Lindenwood University
Digital Commons@Lindenwood University

Theses Theses & Dissertations

1981

The Value of Art Therapy with Institutionalized Children

Morna Freund

Follow this and additional works at: https://digitalcommons.lindenwood.edu/theses

Part of the Social and Behavioral Sciences Commons

THE VALUE OF ART THERAPY

WITH INSTITUTIONALIZED CHILDREN

Partial Completion for

Master of Arts in Art Therapy

Morna Freund

1981

Abby Calisch MS ATR

Lin Merens

ACKNOWLEDGMENTS

I wish to express my gratitude to my committee members Lin Merens and Abby Calish, ATR, for their time, effort, knowledge and professional judgment and to the staff members at Chicago Read Henry Horner Children's Center.

A special thanks is extended to Frank Kaminsky for his help in photographing the children's art work.

TABLE OF CONTENTS

Chapter

I. INTRODUCTION 1
II. REVIEW OF ART THERAPY LITERATURE 3
III. CASE PRESENTATIONS 14
IV. COMPARISON OF CASE RESEARCH ANALYSIS 42
V. CONCLUSION 48
ILLUSTRATIONS 52
SELECTED BIBLIOGRAPHY 72

CHAPTER I

Introduction

Art therapy has accumulated various definitions and values over the years.

This culuminating project uses my personal experiences at an Illinois state residential institution to clarify the definition and value art therapy has for me in my work with institutionalized children* and to inform individuals of the importance of art therapy in treatment planning.

The paper will not analyze or interpret clinical data on the value and purpose of art therapy in institutions; it is not a scientific research report. Instead the culuminating project is a descriptive account of the effects art therapy had upon the children I worked with. It demonstrates that because art expresses an individual's personality and feelings it is important in diagnosis and treatment.

A review of art therapy literature is presented in Part Two. The key concept of the value and the definition of art therapy is elaborated upon in this section. Examples are cited by art therapists and art educators such as Margaret Naumburg, Edith Kramer, Judith Rubin and Viktor Lowenfeld. I will identify and respond to

controversial aspects that relate to my topic.

Part Three describes in detail three children with whom I worked in art therapy at an Illinois state residential institution during my practicum internship. I have collected information on each child's social and psychological background from the psychiatrists and social workers. Sequential illustrations and descriptive evaluations of the art therapy sessions are provided to show progressive graphic development and to justify my major concept.

In Part Four, by means of accessing the differences among the case studies, the importance of art therapy for institutionalized children is further emphasized.

In the summary I demonstrate how my experiences help support the culuminating project and confirm its validity. I review the highlights of the three case studies and the art therapy literature. I state the limitations of my paper and make further suggestions for investigations.

My deep appreciation is extended to the staff members at the state institution, to my teachers, friends, and to the children who enriched my learning experience.

*In the following pages the pronoun "he" represents male and female gender.

CHAPTER II

Review of Art Therapy Literature

Margaret Naumburg, a well known art therapist, defines the special language of art therapy in her book An Introduction to Art Therapy. Naumburg's book deals with the use of art therapy in diagnosis and treatment of six behavior problem children and adolescents. The case studies that are presented are a result of nine years of art therapy research at a New York state psychiatric institute.

She defines art therapy as " . . . a way of stating mixed and poorly understood feelings in an attempt to bring them into clarity and order in the form of a composition."[1] Sometimes a child's thoughts are too threatening or overwhelming. Tension may build and eventually there is a need for emotional release. Art therapy can provide that release for the child.

In the course of art therapy, unfocused and fuzzy images and ideas often become more clear. Art therapy provides an outlet and an understanding of a child's

---

[1]Naumburg, M., An Introduction to Art Therapy: Studies of the "Free" Art Expression of Behavior Problem Children and Adolescents as a Means of Diagnosis and Therapy, New York and London: Teachers College Press, 1973, p. V.

problems because, as Naumburg states, ". . . children are less able to express their thoughts and feelings in words and are closer to the more primitive expression of themselves through the language of images and play."[2] The language of images describes art therapy.

Naumburg cites an example in her book of a boy in art therapy discussing his fears about his dreams. The child, according to Naumburg, was unable to verbalize his problem until he released his repressed emotions through symbolic imagery in art therapy.

The following is an excerpt from Naumburg's case study that helps illustrate the process of art therapy.

> "Sometimes I'm scared when I dream." When asked what had scared him this time, there was no reply. But instead of speaking, the patient pantomined his fear; he hung his head, rolling his eyes and running his hand across his neck to suggest throat slitting. Asked what all this action meant, he simply replied, 'Dead'.
>
> Had he dreamed all this? He replied, 'Yes, a skeleton.'
>
> He would say no more. So the writer (Margaret Naumburg) slipped a sheet of paper before him and asked whether he could make a picture of the skeleton. Resistance to the suggestion came in the reply that 'It's invisible.'
>
> Inquiry as to how the skeleton looked in this dream finally led him to select a white crayon and draw the skeleton form he had mentioned.
>
> Unable to verbalize this anxiety dream, the boy first succeeded in pantomining it and then expressing his dread concerning death and destruction in a picture. In dealing with this

---

[2] Ibid., p. 51.

> anxiety dream, he had been able to verbalize for the first time his own awareness of the compulsive repetition of his dreams.[3]

The boy's dreams were vocalized only after they had been modelled in clay or drawn on paper in the art therapy sessions. Naumburg goes on to say that the boy's art work showed that his inner life did not die. "His terrors, his dreams, his hopes, and his wishes emerged gradually into channels of creative expression."[4] The child began to find a release from his fantasies of death and destruction. Gradually the deep aspects of the boy's fears that had been inaccessible to verbalization began to be released in the unconscious imagery of his design. As the child gained confidence in his ability to express his buried thoughts and feelings in the safe disguise of pictures, he became able to approach the inner source of his conflicts with accompanying talk and questioning.

Naumburg reports that ". . . as the boy gained assurance in the use of both color and form, he was able at last to find a way to build up his ego from within, so that eventually he might be able to meet the world on more equal terms; in time the external world might even cease to threaten and overwhelm him."[5] Two years later Naumburg claims that the confirmation of such a possibility happening was seen through the patient's adjustment in a social agency school.

---

[3]*Ibid.*, pp. 19-20. [4]*Ibid.*, p. 41. [5]*Ibid.*,

Judith Rubin is another art therapist who has worked in a broad range of educational and clinical settings with children and adults. Her book, Child Art Therapy, presents an overview of the art process of children. She defines art therapy as " . . . understanding and helping a person through art."[6] Rubin believes like Naumburg, that art offers a protective framework for emotional release. She says that art therapy is " . . . a boundary between reality and make-believe."[7] This boundary line, Rubin feels, allows a child to " . . . more daringly test himself and more openly state his fantasies . . . "[8] With art the child is able to do the impossible. He can fulfill both his positive and negative wishes without the fear of real consequences. The creative forces of art therapy provide a framework of free play. Free play enables the child to move, think and fantasize by experimenting with a variety of tools, media, ideas, and feelings expressed in the process. The child, Rubin states, is then able to " . . . gain symbolic access to and relieve past traumas . . . "[9]

When a patient is encouraged to express imaginatively and freely his interests, the themes chosen will include a

---

[6] Rubin, J., Child Art Therapy, New York: Van Nostrand Reinhold Company, 1978, p. 17.

[7] Ibid., p. 26.

[8] Ibid.,

[9] Ibid., p. 29.

variety of subjects. Some art work may depict actual situations from the child's personal life or re-creations of wishes or fantasies about the present or future.

One can see the entire process of therapy through art as involving a separation of fact from fancy. Judith Rubin says that art therapy separates " . . . reality from fantasy, and in a deeper sense, separating a child from the conflicts that have caused him unhappiness."[10]

When an idea comes closer to being consciously recognized it frequently is expressed in art before it is talked about. This was the case in the example cited earlier by Margaret Naumburg. The boy was unable to enter into the verbal arena of discussing his anxiety about his dreams. Instead, he represented his ideas graphically. Gradually his dreams, hopes, and wishes emerged into channels of creative expression. The child began to find a release from his fantasies of death and destruction through art.

According to Judith Rubin, a good art program enables children to relate and understand the problems that exist in coping with the outside world. Art helps children to become creative, to think divergently, to explore different avenues that build self-confidence and flexibility. Art therapy can provide a framework that allows for the freedom of movement, thinking, and fantasy.

Viktor Lowenfeld is well known for his years of research in the field of art education. His book

---

[10]Ibid., p. 85.

Creative and Mental Growth provides a clear definition of the creative expression of children. Lowenfeld describes the child's art work as a product of the child. He says the child in art " . . . gives us a part of himself: how he thinks, how he feels and how he sees."[11] Art becomes a language of thought and a special process of communication.

Self-expression, according to Lowenfeld, is the child's process of thinking, feeling, and perceiving. The art a child produces is part of his reaction to his environment. "His feelings, desires, thoughts, his explorations with paint and subject matter will all appear . . . "[12] in a child's art work.

Edith Kramer has worked as an art therapist in different settings with individuals suffering from emotional and social disorders. Art As Therapy With Children contains her experiences with disturbed children.

Kramer defines art therapy as a therapy in which children can symbolically express forbidden wishes and impulses. "Painful and frightening experiences that had to be endured passively for the child can be assimilated by actively reliving them on a reduced scale."[13] Art

---

[11] Lowenfeld, V., and Brittain, W. Creative and Mental Growth, New York: MacMillian Publishing Company, 1975, p. 3.

[12] Ibid., p. 27.

[13] Kramer, E., Art As Therapy With Children, New York: Schoken Books, 1971, p. 27.

therapy enables children to learn how to give form to their feelings, especially those which are difficult or impossible to put into words.

Art is a place where fantasies can take form. For example, Edith Kramer describes in her book an eight-year old boy's fantasy.

Bob had been in the hospital many years because he had tuberculosis. He was frail and short, but his vitality was indestructible. In art therapy he painted a strong man lifting a weight. The picture Bob made was simple but unequivocal. Bob was able to represent his fantasy to be strong in his painting.

Rubin states that art therapy teaches children ". . . how to share, how to respect each other's work and how to live together in a social environment."[14]

Art therapy helps children to understand concepts which relate not only to the arts, but with the outside environment. It helps children become successful in managing the tools and media they need to master in order to make personal statements in their lives.

Margaret Naumburg, Judith Rubin, Viktor Lowenfeld, and Edith Kramer have expressed that art therapy helps children to define themselves and their experiences by forming unformed media, developing their own themes and styles and discovering and delineating their identities.

---

[14]Ibid., p. 209.

Art therapy is helpful in assessing a child's major concerns and conflicts, his primary coping patterns and defense mechanisms and his developmental level. The child can gain confidence through his successes in art. He begins to function independently and tries to meet the challenges of living as he learns the pleasure of accomplishment in making a product of his own. Rubin says art can

> . . . give a child an exciting, stimulating and pleasurable way to enjoy and explore the sensory world. It gives the child a way to be in charge, even in a limited sphere, of a medium or tool which he controls as he wishes. It gives him an opportunity to master whatever tools or processes are appealing and within his reach, and to savor the pleasure of skills achieved with practice. It gives him a way to safely let loose, to regress and smear and pound and release body tensions, or to let loose and express symbolically or verbally powerful scary feelings.[15]

Art therapy allows the child to take control. He can make order out of his chaotic and confusing world by organizing his environment in a productive activity. He can begin to understand and to explain his feelings and learn to accept himself by taking responsibility for both process and product.

Art therapy, according to Judith Rubin, can develop a child's " . . . autonomy and independence . . ." by giving the child the opportunity to " . . . choose, to make, to act, to revise decisions, to appraise and evaluate, and to learn from past experiences."[16] In art, Rubin feels the

---

[15] Ibid., p. 239. [16] Ibid., p. 255.

child learns to visually experiment. His symbolic experimentations eventually exist in reality. Art helps the child master tools and processes. It gives him confidence to accept his abilities and his failures. The child can speak nonverbally. The art products can be seen in terms of their degree of organization, clarity, completeness, symmetry, movement or color. Rubin states that " . . . looking at the formal aspects of children's art tells us not so much what is being said as how it is being conveyed."[17]

The value of art therapy is placed upon the release of a child's personality through his art. It serves a therapeutic purpose that can be reinforced and supplemented with psychotherapy. Art therapy enables a child to experience his ideas under many different guises and prepares him for the symbolic exchange of psychotherapy.

Each line or space of a painting or drawing is seen in terms of its relationship to the whole. The child's art, according to Lowenfeld " . . . can become a means of discovering his internal conflicts and disturbing experiences that influence the child's development. The art product is then valuable as a therapeutic vehicle because the child usually paints freely the events and problems that have caused conflicts in his life. The ability to put these facts down on paper and to see these things in the context with other parts of the child's environment serves as a catharsis. The product then becomes important, not only

---

[17] Ibid., p. 67.

as a record of the problems and conflicts the child is facing, but also as a record of his progress . . . "[18]

For the child, art therapy can " . . . help release unexpected capacities that bring confidence and provide satisfaction. For the psychiatrist or art therapist, the product can provide a revealing projective technique for diagnosis and therapy."[19] The viewing of a child's art work is like observing a part of his life. His feelings, intellectual capacities, physical development, perceptual awareness, creative involvement, aesthetic tastes and social development are reflected in the child's art work. Through an understanding of the products, a clinician can gain insight into a child's behavior and development.

Art therapy for the institutionalized child serves the same purposes and has the same values.

In treatment institutions, recreation in one form or another usually consumes a child's major portion of his life. The residential treatment center is not a boarding school or a substitute family. It is a group living situation that tries to provide help, support, understanding and avenues of release for feelings to be expressed in safe ways. Art offers one way in which the child can experience his anger or hurt.

One of the main deficiencies in the lives of insti-

---

[18] Lowenfeld, V. p. 22.

[19] Naumburg, M., p. 50.

tutionalized children is the lack of any close relationship with one or two adults. Art therapy can help establish some communication with adults or other children because art has a social as well as a personal function. The child's creation is not merely an internal expression but a statement that is intended to have significance for others: a mode of communication.

Experiences with group-sharing of materials, although short-lived, can lead to group solidarity and feelings of group satisfaction. The art experience also provides aggressive children with the opportunity for developing an increase in frustration tolerance and in self-control by observing how the other group members handle their frustrations in appropriate actions.

Art therapy stimulates the institutionalized child, provides him with emotional satisfaction, feelings of self-worth and security. The drawings, paintings and sculptures offer him more than a pleasant exercise. It enables the child to make his thoughts concrete.

The processes, purposes, and values of art therapy that were defined by Margaret Naumburg, Judith Rubin, Viktor Lowenfeld, Edith Kramer, exist for the institutionalized child. Art offers the institutionalized child an open avenue for communication and a method that helps him cope with his problems outside the institution. The following chapter describes the experiences of three institutionalized children in art therapy.

CHAPTER III

Case Presentations

The three case studies are taken from the art therapy sessions I conducted during my practicum internship at a state residential treatment center for children.

Education classes and daily activities, such as swimming, arts and crafts, gym, bowling, music therapy, dance therapy, plant therapy, and art therapy are provided for each child in the activity department at the center. Welfare and medical services for the family are also available at the institution.

The children live in buildings called units. Each unit is designated by a letter of the alphabet. The unit consists of staff members whose day to day function is to create a living environment designed to enhance the functioning of the residents in the context of their entire environment. The total environment includes the child's past, present, and possible future relationships and experiences both inside and outside the residential center.

Case reports are written for each child living on the unit. Included in these reports are medical, educational, and social activity progress developments.

Children's programs are designed individually by department staff members, unit clinical supervisors, and

and department directors to meet the needs of each child.

Unit meetings are held weekly to discuss each patient's progress at the center. Appropriate changes in the child's schedule are made as needed, at the unit meetings.

The following cases describe each child's social, clinical, and educational background. Photographs of the patients' work in art therapy are included with the descriptions of the sessions.

The art therapy sessions were conducted on an individual basis, once a week for forty-five minutes.

Permission to use the illustrations was given by the patient, family, and/or the institution. The names of the children in the case presentations have been changed to protect their identities.

A.

Jeffrey

Jeffrey is a ten year old white male. He was admited to the state residential center three years ago. At the time of admittance, Jeffrey was diagnosed as having an over-anxious reaction to childhood. His placement at the institution was due to his inability to function appropriately at home and the result of the divorce of his parents. During Jeffrey's beginning hospitalization, his mother died. Jeffrey's father visited his son occassionally at the institution after his wife's death.

The American Psychiatric Association defines his disorder as being " . . . characterized by chronic anxiety, excessive and unrealistic fears, sleeplessness, nightmares, and exaggerated autonomic responses. The patient tends to be immature, self-conscious, grossly lacking in self-confidence, conforming, inhibited, dutiful, approval-seeking, and apprehensive in new situations and unfamiliar surroundings."[20]

Since the time of admittance, Jeffrey's diagnosis has been changed to childhood autism.

Childhood autism is a complex and severe disorder of children. It involves an impairment of perception and

---

[20]The American Psychiatric Association, Diagnostic and Mental Disorders, Washington, D.C.: American Psychiatric Association, 1968, pp. 50-51.

conception that results in confusion as to time, space, person, and body schema. The confusion creates anxiety for the autistic child and is a factor in the child's inability to distinguish the self from the non-self.

Contact with reality is lacking in the autistic child. The child loses contact by withdrawing, by actively refusing to accept reality or by transforming and distorting it.

Research studies conducted by C. H. Delacato and Lorna Wing have shown that autistic children exhibit abnormal receptor behavior. For example, an autistic child can exhibit an increased sensitivity, a decreased sensitivity or avoidance especially in the areas of seeing or hearing.

His level of awareness and kinesthetic activity is abnormal. Instances occur where he can be physically passive or intensely active.

Jeffrey displays most of the characteristics described above. On the unit or in school Jeffrey does not socialize with the other children. He talks and remains physically close to only one or two of the unit staff personnel or teachers.

It has been reported at unit staff meetings that Jeffrey becomes aggressive when he is frustrated. His frustrations are due to his confusion to changes in his life at the treatment center. These changes can include program revisions, staff personnel or new children.

Jeffrey has poor contact with reality. He does not

acknowledge an awareness of himself, other people or his surrounding environment. His world is a mixture of confusion, frustration and fear.

Art therapy was chosen for Jeffrey as part of his treatment modality program. Through art, it was hoped that Jeffrey could become aware of his environment by the utilization of a variety of materials.

In an art therapy program designed for an autistic child, the initial step is to make contact. Eye contact, verbal or physical awareness can be reinforced by rewards such as candy. Continued reinforcement can strengthen the child's awareness. Sometimes this awareness never occurs depending upon the severity of the child's disorder.

Autistic children need structured lesson plans and work areas. Decisions as to what materials will be used or where to sit usually cannot be made by the autistic child.

Every art activity needs to be broken down into small sequential steps. Only after each task is completed, can another instruction be given to the child. Repetitions and physical demonstrations of each direction are often a necessity when showing an autistic child what to do.

New materials in art therapy are introduced gradually to the child. Simple explorations of the new materials can be increased every day. Each time the experience becomes longer, less frightening and less confusing.

Abstract concepts need to be made concrete for the autistic child. If the child has difficulty in visualizing

the shape of a circle, ribbon or yarn can be used to demonstrate what a circle looks like.

I began observing Jeffrey in art therapy under the supervision of the art therapist at the treatment center. In art therapy Jeffrey exhibited poor eye contact. He rarely looked at anyone. He was unable to focus his attention on one activity for an extended length of time. Jeffrey's art therapist divided the art therapy session into two parts because of his inability to maintain attention on one activity for forty-five minutes.

For the first thirty to thirty-five minutes in art therapy, Jeffrey drew or played with clay. He used magic markers, crayons, chalk or craypas to depict the children on his unit, cartoon or television characters, and famous atheletes. With the clay, Jeffrey would build cars, racetracks, basketball courts, and football fields. The remaining ten to fifteen minutes was devoted to reading. Jeffrey would choose a book from the bookshelf that he would read with the art therapist.

Four months later, Jeffrey's art therapist left her position at the center. Jeffrey's unit staff personnel and clinicians felt it was beneficial to keep Jeffrey in art therapy with me. The art therapy program that was developed by Jeffrey's previous therapist would be continued. The staff members at the center and I felt that Jeffrey would need a period of adjustment toward his new art therapist before his program could be revised.

Jeffrey had difficulty accepting the departure of his art therapist. He was confused. This confusion created anxiety, fear, and frustration for Jeffrey.

For four to five months Jeffrey exhibited his hurt and confusion in the form of anger. He would enter the art room in a frenzy and refuse to do any art work. He would fling the drawing paper on the floor and draw on the table with hard, short strokes.

Jeffrey continued at every session to ask where his art therapist was. He did not appear to understand the fact that the therapist had moved to California. His anxiety disrupted into more aggressive outbursts in the art room and resulted in his returning to the unit.

Jeffrey began to forget he had art therapy sessions to attend. Sometimes he refused to attend. When he was brought by staff personnel to class, he frequently became aggressive and was returned to the unit.

At the unit staff meetings, Jeffrey's problems in art therapy were discussed. No behavior difficulties were reported other than mine.

I was reminded of Jeffrey's inability to accept change in his daily routine. His response to any changes was displayed in my classes in the form of aggression. The staff personnel did not want to remove Jeffrey from art therapy. They felt it was necessary for him to understand that his art therapist had left the center.

Approximately five months later, there was a noticeable

change in Jeffrey's behavior. When he arrived in the art therapy room he was calm. Instead of throwing the materials on the floor he used them to create pictures or clay sculptures. He stopped asking where his previous art therapist was and began to accept me as the replacement.

In art therapy, Jeffrey and I made an art folder for his pictures. The folder remained in the art room at all times, but Jeffrey was allowed to take his pictures back to the unit.

Jeffrey's art therapy class was divided into three different activities during the forty-five minute period. For five to ten minutes Jeffrey and I did circular exercise movements to music. These exercises helped Jeffrey become more aware of me and himself. First, I would demonstrate the movement. Jeffrey would have to repeat my exercise.

Twenty-five minutes was devoted to art. Jeffrey found this activity the most difficult because of the length involved.

Magic markers, chalk, crayons, craypas and clay were used for the art activity. Jeffrey did not like to use messy materials since he could not work with their fluency. Jeffrey needed the structure that the above tools provided.

Step by step directions were given throughout the activity. For example, Jeffrey was told to choose a colored marker. This direction had to be repeated before Jeffrey could make the decision.

Only one box of crayons or markers would be available.

Jeffrey was distracted by a variety of materials. Distractions caused Jeffrey to become frustrated and withdraw into himself.

Plate 1 and plate 2 contain the themes that were prevalent throughout his art therapy classes.

In plate 1 Jeffrey drew his circular movements. When the circles were completed, Jeffrey encouraged me to write what the circles represented. They were the robot characters from the movie Star Wars. Jeffrey had seen the movie with the other children from the unit.

The circles in plate 2 represented television and cartoon characters. When Jeffrey was on the unit he watched television for hours. Many of the children on the units spend time watching television. The characters from the programs sometimes become models whom the children wish to emulate.

Clay was also introduced in the art activity. Jeffrey would build cars, racetracks, or football fields. Rarely did he build a person.

Jeffrey and I read for the remaining ten minutes of the art therapy session. Together we would take turns reading paragraphs.

At the unit staff meetings, Jeffrey's progress was discussed. We decided to include more sensory experiences for Jeffrey in the art class, to develop a greater awareness of himself, other people, and his environment.

The movement exercises were continued. Various

textured materials were collected and individually introduced to Jeffrey.

He would be encouraged to touch, smell, and talk about the size and shape of the material. Simple repetitions of how the item felt helped Jeffrey to assimulate the information.

Jeffrey's drawing themes began to include pictures of his family, and the children and staff personnel at the center.

Plate 3 shows Jeffrey, with his mother, father, and a neighborhood friend. The circles in plate 3 resemble one another. There is no difference between the male figures and female figures. Jeffrey was unable to make individual distinctions in his drawings.

In plate 4 Jeffrey had drawn me, the first representation that Jeffrey had included of me. The drawing was synonymous with Jeffrey's attitude. He was now able to accept me as his new art therapist.

Television and cartoon representations did not disappear from Jeffrey's drawings. Plate 5 shows the television characters of The Three Stooges.

Jeffrey and I continued the sensory experiences in art therapy until my termination.

My student work at the center was completed. I would be leaving within a month. Jeffrey had been told that I would be leaving the center soon.

As the termination time grew closer, Jeffrey became

unable to function in the art therapy room. He displayed anxiety and frustration when he tried to complete the tasks I gave him. Jeffrey's behavior was a repetition of the earlier sessions in art therapy. However, this time there was a difference in his ability to express his feelings.

Jeffrey verbalized his anger toward me through his picture in plate 6. This picture represented the first time that feelings were expressed and the beginning of human characteristics such as hands and feet.

At Jeffrey's final art therapy class, he asked to take most of the pictures he had made in art therapy back to his unit. I gave him the ones he wanted along with his folder.

When I said goodbye to Jeffrey at that session I was surprised by his physical response. He hugged me.

Five months later Jeffrey was discharged. He was placed in a permanent residential home.

Jeffrey's illustrations in art therapy indicated that he was functioning developmentally below his chronological age. Plates one through six are typical examples of the circular shapes that are made by children at age two. The basic form of the circle is the child's first attempt at representing a person. In the graphic development of children at three years old, these circular shapes begin to combine the body parts to make a human figure. The extensions of arms and legs, and facial features appear.

In art therapy Jeffrey continued to draw circular

scribbles. His human figures did not contain the body parts. Facial features, arms and legs were rarely drawn by Jeffrey because he was not aware of their existence. The movement exercises and the tactile experiences were employed in the art room to develop his perception of himself and others. Art was used for Jeffrey to help stimulate his language development and increase his ability to process external stimuli.

Jeffrey had difficulty initiating or forming close relationships at the center. Autistic children like Jeffrey do not establish contact with the outside world. They become isolated and withdrawn. During the end of the year Jeffrey made contact with me. This contact was an initial step toward Jeffrey's continued improvement.

B.

Keith

Keith is a thirteen year old black male. He was admitted to the state institution because of his behavioral problems. At home, Keith displayed periods of self-abuse, screaming, and aggressive outbursts that resulted in property destruction.

The admitting diagnosis was an unsocialized aggressive reaction to childhood and a non-psychotic organic brain syndrome. A non-psychotic organic brain syndrome is the medical category for patients who have an organic brain syndrome but are not psychotic.

The American Psychiatric Association states that "in children the brain damage often manifests itself by hyperactivity, short attention span, easy distractability, and impulsiveness. Sometimes the child is withdrawn, listless, perseverative, and unresponsive."[21]

Organic brain syndromes are manifested by impairment of orientation, of memory, of judgment, and all intellectual functions such as comprehension, calculation, knowledge, and learning. There also is a shallowness of affect.

The American Psychiatric Association states "that organic brain syndromes are a basic mental condition

---

[21] *Ibid.*, pp. 31-32.

characteristically resulting from diffuse impairment of brain tissue function from whatever cause. Most of the basic symptoms are generally present to some degree regardless of whether the syndrome is mild, moderate or severe."[22]

Psychotic symptoms and behavioral disturbances can also be associated with the syndrome. "The severity of the associated symptoms," says the American Psychiatric Association, "is affected by and related to not only the precipitating organic disorder but also the patient's inherent personality patterns, present emotional conflicts, his environmental situation, and interpersonal relations."[23]

Keith's organic handicap was not the major etiological factor. The behavioral problems that were associated with the first part of his diagnosis predominated.

An unsocialized aggressive reaction to childhood is "characterized by overt or covert hostile disobedience, quarrelsome, physical and verbal aggressiveness, vengefulness, and destructiveness. Temper tantrums, solitary stealing, lying, and hostile teasing of other children are common. These patients usually have no consistent parental acceptance and discipline."[24]

At unit staff meetings, it was reported that Keith's home visits are poor. His mother and older sister describe Keith to be "unmanageable."

---

[22] *Ibid.*, p. 22. [23] *Ibid.* [24] *Ibid.*, p. 51.

Keith's parents are separated. His father assumes no responsibility for his son except contributing to his financial support. Both parents want him to be placed in a permanent residential home.

Keith is mildly retarded as a result of his premature birth. His retardation "refers to subnormal general intellectual functioning which originates during the developmental period and is associated with impairment of either learning and social adjustment or maturation, or both."[25]

According to the American Psychiatric Association, the intelligence quotient of a mildly retarded individual is between 52 and 67. This classification should not be the only criterion used when making a diagnosis of mental retardation. The association feels that ". . . the judgment should also be based on an evaluation of the patient's developmental history and present functioning, including academic and vocational achievement, motor skills, and social and emotional maturity."[26]

Keith's teachers place his vocabulary recognition at two years ten months. His language age level is five years six months. Keith is reported to have good articulation skills with single word responses for food.

Since the age of two, Keith has been hospitalized for the treatment of pneumonia, anemia, ear infections and surgery on both of his legs because of his developmental

---

[25]Ibid., p. 14. [26]Ibid.

anomaly called spina bifida. Spina bifida is characterized by a defect in the bony encasement of the spinal cord. Keith has an abnormal gait due to his anomaly.

Keith remains withdrawn and isolated at school and on the unit. He is not able to accept limitations for his immediate gratifications or to tolerate interferences from other children and staff members. He responds well to routines, not changes.

At school it is reported that Keith's communicative verbal output is poor. He exhibits echolalia, which is the meaningless repetition of words addressed to him, and unintelligible mumblings. Keith's mumblings are an indication that he is withdrawing.

The child displays violent aggressive outbursts at the center when he becomes agitated. He pounds on desks and floors, screams, throws furniture, bites, and hits other children or staff personnel.

Art therapy was recommended for Keith to improve his socialization skills, reduce his aggression and improve his verbal expressions. Keith's art therapy program was designed to encourage verbalizations for his needs and to reduce his aggressive outbursts.

Keith is always escorted by staff personnel to his classes. On his first visit to the art room he was brought by his teacher. I met them at the art room door.

At this first meeting, Keith became violent. He hit and kicked me. No words were spoken by Keith; he screamed.

His teacher took him back to the unit until he calmed down.

This incident was repeated several times. I reported my difficulties to the staff members at Keith's unit meeting. The staff personnel informed me that Keith's reaction to me was normal. Keith disliked changes. He understood what was expected of him in his daily routine at the center. His aggressive outbursts were the result of his fear of new situations.

A month later, Keith entered the art room. Together we made a folder to keep his art work in. To help make Keith comfortable, I encouraged him to explore the work area. He quietly looked in the cabinets, drawers, and shelves. The variety of materials excited him.

To help Keith become more relaxed in this new environment, I explained the procedures to him. The time limit of the class, the work area, and materials were described for Keith. He was also told that behavioral disturbances would not be tolerated in the art room. These disturbances included aggressive outbursts such as screaming, hitting, biting, or throwing materials on the floor or at me. The result of any outbursts would be his returning to the unit.

Magic markers and clay were Keith's favorite materials. He became frustrated with unfamiliar utensils and media. New materials were introduced gradually at each session. Keith rejected most of them except for drawing materials.

Eventually Keith used the blackboard for some of his

larger pictures. However, sometimes I discouraged the use of the blackboard because Keith became upset when his drawings could not be put in his art folder or taken back to his unit.

At the art sessions, Keith chose the different colored magic markers to work with. He would pick up the individual colors and smell them. Then he usually took a seat at the far end of the art table, move his materials very close to his body and start drawing.

During the art sessions, Keith would keep his drawings covered. He rested his head upon one extended arm and covered his papers. He did not want me to see what he was doing. I acknowledged his wish for privacy.

While he worked, Keith rocked in his chair. His arms moved wildly in the air. When he picked up a marker to draw, he would be able to control his spordaic movements.

As Keith worked, he would laugh or talk softly to himself. Since actions were indications of withdrawal, I would interject questions to maintain contact with him. However, he never answered me.

Plate 7 and plate 8 contain Keith's drawings from the art therapy classes. In plate 7, Keith drew the figure of a man, as he indicated with a hat.

Keith drew his mother and father in plate 8. The depiction of his family was a familiar theme throughout the art therapy sessions. He never drew the children on the unit or hospital staff personnel.

Each figure Keith drew was the same. During one art session as many as ten drawings would be made and each one included the same human figure. This was an example of perseveration. Perseveration is the continued repetition of any activity. It is often associated with brain damaged children such as Keith.

Keith also included in his drawings the names of the figures. He wrote the names himself without my assistance.

At the unit staff meetings I discovered that Keith displayed perservation in school. The staff members felt that the perservated activity should not continue if it served no particular purpose. The activity could be an indication of withdrawal. Therefore, the clinicians felt it was necessary to observe the behavioral patterns that accompanied the repeated activity.

Throughout the art therapy classes Keith continued his perservated drawings of his mother or sister as seen in plates 9 and 10. Rarely did his father appear in his pictures.

Clay was also used in the art room by Keith. He never built any human figures. Instead, Keith made round balls that he would flatten on the table.

During the art activity I watched Keith closely for any signs of withdrawal or loss of contact with reality. At times during our forty-five minute class, Keith would begin to talk. However, his verbalizations were unintelligible. When I attempted to help Keith make clear what he said, he only repeated my questions that were directed to him.

Gradually changes were noted in Keith's behavior. In the art room, Keith began to sit closer to me. During some of the art therapy sessions Keith would gently touch me. He was no longer afraid.

I discovered that I could make contact with Keith by mirroring his actions.

In the art therapy class I would provide Keith and myself with the similar art materials. I would duplicate Keith's drawings or clay pieces. He reacted positively. Soon Keith began to share his pictures with me. He no longer hid them from my view.

Keith's teacher no longer brought him to class. I picked him up and returned him to his unit after each art therapy session.

When I arrived at his teacher's door, Keith knew who I was and where we would be going. Sometimes Keith would hold my hand as we walked down the hall.

Plate 11 depicts another picture Keith drew of his mother and sister. Although the human representation is the same, the two figures are now touching hands. Gradually Keith's pictures showed minor differences. His figures were drawn closer together.

In art therapy, Keith did not become frustrated. I directed his projects towards materials I felt he would be able to efficiently use. Any utensil or medium that Keith could not adequately manipulate would be put away because these products could cause Keith to become frustrated and

result in an aggressive outburst. New materials that required instructions were gradually introduced. The perseverated activities were decreased by my encouragements to start new projects.

At the unit meetings Keith's progress in art therapy was reported. The staff personnel was happy to hear about Keith's behavior in class. His teachers and unit staff members also made positive comments concerning Keith's behavior. Program revisions were made to increase his verbalizations. Each staff member was urged to encourage Keith to talk.

In art class Keith had to ask for the materials he wanted. I no longer put them on the table for him unless he told me what he wanted to use. When I picked him up for class, he had to tell his teacher where he was going before he could accompany me to the art room.

Keith had improved his communication and socialization skills in art therapy. His perseverated actions and aggressive outbursts decreased. His repetition of words demonstrated that he had a good memory and a high potential for progressive development.

At the time of my termination, rehabilitation programs, and permanent residential placements were being investigated for Keith.

C.

Mark

Mark is a ten year old white male. He was admitted to the institution because he had become disruptive and aggressive at his previous residential placement center.

Since infancy, Mark has had behavioral problems at home and school. He has spent five to eight years in special education classes and behavior disorder programs at several residential homes.

At the age of five Mark's parents were divorced. Mark's father has custody of him and his older brother.

Mark is an organically brain damaged child. He functions on a moderate level of retardation. His behavior suggests autistic-like features.

Organic brain syndromes, retardation, and autism were defined in the two previous case studies. Their definitions will not be repeated. However, the manifestations of the disorders present in Mark will be discussed.

Mark's intelligence quotient is placed between 36 and 51. He exhibits poor judgment, poor impulse controls, bizarre behavior, inappropriate affect, and poor socialization skills.

On the unit Mark remains isolated. He prefers solitary play instead of group interaction because he exhibits

difficulty in relating to the other children. It has been reported that Mark bites, kicks, or hits other children, staff members or himself.

Emotionally, Mark is immature. He cries for no apparent reason and seeks out inappropriate physical touching of staff members and peers.

Mark is an impulsive, distractible, anxious, fearful, and aggressive child. He exhibits withdrawal by his distant, glazed expressions and nonsense verbalizations.

His teachers report that Mark shows some capacity to relate. He responds well to structure, but has a very low frustration tolerance because of his inability to regulate his own internal impulses. Art therapy was recommended for Mark to reduce his aggressions, increase appropriate speech production and socialization skills.

When I came to the institution to complete my art therapy internship, Mark was enrolled in a group art therapy class. The art therapist reported that Mark was having difficulty with the children in art therapy. He often became disruptive and had to be removed.

I observed Mark in his group art therapy class for about two months. During that time Mark rarely completed any art activity. He remained isolated from the other children and resisted assistance on his projects from me or his art therapist.

Mark's behavior was discussed at a unit staff meeting. The staff personnel explained that Mark was still

adjusting to the new center. Everyone was advised to help Mark release his aggression thru channels other than violent outbursts. Staff members were to report on observations of withdrawal and verbal communication.

The art therapist left the center one month later. I continued to see Mark in art therapy. However, the staff members and I felt that more progress could be made if Mark was seen on an individual basis.

In art therapy, Mark was informed of the limitations that existed in the art room. These limitations included the amount of time scheduled for the class and the appropriate behavior that was expected of him.

A behavior chart was made. After each class Mark and I would evaluate his performance and behavior. Edible rewards and verbal praises were given for positive reinforcement.

Each art therapy class was highly structured. Mark needed external control. He was not able to make decisions about what art materials he should use. Mark was also not able to control his impulsive actions.

To eliminate Mark's frustration and decrease his aggression, simple step by step instructions were given. After each activity was completed, a new instruction was demonstrated. Repetition and individual assistance were often necessary. Sometimes Mark refused help from me; he wanted to accomplish his task by himself. New materials were carefully introduced. Each item was evaluated in terms of its consistency to routine and simplicity. Magic markers,

chalk, craypas, clay, and paper were used in the art room to make drawings and sculptures.

Mark's art period was divided into two activities because of his inability to remain focused on one task for forty-five minutes. The first twenty-five to thirty minutes of the art therapy session was devoted to a specific art activity that provided confidence and satisfaction. For the remaining twenty to fifteen minutes, Mark was encouraged to choose a material he wanted to work with in the art room. The staff members at the center felt it was necessary to increase Mark's ability to make decisions for himself.

At Mark's unit staff meetings his adjustment to the institution was discussed. Mark's aggression was not decreasing on the unit. He kicked, bit, or punched the other children and unit staff members. His teachers reported that in school he was not completing his work. His overall performance and behavior was poor.

For about six months Mark showed little improvement at the center. His aggressive outbursts did not decrease. He showed clear signs of further withdrawal. Program and treatment plans were revised continually. Gradually Mark began to adjust to his new environment. He was given more individual attention in his classes and on the unit. He began to exhibit compliance with staff personnel and other children.

In art therapy Mark's behavior improved. His violent attacks were diminishing in the art class. Mark began

to show a fairly appropriate adjustment. He displayed a normal affect, had an improved retention, and completed his work. Together Mark and I evaluated his progress on his chart. He responded well to my praises on his adjusted behavior.

Mark's pictures in art therapy contained many themes. He drew pictures of his father, and brother Tony, of the children on his unit, of staff personnel, of monsters, and of himself. Mark rarely included his mother in his drawings.

Plate 12 is an example of Mark's work in art therapy. Mark would recite a story for his drawings. Sometimes he made the people in the pictures talk. I wrote the stories on the paper for him. Titles for his drawings were also made by Mark. Plate 13 shows a familiar family sports scene. Gradually the monster drawings began to disappear. They were replaced by pictures of the center and the children on the unit as seen in plates 14 and 15. Mark was beginning to accept his new environment.

Revisions in Mark's art therapy program were discussed at the unit meeting. I felt that Mark's drawings indicated a poor body image concept. He did not draw the human figure with fingers, legs, feet or facial features. He needed to become aware of their existence.

In art therapy Mark and I did body sensory exercises. I would call out the names of the various body parts and he would point to them. I would write their names on the blackboard to help Mark remember what they were. We

started a series of body tracings in the art class. Giant sheets of paper were laid on the floor. Mark would put his feet, hands, or entire body on the paper and I would trace their outline with a magic marker. We took turns tracing each other. Once again the names of the individual parts were written on the blackboard.

Months later Mark and I began to draw the human figure. To remember the body parts Mark would use me as his model. Sometimes he looked in a mirror to examine his own facial features and body parts. After each drawing Mark and I evaluated his picture. We checked to see what body parts were missing.

Plates 16 and 17 are representations of how Mark's drawings had improved. Although his body parts were over-emphasized, they were now included.

Mark's progress was also seen on the unit and at school. His violent disruptions had decreased. His vocabulary was improving and his production in school was increasing.

In art therapy Mark was drawing the human figure without my assistance. He remembered to include all the body parts. Once again his stories reappeared as is illustrated in plates 18 and 19. At this time Mark was also becoming interested in new materials and in new ways to explore his creative abilities. He started to make sculptures out of paper tubing and cardboard boxes.

Mark's improved behavior was short-lived. He regressed to his earlier behavior of aggression, nonsensical

speech, poor retention, and work habits.

At the time of Mark's termination in art therapy he showed continued progress in his speech production and behavior. He did not cry when he wanted something in the art room. He asked for the materials he wanted to use. Mark verbalized when he needed my assistance with his projects. He no longer rejected my help. Mark did not become frustrated and aggressive in the art class. He learned to control his internal impulses by sitting alone until he felt calmer.

At the present time Mark is being evaluated by a permanent residential placement center for acceptance.

CHAPTER IV

Comparison of Case Research Analysis

In the preceding chapter, I described the three art therapy programs individually. I explained the social history and the psychological background of the children. Their behavior at the center was discussed in relation to the art therapy sessions. Included in the case studies was a description of the art materials used and illustrative examples of the children's art work. The comparisons and contrasts of Jeffrey, Keith, and Mark will be assessed in this chapter. The analysis of the children will demonstrate the value of art therapy for these institutionalized children.

Jeffrey, Keith, and Mark were brought to the residential center because of their families' inability to cope with their behavioral problems. The three children were not able to function appropriately. They had previous hospitalization in treatment programs designed to meet their individual needs. The boys' parents wanted the state institution to find a permanent residential home for their children.

Jeffrey, Keith, and Mark had difficulty adjusting to the state institution when they arrived. They displayed signs of aggression in the school classes and on their

units. The children did not comply with the demands given by staff personnel. Each was openly hostile to requests for personal hygiene and unit cleaning yet each child exhibited hostility in his own way.

When Jeffrey became angry he was unable to verbalize his feelings. He would withdraw into himself or become physically active. When Jeffrey withdrew he would eliminate all external stimulti; he would lose contact with reality. If Jeffrey became physically active, his body would shake. His face would turn red and he would begin to talk to himself.

Keith showed his aggression in violent outbursts, he did not withdraw. Keith would become physically hostile. He would bite, kick or hit children, staff personnel or himself. All verbalizations stopped when Keith was angry. He would scream and fight instead of talk.

Mark was the most violent of the three children. When he was angry, he would attack anyone. Mark would scratch and hit the victim until he was pulled away by staff guards.

Jeffrey, Keith, and Mark exhibited socialization problems with others at school and on the unit. They did not interact with their peers or staff members. When social encounters did occur, the result was negative.

Jeffrey did not talk to the other children at the center. On the unit, Jeffrey remained alone or with staff personnel that he knew. He did not watch television or play games with his peers. In school Jeffrey did not interact

with many people. He was cautious of strangers. In group activities at the center, Jeffrey would remain with a staff member. He refused to participate in the group activities.

Keith also had poor socialization skills. He did not interact appropriately with the other children on the unit and in his classes. He became aggressive in groups because of his inability to verbalize his needs to others. As a result, Keith's group activities were carefully monitored.

Mark did not function appropriately with people at the center either. Unlike Jeffrey and Keith, Mark was able to participate in group activities for short intervals. In the activity classes and on the unit, he demonstrated to staff personnel his capabilities of becoming a group leader. He was able to share his belongings and to engage in play activities with his peers. But Mark's appropriate behavior was short-lived. When his needs were not readily satisfied, he would explode. The outbursts happened frequently at the center and as a result Mark was constantly observed by staff members.

Behavior modification treatment programs were proposed for Jeffrey, Keith, and Mark. In a behavior modification program, a child's behavior is changed by repeated positive stimuli. Rewards such as candy or money are stimuli that were used at the treatment center. These rewards were incentives for the three children. In a behavior modification program it is important that all

staff members follow the same reward or punishment procedure to insure the repetition of the desired behavior. Long term goals were made for Jeffrey, Keith, and Mark by the hospital staff personnel. The procedures that encouraged the children to respond appropriately were included as part of the treatment plans.

The long term goals for Jeffrey were to increase his self-awareness, to decrease his aggression and withdrawal, and to improve appropriate socialization skills and speech production. Edible rewards were given to Jeffrey in his classes for appropriate behavior and for completed work. Staff personnel were required to remove Jeffrey from class if he lost control. He would be sent back to the unit to become calm.

Keith's treatment goals were to decrease his aggression and echolalia, increase his verbalizations, and improve his socialization skills with his peers. He was given candy as reward and verbal praises for appropriate behavior, and speech production and the completion of his tasks at school. If Keith became aggressive or continued screaming, he was brought back to the unit immediately. The unit staff members would keep Keith in his room for twenty to thirty minutes. This was called "time out."

Mark's long term goals were to decrease his aggression, to increase his appropriate socialization skills and verbalizations for his needs, and to increase

his frustration tolerance. Verbal praises were given to Mark for his appropriate behavior at the center. He responsed well to the positive reinforcement of the staff members. When Mark became aggressive he was also taken back to the unit for "time out."

The art work of Jeffrey, Keith and Mark demonstrated that they were functioning developmentally below their chronological age. Jeffrey and Mark's drawings stressed their poor images of the human body. Keith drew his figures with all their body parts. The drawings made by the three children indicated their inability to depict individual characteristics. Each figure Jeffrey, Keith or Mark drew looked the same.

The state institution provided an environment in which personality distortions common in disturbed children could be observed. These distortions in the three institutionalized children are found in the lack of close emotional relationships with adults, in the uninterested attitude of obtaining sources of pleasure, and in the inability for the children to demonstrate self-control and direction for their lives.

Art therapy helped provide Jeffrey, Keith, and Mark with emotional satisfaction. Jeffrey was able to draw his cartoon characters. Keith was able to maintain control with the magic markers. Mark was given the freedom to fantasize. The art experience provided the children with successful achievements. This success led to improvements

in the children's social relations with their peers, staff members, and me. Art therapy continued to demand more skill, more concentration, and more imagination by encouraging each child to help himself.

CHAPTER V

Conclusion

The quotations from Margaret Naumburg, Judith Rubin, Viktor Lowenfeld, Edith Kramer defined the meaning and the value of art therapy in Chapter Two. The authors expressed belief that art therapy has value as an emotional outlet. Through art, hidden fears, doubts, unvocalized hates and anxieties are liberated in imaginative and objective form. The art experience offers the child an open avenue for the discharge of his feelings.

Art therapy provides a means of communication. It is a special language that reveals a record of the child's concepts, feelings, and perceptions of the environment and himself. The art process is a non-threatening visual tool of creative play. Through art, the child can begin to organize and identify his environment into a meaningful experience. In art the child is willing to put down his pleasant and unpleasant thoughts, to clarify his relationship between objects and people, and to express himself in a tangible way.

As part of a treatment plan for children art therapy can help unblock repressed feelings. It provides a pictorial representation of the child's life. When art therapy is used within a treatment program, it enables

the physician to understand the child.

The authors believe that art therapy plays a crucial role in enabling the child to face new situations. In art, the child can relive a frightening experience or he can fantasize about his past, present, or future life. Art work gives the child a method to control, to organize a confusing sense of his body or of his environment. Productive art activity adds true meaning to his reality and to his fantasy.

The three institutionalized children discussed in chapters three and four benefited from the art therapy classes. The art experiences provided the children with emotional satisfaction; the art products were the children's proud, personal accomplishments. At the institution these children often felt physically and psychologically out of control. The materials and the modality in the art room enabled the children to be in charge. This provided each child with a pleasurable emotional experience: a feeling of self-worth and confidence. Jeffrey, Keith, and Mark learned the joy, the pleasure, and the pride of skill development. They enjoyed the results produced by themselves.

Art provided the children with an alternate avenue for the release of aggression. In the art room Jeffrey, Keith, and Mark could exhibit their hates, their anxieties, their fears, and their frustrations in their art work. The children could "hit" or "bite" anyone in their drawings or sculptures. They could release the tensions that were

under control in the other classes and on the unit. This process encouraged the children's fantasies and verbalizations. They were willing to talk about their feelings thru the unthreatening disguise of their art fantasies.

Art therapy stimulated the institutionalized children mentally. Most day to day activities at the center were the same. They did not experience many changes in the daily routine of the program. In art, the experience was slightly changed to creatively and intellectually help the child think for himself. Gradually the children were encouraged to choose their own materials and discover new methods for using them and to function as independently as possible.

For Jeffrey, Keith, and Mark, art therapy increased their contact and awareness, decreased their hyperactivity and aggression, increased their ability to participate in some group experiences, improved their motor skills, increased their ability to accept limitations, and provided a new means of self-expression.

The limitations of this culuminating project provided an opening for further investigation. A comparison and analyzation of the children's improvement in other classes or on the unit could be researched. The regressions and progressions in and out of the art therapy class would be dated to show the behavioral patterns of the children. This can provide a more detailed and extensive outline of the children's total environment.

A comparison and contrast of the importance of art therapy between institutionalized and non-institutionalized children can be examined. Factual information and illustrative examples of the children's art work can be catalogued. The differences and comparisons of the children's social and psychological background could be included.

The importance of art therapy as a diagnostic aid for children can be investigated. Art therapy could be analyzed in terms of its ability to be used as a diagnostic technique by clinicians. Comparisons would be made between the other diagnostic methods and art therapy. Actual research could be done. Charts would be made to note the similarities between the diagnostic results of art therapy and other techniques.

The discussion and ideas presented in this culuminating project provide a beginning for further research into the possibilities of art therapy.

ILLUSTRATIONS

(Plate I - through XIX)

PLATE I

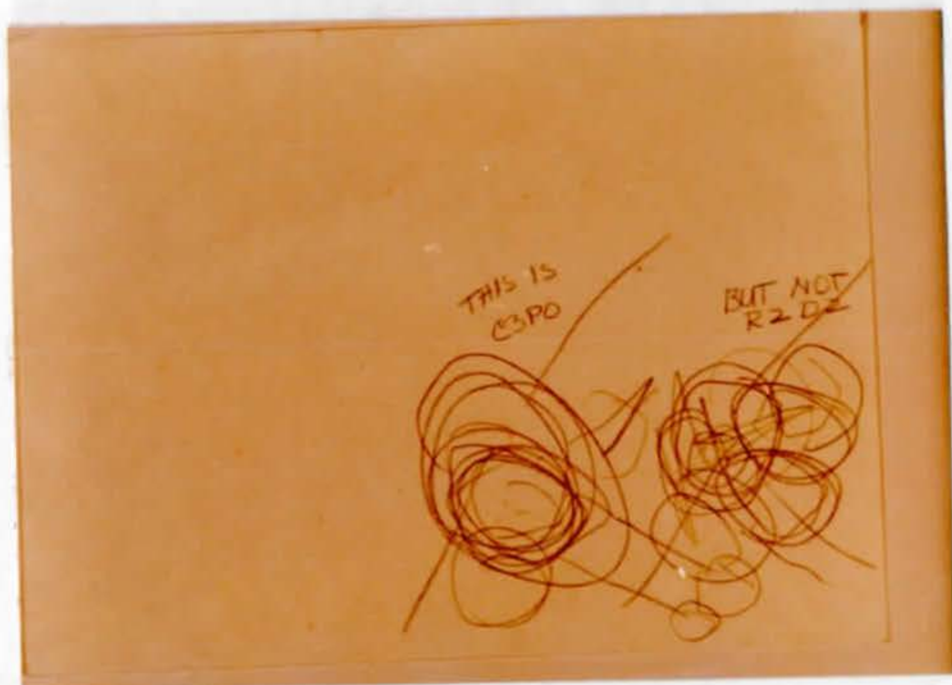


PLATE II

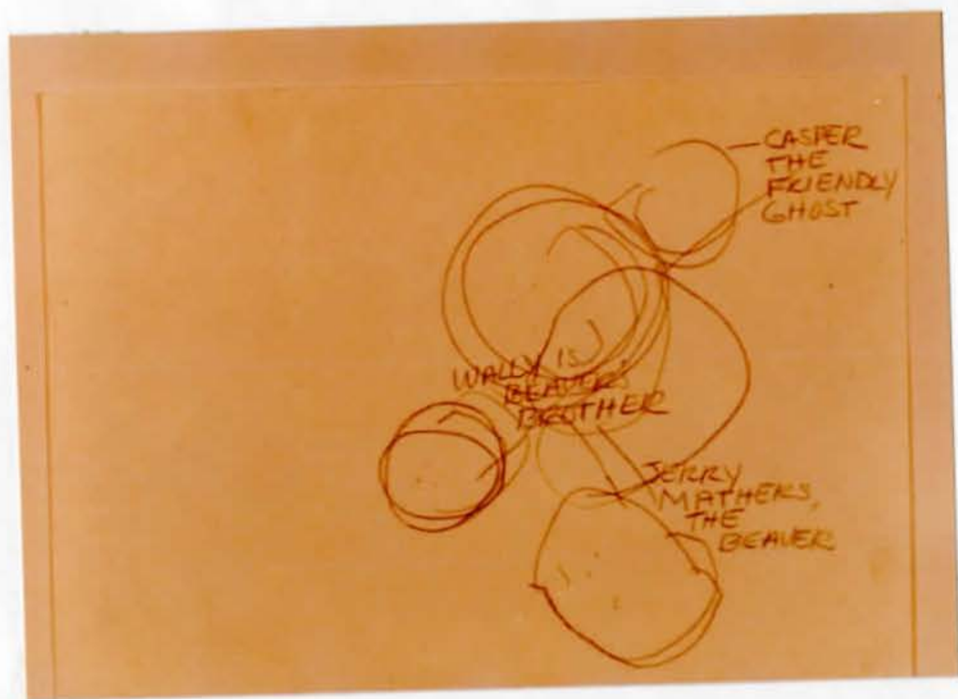


PLATE III

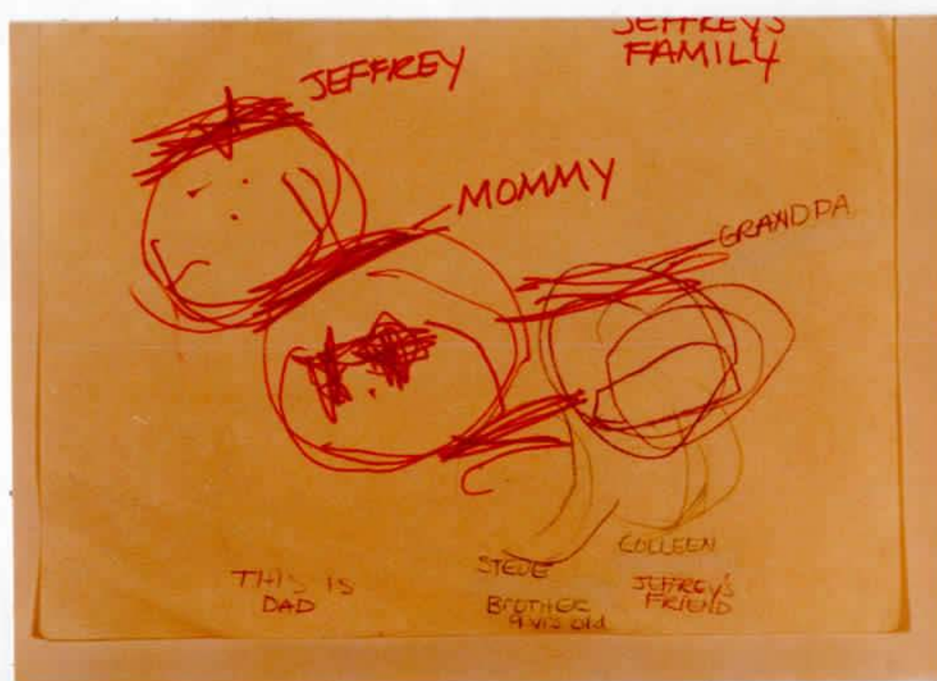


PLATE IV

PLATE V

PLATE VI

PLATE VII

PLATE VIII

PLATE IX

PLATE X

PLATE XI

PLATE XII

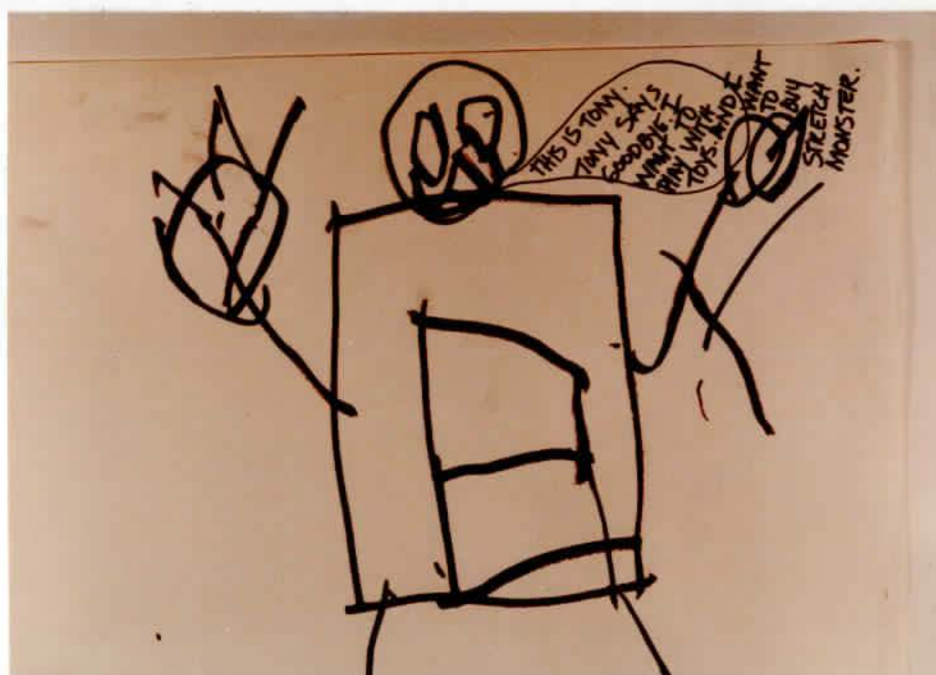


PLATE XIII

PLATE XIV

PLATE XIV

PLATE XV

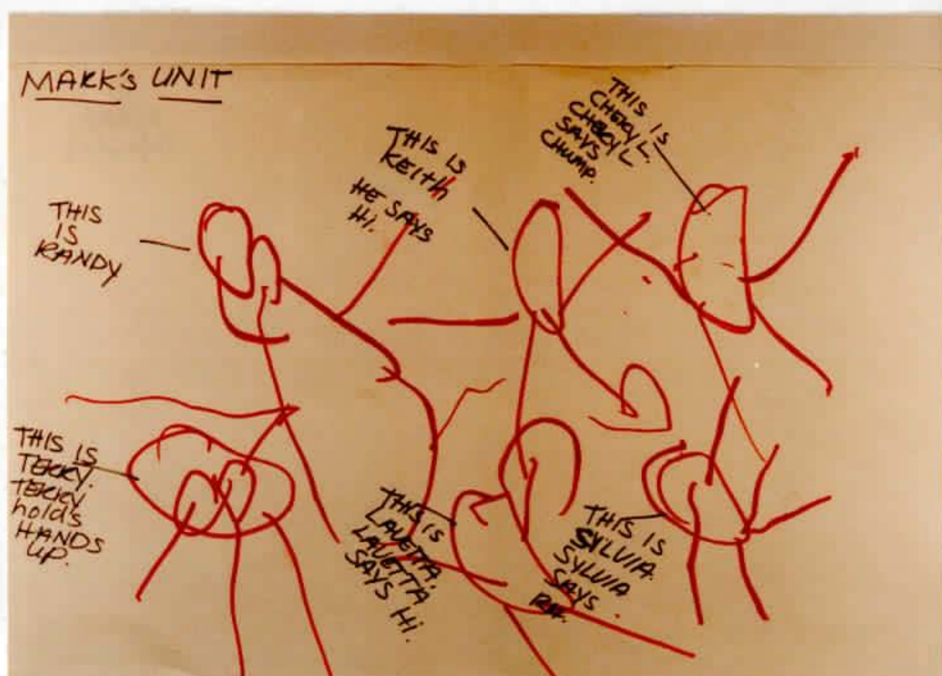


PLATE XVI

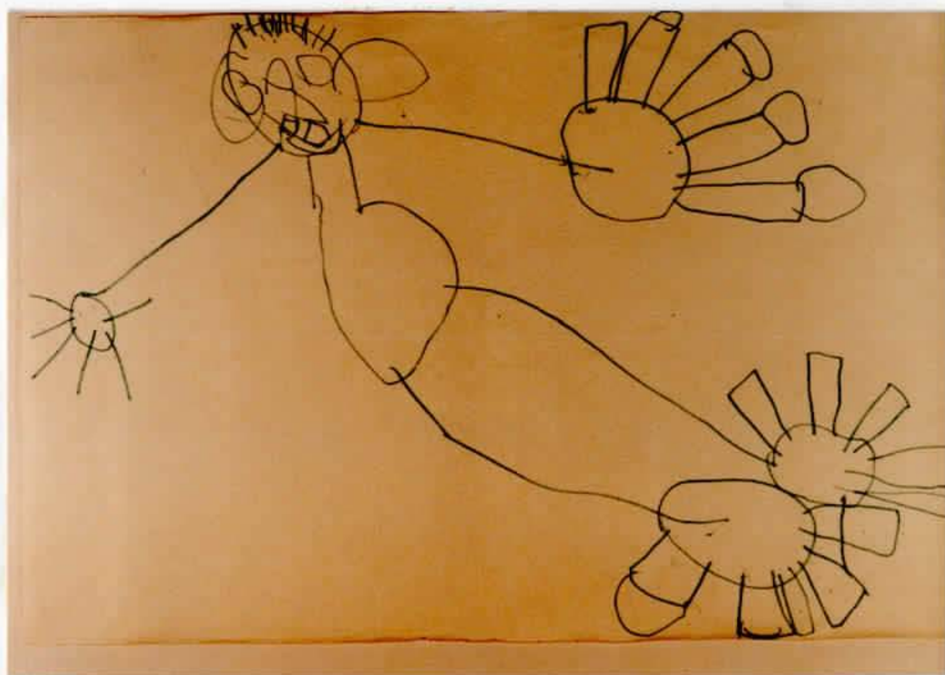


PLATE XVII

PLATE XVIII

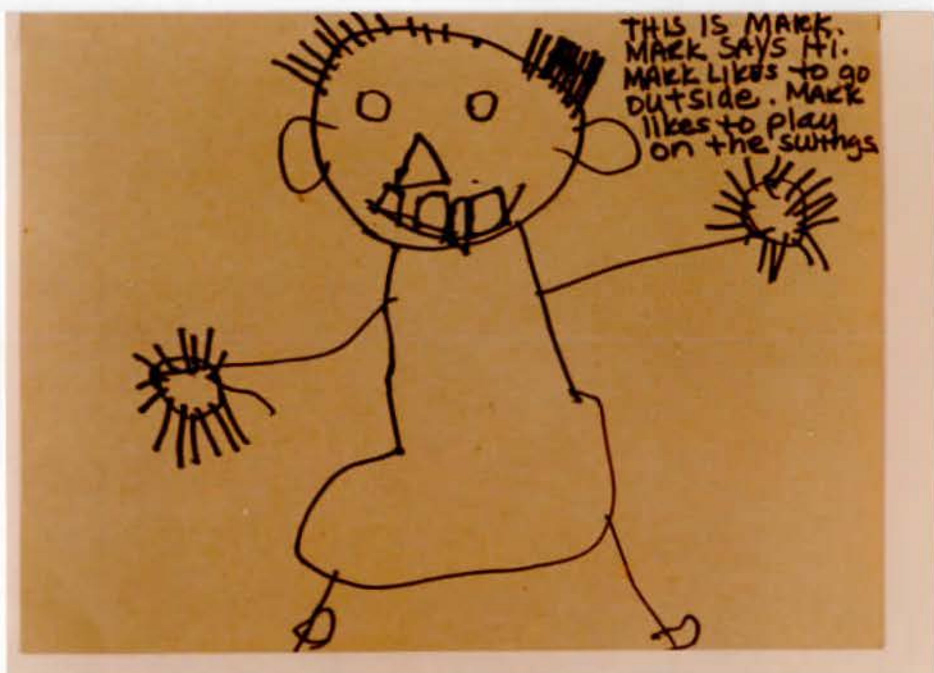
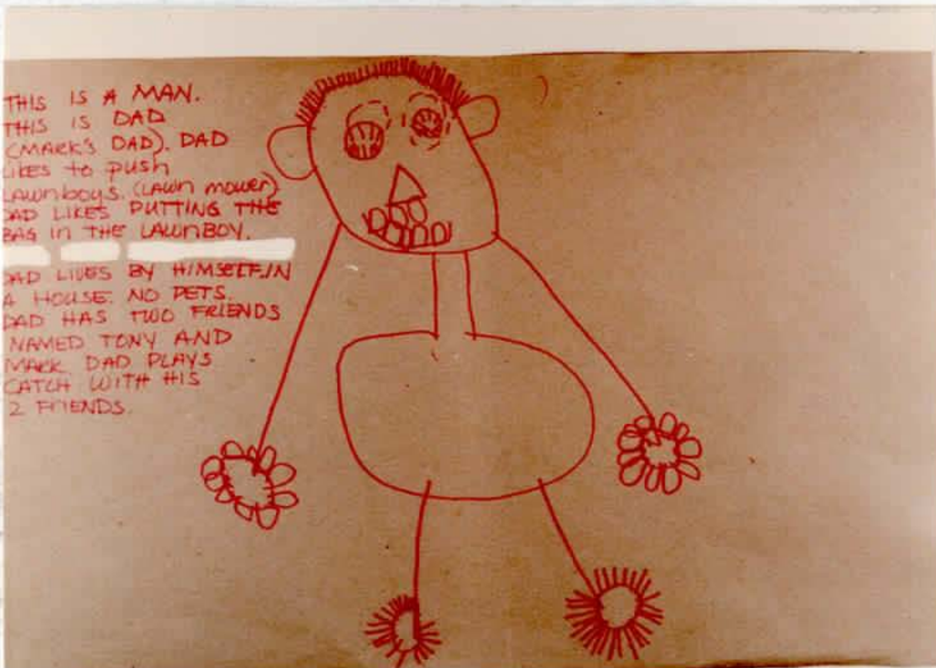


PLATE XIX



SELECTED BIBLIOGRAPHY

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Washington, D.C.: American Psychiatric Association, 1968.

Berry, J., Daily Experience in Residential Life, London and Boston: Routledge and Kegan Paul, 1975.

Betensky, M., Self-Discovery Through Self-Expression, Illinois: Charles C. Thomas, 1973.

Dorland's Medical Dictionary, Philadelphia and London: W. B. Saunders Company, 1965, p. 976, 1418.

Flint, B. The Child and the Institution, USA: University of Toronto Press, 1968, p. 3, 8, 14, 61.

Kellogg, R., Analyzing Children's Art, California: Mayfield Publishing Company, 1970.

King, R. D., Raynes, N. V., and Tizard, J., Patterns of Residential Care, London: Routledge and Kegan Paul, 1971.

Kramer, E., Art as Therapy with Children, New York: Schoken Books, 1971.

Lowenfeld, V., and Brittain, W., Creative and Mental Growth, New York: MacMillan Publishing Company, Inc., 1975.

Naumburg, M., An Introduction to Art Therapy: Studies of the "Free" Art Expression of Behavior Problem Children and Adolescents as a Means of Diagnosis and Therapy, New York and London: Teachers College Press, 1973.

Rhyne, J., The Gestalt Art Experience, California: Brooks/Cole Publishing Company, 1973.

Rubin, J., Child Art Therapy, New York: Van Nostrand Reinhold Company, 1978.

Whitaker, J. K., and Trieschman, A. E. (eds)., Children Away From Home, Chicago and New York: Aedine Atherton, 1972.