the boy who had kicked him, but at some level he was also grateful that the fight had disclosed the diabetic condition before it grew critically worse. On the other hand, Don remained aware that, without the fight, he would still not know about his condition, and he would not currently be faced with the life-long seriousness of the illness.

Don was already having to face a drastic change of life-style. He talked about his diet restrictions, and about the emotional trauma of adjusting to insulin injections. These problems had suddenly emerged as major concerns in Don's life. The low-keyed, supportive environment of the art therapy session allowed him an opportunity to verbalize and work through some of his feelings as he gently smoothed his little clay vessel.

The soothing qualities of art work and the supportive atmosphere of an art therapy session sometimes contrast dramatically with the various traumas which occur during hospitalization. Phil, thirteen, was

experiencing intense abdominal cramping on his third day following an emergency appendectomy. He had gone most of the night without requesting pain medication due to his intense dislike of injections. Phil's right hand was still taped to a board with an I.V. running. In addition to these circumstances, Phil had experienced several inconveniences during his routine morning nursing care of bath and bed change.

Phil verbalized very little during his art therapy session. I could see that he enjoyed art and that he had developed very good skills in using art materials. With gentle, feathery strokes, Phil created a pastel picture of sand dunes, water, sky, birds, and a small orange sun. (SLIDE 42) He told me, when it was finished, that it was similar to a painting he had done in fifth grade. His art teacher had placed the painting on display in his school library, and he was obviously proud of the memory.

Zaidee Lindsay, in Art and the Handicapped Child, writes, "Creative activities are valuable as they not only have the power to calm but also provide for the emotions positive outlets that will help a child to build up confidence and self-respect" (Lindsay 1972, 41). Phil had been able to use the art time as a soothing way to focus on a pleasurable memory which was reaffirmation of his self-worth and of his capabilities.

Workers in pediatric units are sometimes faced with widely differing young people within the same age group. Sometimes it takes flexibility and skill to be able to adjust from one extreme to the other. Two patients were referred to me in the same day, fifteen-year-old Freddy and fourteen-year-old Cynthia. The two young people were only one year apart in age, but worlds apart in their life experiences.

Freddy was a severely retarded Cerebral Palsied boy who was hospitalized with pneumonia. He required the same care as a small baby. Freddy could not walk, stand, talk, feed himself, or take care of his personal hygiene. He slouched in his special rolling chair with tray, and he drooled constantly. His communication was limited to vowel sounds as he pointed or handed things to people. Freddy could make eye contact, and he laughed or smiled freely whenever he was spoken to.

I encouraged Freddy to use clay, which he handled tentatively at first. Soon he became quite gleeful and animated, imitating my motions to pound, tear apart, put together, and poke holes. He could have benefited from extensive art therapy time each day he was in the hospital, and I felt badly that we could not offer it that often.

Cynthia, at the other extreme, was married and the new mother of a four-week-old, premature infant. Following the birth, Cynthia had been unable to care properly for herself or the infant. The baby was placed in foster care when Cynthia was hospitalized for pulmonary embolism and multiple complications.

She remained withdrawn and verbalized very little during the art sessions. Cynthia repeated several very controlled drawings of a house and fence. (SLIDES 43-45) I asked her once if it was her house, and she just shook her head.

In one session Cynthia was asked where she might like to place herself in the house picture. She added a swing set in the background with two playful figures nearby. The figures and swing set, however, remain floating and detached from the house and ground, as though not a part of this scene.

Cynthia retained tight controls throughout her hospitalization. She did not converse with me except to answer questions with one or two words. I never saw her smile. She seemed to be simultaneously grieving for the abrupt loss of her own childhood and for the loss, through separation, of her baby.

Fifteen-year-old Freddy's childlike innocence contrasted dramatically with fourteen-year-old Cynthia's very controlled, adultlike behavior. My capabilities as an art therapist felt challenged as I adjusted to the divergent demands of two very needy early adolescent patients.

Late Adolescence (Sixteen to Eighteen Years)

Many teenagers of about sixteen or older feel very self-conscious and threatened to be hospitalized in a pediatric unit with crying babies and small children. The unit I worked in is called Pediatric/ Young Adult. Often young people in their twenties are placed in this unit, and occasionally even those in their early thirties.

Young adults seem to feel less threatened by this situation than do older teenagers. They have a better understanding of the hospital's admittance and placement difficulties. Also, their maturity allows them to feel self-assured in the presence of younger patients.

Older teenagers who are placed in four-bed rooms with three other patients their age usually develop a supportive group feeling which helps to overcome any feelings they may have about being in a pediatric unit. Those without roommates their age often remain isolated and reserved.

Offering the use of art materials to young people who are already feeling confined by their placement with little children is often perceived as an added threat to their security. The immediate reaction, whether verbalized or not, is "that's kid-stuff."

Older teenagers placed in the psychiatric community do not react in this way. Art therapy is offered several times a week as a regular part of the milieu treatment for all psychiatric patients. The teenagers do not appear threatened by the art materials in that setting.

It is sometimes necessary to approach older teenagers several times before they become willing to participate in the art therapy program.

If they remain completely uninterested and unwilling to participate, they usually state this more quickly and strongly than do younger teenagers.

Some sixteen- to eighteen-year-olds have continued to study art throughout their teenage years. These young people feel comfortable using the art materials and often seem quite pleased to hear about the art therapy program. In some cases, however, patients who have continued their art classes in high school bring their art materials to the hospital, just as they might bring school books and papers. When art therapy is offered, they see no need for what they assume to be "art instruction," and they refuse to participate in the program. They are already aware of the therapeutic effects of working with art materials, and they are providing this service to themselves.

The older adolescent is more likely to hear the word "therapy" and sometimes remains wary of art therapy because of the implications of that word. They may question its purpose rather directly (i.e., "What do you do? Diagnose me?") It takes careful wording to answer these questions honestly, maintaining a fine balance between art therapy being "just for fun" (which makes it sound unimportant and frivolous) and the other extreme of its being for diagnostic or interpretive use. Even with a direct answer, the patient may remain wary, sometimes to the point of refusing to participate. I did not count, but my guess is that, in the nine months I worked at the hospital, there were far more patients of sixteen or older who turned us down than those who participated.

When the older adolescent patient does participate in art therapy, the problems which the younger teenagers experience still exist, only

more exaggerated. If they have hardly touched art materials since sixth or seventh grade, they remain very unsure of their capabilities. They may feel intimidated by children or younger teenagers who are freely creating works of art right next to them. It takes gentle, patient coaxing and encouragement to get them started.

Ken was a sixteen-year-old who did not know where to start when he came to the art therapy group. We talked about his various interests, most of which centered around sports. This led him to the idea of drawing a soccer field, sketching in various plays which he had previously tried with his team. (SLIDE 46) Ken's hospitalization for Testicular Torsion had created physical limiations for a period of time. Art therapy allowed Ken to concentrate on sports at a level other than physical.

The art work of some patients remains focused on the hospital environment, itself. My hypothesis is that patients whose art work centers on the here-and-now of their hospital experience are either working through or have already adjusted to and accepted their hospitalization.

When Teri (page 63) and Derek (page 95) drew pictures of themselves lying in the hospital bed in traction, I believe they were working through this adjustment to hospitalization.

Karen, on the other hand, is an example of a patient who seemed to have already accepted her hospital situation. She was hospitalized during semester break of her freshman year at college for correction of a toe malformation, a problem which had bothered her since childhood.

Karen came to the art therapy group and remained focused on her hospital environment by drawing a picture of the piano in the lounge area. (SLIDE 47) Next she tried a water color painting of the lounge Christmas tree, but the picture remained incomplete, just as Karen's Christmas vacation would remain incomplete due to her hospital stay. (SLIDE 48) Karen had planned for the surgery and convalescence to take place during her four-week break, and she seemed satisfied with, and accepting of, this arrangement.

Symbolic expression of emotional or mental processes remains a desireable goal for art therapy with all ages of patients. When older adolescents allow themselves to become involved in truly creative art work, symbolic expression takes place, whether they recognize it or not.

Amy, eighteen, was hospitalized for surgery of torn knee cartilage from playing basketball. The hospitalization interfered with her usually active life of various sports and other interests. Amy was not referred to art therapy. She discovered us.

It was the (well-recorded) day of my two-time art therapy group. Amy came through the open lounge area in her wheel chair. She noticed the young people, aged four to fourteen, busily using the art materials and happily engaging in conversation. I invited her to join us. At first she started to decline, with the usual, "Oh, I can't draw anything," but the environment was appealing and she wheeled herself closer "just to watch."

I moved some paper and bright markers closer to her. She sort of shrugged and said, "Well, why not?" Amy stared at the paper for a few minutes, then decided to make a poster of the words on the large button-type pin she was wearing on her thick knee padding. It said, "I'VE GOT TROUBLE ALL DAY LONG." (SLIDE 49) She decorated the letters with a black raining cloud, and she added some lines and shapes behind the words "all day long."

On a second paper, Amy began by drawing a smile-face, fringed in yellow, orange, and red lines, like a sunburst. (SLIDE 50) Agitated purple marks fill in the background. "I don't know what this is," she commented, looking puzzled. I was not sure whether she recognized the similarity between the face picture and the lines/shapes behind "all day long." The second picture seems to be a blown-up detail of the first. The "smile-face" looks more worried than happy. It certainly is placed in a very disturbed environment.

Amy hung the pictures in her room, but left them behind when she was discharged, as though leaving her "troubles" with us. My observation in talking with Amy and watching her interact with other group members was of a young woman who, in spite of her physical difficulties, was trying to maintain a cheerful disposition and positive attitude. It was probably more of a struggle for her than even she realized.

Namita: Universal Symbolism

There are times when feelings and thoughts cannot be adequately expressed through words. This may be caused by an individual's limited capacity to verbalize (as with very young children, such as Rosco, page 79), or by severe obstructions within the personality which make verbalization difficult (as with schizophrenic patients), or by physical impairments which make verbalization impossible (as with Clarisse, page 105). Inability to express oneself through words may also be caused by language barriers, as with persons traveling between cultures.

Beyond the limitations which spoken or written language imposes, there is international understanding of symbolic expressions. Symbols, according to Carl Jung in Man and His Symbols, "...are natural and spontaneous products." Jung states that "...a symbol always stands for something more than its obvious and immediate meaning," as differentiated from a sign which "...is always less than the concept it represents" (Jung 1964, 55).

A person's unique symbolism is expressed in a number of different ways. At a subconscious level, symbols are represented through dreams. Each person's dream symbols remain unique, that is, understood only in terms of that person's life experiences (Jung 1964, 18-103). This is also true of symbols expressed in other ways.

Play therapy is based on symbolic expression which occurs through spontaneous play. Jean Piaget, in Play, Dreams and Imitation in Childhood, states, "...the very existence of imaginative or make-believe play, which plays so important a part in the child's thought, proves that symbolic thought extends beyond the unconscious, and that is why we have called this form of ludic activity 'symbolic play'" (Piaget 1962, 170).

Symbolic expression occurring through bodily movement is described by Blanch Howard in Dance of the Self. "The quality of the symbol and the feeling it engenders are its life force. Consciousness responds to that life force subjectively, then the body expresses it through movement" (Howard 1974, 24-25). Physical gestures, bodily movement, and facial expressions also add much to the total meaning of what is being said.

Symbols are an important part of spontaneous art expressions. Symbols, in fact, form the basic structure of the language which art therapy uses. Felice Cohen, in a descriptive accounting of Mark and the Paint Brush: How Art Therapy Helped One Little Boy, states,

> The drawing page serves as a canvas upon which the subject may sketch a glimpse of his inner world, his traits and attitudes, his behavioral characteristics, his personality strengths and weaknesses including the degree to which he can mobilize his inner resources to handle his psychodynamic conflicts both interpersonal and intrapsychic. (Cohen 1971, 4)

Symbols through art expression allow the individual to show, without words, the feelings which spoken or written language cannot provide. The universal language of pictorial symbols can express deep human emotions. Symbols are a part of every personality. "The techniques of dynamically oriented art therapy are based on the knowledge that every individual, whether trained or untrained in art, has a latent capacity to project his inner conflicts into visual form" (Cohen 1971, 20).

Because symbols evolve primarily from nature, there exists an international understanding of symbolism which bridges the gap between cultures. Namita was a patient who used the art therapy experience as a corridor through which she could move emotionally from her homeland of India to her new home in the United States.

Namita's first home in this country was the hospital pediatric unit. She was a seventeen-year-old patient with a fractured femur, the result of a car accident in India just prior to her family's move to the United States. Namita had been hospitalized in India for several weeks, but when her condition worsened, her parents continued with plans for the move in order to secure better health care for their daughter.

Namita was brought straight to the hospital, where the old cast was removed and her leg was placed in traction. Her leg was found to be badly infected. Namita was placed in isolation for the wound infection, and also for headlice, which had developed at the Indian hospital.

Namita had not reacted well to this traumatic series of events. She remained extremely sensitive to the pain and discomfort of traction. Her formerly very long hair had been clipped short, adding to her misery. By the time I met her on her third hospital day, the nurses were experiencing difficulties in getting Namita to eat or to participate in routine nursing care.

I may have been the first person Namita met in this country who was neither family member nor medical worker. Her initial reaction to me was one of disbelief.

Namita responded positively when she saw the art materials. Communication was difficult for us, requiring numerous gestures and attempts at re-wording. At first, Namita thought I was going to draw a picture of, or for, her. When I indicated that she should do the

drawing, she looked horrified, shaking her head that she could not possibly do that. I encouraged some more, and she relinquished. She spoke to her mother in her Indian dialect, and her mother handed her a small greeting card from a stack of mail. Namita indicated her wish to copy the cartoon mouse pictured on the greeting card.

I was willing to accept any art expression from her by then, and I did not wish to risk offending her by insisting on something original. As she began to draw, I could see that Namita was highly skilled in her visual perception and manual dexterity. I could also see that it would take her several hours to complete the picture. She worked painstakingly slowly, going over and over every part of the drawing with multiple layers of colors.

Toward the end of that first drawing, I suggested that Namita should write in her own message, rather than the "get well soon" which was printed on the card. At first she said she would write, "please help me," but then she changed it to, "I Need Help." (SLIDE 51) I was pleased that Namita had been able to alter the picture she was copying to express a message which was highly significant to herself. Namita did need help--a great deal of help--and art therapy became an important part of her lengthy convalescent care.

I met with Namita each week, sometimes for two hours or more. This was during the early weeks of my hospital work, when I was only in the pediatric unit for a few hours at a time. On some days Namita was the only patient I had time to visit. This slowed the development of the art therapy program, but I felt the consequence was worth it when I saw how important my contact with Namita was becoming.

Namita looked delighted when she saw me each week, and she was visibly pained when I had to leave. I made an effort to stop by her room on my way out of the hospital in the evening. Namita initiated many topics of conversation in order to prolong my visit, knowing that we would not see each other again for a week.

I recommended that art materials be left in Namita's room for the duration of her hospital stay, and I encouraged her to continue working on pictures each day. Some weeks she completed several pictures, and other weeks she did very little art work.

Initially, it bothered me that Namita insisted on copying other pictures, either greeting cards or pictures from magazines. Gradually I learned to look for subtle changes or additions in her representations. Sometimes these changes told me as much about Namita's concerns as original expressions could have.

One time, for example, Namita copied a picture of a baby elephant holding onto a mother elephant's tail. In Namita's representation, the baby was completely separated from the mother. The leg of the baby was enlarged and oddly distorted. The way in which the elephant symbols were drawn, also the fact that Namita insisted on coloring the baby elephant a different color from the mother, told me about Namita's ongoing dependency-independency conflicts with her own quiet mother, who remained in her room every day.

Namita frowned at the picture and exclaimed that the baby elephant was not right. In spite of her acute visual skills, apparent throughout most of her other art work, Namita remained incapable of seeing the

change she had created in the baby elephant's leg. Her own distorted, inflamed leg loomed in front of her twenty-four hours a day, for many weeks, causing excruciating pain and constant discomfort.

Many of Namita's pictures were beautiful. They echoed scenes from the place where she had lived in India. One oil pastel picture of two cartoon animals, copied from another greeting card, had mountains of India in the background and a "hut" in the foreground, which she identified as her new home in the United States. Namita did not like the picture. She spent a long time rubbing over the mountains with a tissue, as though trying to erase them, not only from the picture, but from her life. It was a visible expression of her pain involved in the separation from her birthplace.

Namita was intent upon maintaining our friendship after she left the hospital. I knew she was going to start junior college in about two months, and she would quickly form important friendships in that new environment. On our last day together, however, she needed the promise and hope of our continuing relationship.

Namita wanted to complete one last picture to give to me. It was a striking scene from India. (SLIDE 52) She requested that I call her at home if she was discharged before I came again, to confirm that I had received it. That was the only time I spoke with her outside the hospital.

Less than three months later, Namita was readmitted to the pediatric unit. She had tripped down some steps at college, and her leg was broken again. This time a long pin was inserted for reinforcement, to be left in place for one year, until the bone is completely healed.

Namita appeared very depressed when I approached her. She was miserably sad about this drastic turn of events in her life, just as she was beginning college. That week she worked on a night scene of a moon barely reflected on a large body of water. The picture was almost entirely black.

The following week Namita spotted a large wall plaque of Goofy on the playroom wall. She asked to have it hung in her room to copy. As she drew, Namita expressed her fears about returning to college again. She had difficulty trusting that another disaster would not occur.

Namita made several Goofy pictures, all of which she gave away. They seemed to be Namita's acknowledgment of her own awkward clumsiness which had caused the second accident to occur. At some level, she undoubtedly felt "goofy." As a result of her "goof," she would not be able to return to college until the following semester, when she would be nearly eighteen.

Toward the end of her second hospital stay, Namita appeared happier and better adjusted than I had ever seen her. She no longer drew pictures with scenes from India. Her mother no longer remained with her at the hospital each day. Namita had made new friends, and she seemed to be gaining control over her own life.

Our relationship was still very special, but she did not cling to me as she had several months before. The hospital art therapy experience had provided Namita with a valuable means of communication, an opportunity for symbolic expression, and friendship which affirmed her as a worthwhile person.

Art Therapy With a Homebound, Chronically Ill Child

Concurrently with my months of practicum work in the pediatric unit, I began to conduct art therapy sessions with a homebound, chronically ill child. Kristi, ten-and-a-half, is the daughter of a friend and is a victim of Cystic Fibrosis. Our sessions are held twice a week and, at this time, have been ongoing for nearly eight months.

Preliminary findings support the hypothesis that art therapy has much to offer the homebound, long-term ill child. Many of the same emotional needs of the hospitalized child are present in the child who is ill at home. In addition to these, the situation has complexities which add new areas of anxiety and turmoil.

Kristi, for example, has been hospitalized periodically for various tests, examinations, medical treatments, or at times when her symptoms require more extensive medical care than can be obtained at home. In addition, she is seen weekly as an out-patient at the hospital Cystic Fibrosis clinic. This situation causes a constant shifting between the role of hospital patient and that of home patient, creating additional strain on the part of Kristi and her family.

In cases such as Kristi's, where prognosis remains vague and there is no end in sight for the chronic condition, feelings of uncertainty and anxiety are created within both the patient and members of the immediate family. Ambiguity and role confusion may exist, as the child vascillates from being a patient in need of constant medical care to being a fully-functioning family member.

The chronically ill child at home needs a place in which to freely express feelings, anxieties, and innermost thoughts within a secure and trusting environment. Provision must also be made for symbolic expression and sublimation to occur. Art therapy provides for these needs. It helps ease the emotional pressure between the child and the primary caretaker, often the mother, who may be devoting much of her energy to the care of her ill child.

Long-term art therapy offers elements not seen in short-term hospitalized patients. It offers an opportunity for the development of a trusting, secure relationship with a person outside the family environment. Verbal and creative art expressions expand and deepen as the relationship grows.

The lengthy period of time may also allow the patient to experiment and become very familiar with a variety of art media and techniques. This allows the child to choose the form of art expression which feels the most comfortable at each session. Kristi, for example, learned that clay sculpture takes much concentration and usually requires a number of sessions to complete. Drawing from life, where she is learning to improve artistic skills, also takes more concentration than "fun drawings."

Of utmost importance in long-term art therapy, the patient is able to progress from one stage of development to another. This, of course, occurs as the child continues to grow and develop, regardless of the severity of the illness. Art therapy not only becomes an important part of that development, but it provides a valuable visual record of the ongoing, developmental patterns being experienced by the patient.

CHAPTER 8: PEDIATRIC ART THERAPY IN THE 21ST CENTURY

If the Art Therapy profession continues to grow at its present rate, by the year 2000 it will be well known, widely used, and accepted in a variety of institutions and facilities throughout this country. Many art therapists are likely to be in private practice, or they may work in small clinics alongside other professional mental health workers, such as psychologists, psychiatric social workers, dance and music therapists.

It is hoped that by the turn of the century, all mental health services, including art therapy, will be covered by insurance. Many predictions concerning art therapy in the 21st century are contingent upon patient demand for mental health services and upon financial backing for these services.

Nationalized health insurance, which includes mental health care, or government-backed mental health facilities will greatly increase the availability of art therapy services throughout the country.

Equally important to the development of art therapy with medically ill patients is the financial support offered by hospitals and other medical facilities. With the rising costs of medical care, much emphasis is currently being placed on cutting services which do not directly relate to a patient's physical or medical needs. Such financial backing may be difficult to obtain when the results of mental health services such as art therapy are not always readily apparent.

The growth of all mental health services is contingent, in part, upon patient demand for these services. As the public increases in its understanding and acceptance of emotional well being as a necessary element in one's physically healthy state, demands for these services will be heard.

With appropriate patient demand and with secure financial backing, perhaps no area of art therapy will display as much growth in the next twenty years as that of art therapy with medically ill patients. The recognition of both children's and adults' emotional needs during hospitalization or convalescence will be considered crucial to complete medical care. Art therapy can then become a routine part of hospital care for all ages of patients.

Art therapy will be especially encouraged among children and adolescents for it has already been found that children respond readily to therapeutic art activities and creative expression. Children have limited capacities to form verbal expressions of inner feelings or areas of anxiety. Art therapy provides an accurate and reliable record of the child's ongoing, developmental (or regressive) processes. The art therapist's interpretive remarks in the patient's hospital record will become vital to members of the hospital medical team.

Children who participate in pre-hospitalization orientation programs (prior to scheduled hospitalization) will have their first visit with the pediatric art therapist. The art work from this first session will be maintained on microfilm, along with the rest of the patient's hospital record. All succeeding art work from later sessions

occurring during the hospital stay will be added to this microfilm file. This might be referred to as the patient's Art Therapy Medical Record.

Children who come to the hospital for emergency care, as well as those who have already participated in the pre-hospitalization program, will be visited by the art therapist as soon after admission as possible. All of the art work, from the first session on, will be added to the A.T.M. record, a permanent and valuable part of each patient's hospital file.

Children with chronic illnesses are often seen for many years, requiring periodic hospitalizations and regular clinic visits. These children will participate in weekly or biweekly out-patient art therapy sessions at the hospital clinic throughout their periods of remission.

Advancements in the field of data processing should make it possible by the turn of the century for members of the hospital team to have access to a patient's microfilm file at any time. The patient's past A.T.M. record, along with other medical records, will provide complete information about the patient to all members of the hospital team. The more information about the patient which is available to the art therapist, the more accurate and specific can be the interpretations of the patient's art expressions.

In large units which employ more than one art therapist, the A.T.M. record will provide a basis for communication between professionals. The record will also be a valuable teaching devise for art therapy students, as well as student nurses, hospital aides, and members of the hospital team who wish to increase their understanding of art therapy.

Young people who have been readmitted to hospital numerous times since early childhood are likely to have extensive Art Therapy Medical Records, showing not only the child's development over the years, but also indicating the way in which the child perceives or reacts to hospitalization. The record might indicate whether regression is occurring, and if so to what extent. It may also indicate the kinds of problems which the child has already resolved, and those which may still lie dormant as possible areas to provoke anxiety in the future.

Research studies are being conducted to determine the reliability of a patient's symbolic art expression as an indicator of the progression of the illness, and of the deterioration of the patient's physical processes. It appears likely to this writer that a patient's internal sensory perception may be able to predict the outcome of an illness and the course that the illness will take even before these events occur. If this is so, it may be possible for a person who is highly skilled in the interpretation of art symbolism to be able to provide, from the A.T.M. record, accurate interpretations of the patient's internal emotional state. This information, compiled with medical findings, will increase the reliability and accuracy of statements concerning prognosis.

Studies are also being conducted to help determine a number of as yet unknown factors regarding the use of art therapy with medically ill patients. One example is the comparison of chronically ill children who participate in ongoing art therapy programs with children who participate in such programs only during hospitalization, or do not participate in art therapy at all.

Additional studies need to be conducted with homebound chronically ill patients who participate in art therapy sessions with visiting art therapists. It is the belief of this writer that homebound chronically ill patients who are allowed opportunity for creative art expression through regular, long-term art therapy sessions, are more likely to retain a firmer grasp on the life energies which help in delaying the deterioration of physical processes.

It is clear that a great potential exists for the development of art therapy with medically ill patients. The development is contingent upon research in art therapy and upon financial support for the research and development of this rapidly growing field.

As public interest in mental health continues to mount, and as more research is conducted in areas concerned with the affects of emotions on an individual's physical state, demand for a variety of mental health services will be felt.

As research continues in the areas of interpreting spontaneous symbolic art representations, general acceptance of art therapy in the healing process will occur. Art therapy will then take its rightful place among professions concerned with the healing arts.

[Name of hospital] PEDIATRIC UNIT A2

Memo to Nursing Staff (for staff use only)

Re: ART THERAPY PROGRAM

[date]

Art therapy is currently being offered to young patients on A2 by art therapy masters degree students. The primary goal of art therapy is to allow participants to create meaningful (not necessarily "beautiful") art products. The art activities encourage productive, creative physical activity, which is highly beneficial to hospitalized young people, who find they have too few choices or creative outlets in the routine of a large institution.

The art work is primarily non-directive. This encourages self-expression which will be personal and individualized for each participant. Materials are offered for work in drawing, painting, collage and clay sculpture. Patients are allowed to keep their art work if they wish.

Participants are provided with an opportunity to allow unconscious expressions to emerge. Many hospitalized young people are struggling internally with such problems as coping with enforced hospitalization, adjusting to their changed physical condition, dealing with future medical problems, maintaining relationships outside the hospital, and experiencing loneliness, anxiety and fears. The art work often reflects feelings which the young patient may not feel comfortable verbalizing.

It is hoped than an art therapy program in pediatrics will not only be helpful to the patients, but will also benefit the nursing staff. In some cases, patients become more manageable as a result of the creative expressions and their contact with the art therapy students. In reviewing the art therapy notes, the nurses may gain a clearer understanding of the patient's feelings and their adjustment to the hospitalization. This will provide an avenue for better communication between the patient and staff members.

Patients are referred to the art therapy program by the patient's physician or the nursing staff directly involved at the beginning of each day. After patients have participated in an art therapy session, the student writes notes about the session, giving an objective statement of what took place during the session, a personal assessment of the patient, art work, and/or the therapeutic process, and stating goals or plans for future sessions. These notes are read and co-signed by the student's art therapist supervisor, [name]. They are then placed in the patient's chart at the back of the "Nurses' Progress Notes" section.

Ambulatory patients, as well as those who may be brought in wheel chairs or on stretchers, are encouraged to attend the morning art therapy group (which meets in the time of 9:30-11:30, 2-3 times/week). Usually four to six patients, ranging in age from four to eighteen, gather in the [name] Lounge area for the art activities. Patients will be contacted by the students as to when and where the art activities will be held. Nursing assistance is needed in moving patients to wheel chairs or stretchers since the students are not covered by hospital insurance.

Within the group time, attendance may be flexible so as to not conflict with medical or nursing procedures. Nurses are asked to communicate their patients' morning needs to the students, so the timing for group participation can be adjusted. A list of patients participating in the program will be maintained on the chalk board outside the conference room. Patients who cannot be moved will be visited individually, usually in the early afternoon.

The art therapy students welcome questions or comments from members of the nursing staff regarding the program, scheduling, or specific patients.

Appendix II (See page 67)

ART Therapy

[Name of hospital, City]

[date]

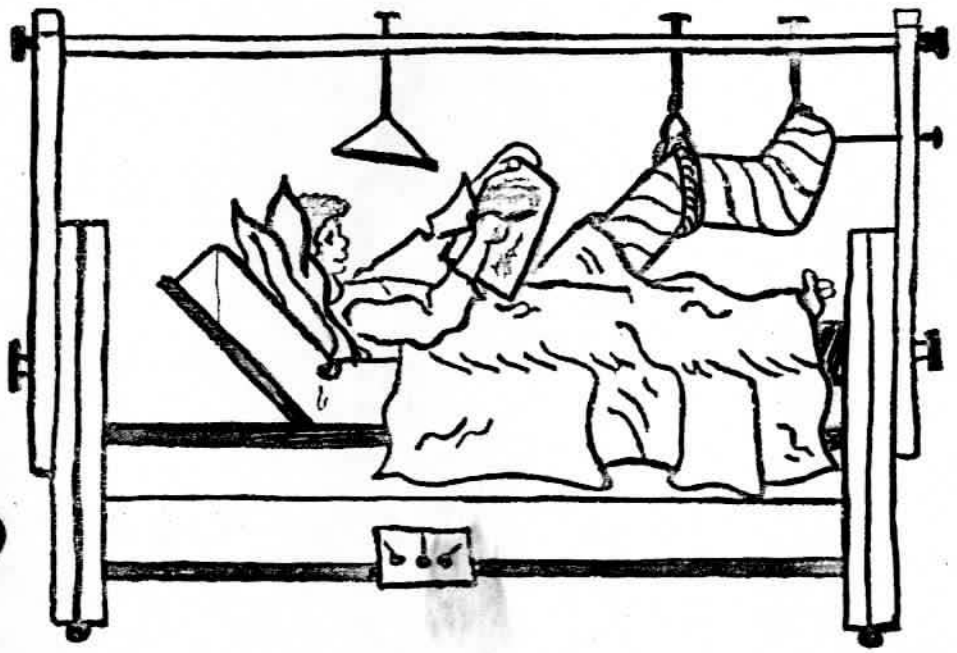
To Families of Patients in the Pediatric Unit,

Art Therapy is currently being offered to patients on A2 by volunteer, supervised, art therapy masters degree students. The primary goal of art therapy is to allow participants to create meaningful (not necessarily "beautiful") art products. The art activities encourage productive, creative physical activity, which may be highly beneficial to hospitalized young people who find they have too few choices or creative outlets in the routine of a large institution.

The art work is primarily non-directive. This encourages self-expression which is personal and individualized for each participant. Art materials are offered for work in drawing, painting, collage, and clay sculpture. Participants may keep their art work if they wish.

Patients are referred to the art therapy program by the patient's physician or the nursing staff directly involved at the beginning of each day. Ambulatory patients, as well as those who may be brought in wheel chairs or on stretchers, are encouraged to attend the morning art therapy group (which meets in the time period of 9:30 to 11:30, 2-3 times/week). Usually four to six patients, ranging in age from four to eighteen, gather in the [name] Lounge area for the art activities. Patients will be contacted by the students as to when and where the art activities will be held.

The contact with other patients in a group setting offers an opportunity for sharing experiences with others, "comparing notes on hospital routines and medical problems, supporting each other, and relieving loneliness and boredom. Patients who cannot be moved will be visited individually in their rooms.



The art therapy program on this unit is a free service led by volunteer graduate students. The students participate in weekly supervision with a trained art therapist.

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