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Art Therapy with the Orthopedically Hospitalized Child: Helping the Child Master the Stress of Hospitalization

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ART THERAPY WITH THE ORTHOPEDICALLY HOSPITALIZED CHILD: HELPING THE CHILD MASTER THE STRESS OF HOSPITALIZATION

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ABSTRACT

This work presents many aspects of the use of art therapy with the orthopedic child in the medical setting. It deals specifically with the use of art therapy to promote mastery of fears, fantasies and conflicts about injury, hospitalization or surgery. Case studies are included to illustrate the use of art therapy in this capacity.

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PREFACE

The following work emerged from a practicum placement in the orthopedic[1] unit of a children's hospital where art therapy was introduced within the existing pediatric play program. In this setting, I have become increasingly aware of the psychological aspects of hospitalization, particularly the stress evoked through separation, pain, real or imagined body injury, and immobilization. I have explored ways in which the hospitalized child might benefit from art therapy in coping with this stress.

Establishing such a program has proved challenging because the use of art therapy in the general medical setting is relatively undeveloped, and little relevant literature is available. During the practicum experience I have become increasingly confident that art therapy plays an important role with the hospitalized child, and I hope more hospitals will open their doors to the art therapist and to his or her unique skills and knowledge.

This work represents an effort to integrate many aspects of my experience in using art therapy with the hospitalized child. It offers the reader a new application for art therapy, an ever-growing profession.

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[1] Orthopedics is the branch of medical service concerned with the diagnosis and treatment of congenital or acquired injuries to the skeletal framework of the human body.

INTRODUCTION

All children need creative opportunities. Through the creative experience, the child may communicate ideas and feelings, explore fantasies, resolve fears. Art is one such form of expression, a form through which every child may expand his capabilities. Art engages the child's manual skills, mental processes and emotional faculties. The natural relation between art and the developing child's personality may explain why it is often employed to deal with emotional trauma and to heal scars in development.

The intent of therapy is to facilitate the child's growth. It attempts to help the child learn about himself and his environment and to establish a relationship between the two.

Art therapy may be broadly defined as a process whereby the individual is understood and helped through artistic expression and communication. It encompasses the healing and integrative aspects of the artistic process, as well as its capacity for uncovering the unconscious, strengthening defenses, facilitating emotional discharge, and establishing communication.

There are several approaches to the therapeutic use of art, specifically, art psychotherapy, "art as therapy" and Gestalt art therapy. The particular form that art therapy may take depends largely on the setting in which it is utilized.

Margaret Naumburg has developed the practice of using "free art expression" to enhance communication within psychotherapy. Such an approach emphasizes the uncovering and release of unconscious drives, fantasies, memories and conflicts through spontaneous projection of images. Through the use of imagery, the restrictions of conscious, verbal

communication are eliminated.[2]

Edith Kramer regards the creative process itself as therapeutic. Her emphasis is on "art as therapy," that is, the therapeutic aspects inherent in the art process, rather than on psychotherapy, which utilizes art. Art therapy is conceived as "primarily a means of supporting the ego, fostering the development of a sense of identity and promoting maturation in general."[3]

Naumburg and Kramer provide the basic framework for the practice of psychoanalytically-oriented art therapy. In contrast to the psychoanalytic approach which focuses on the unconscious, symbolic aspects of art, Janie Rhyne advocates the Gestalt approach, emphasizing insight into problems and potential through creation and viewing of personal art forms. Through this more deliberate, conscious process, the individual gains greater self awareness.[4]

Art therapy has utilized many other psychological frameworks, including Jungian (Lydiatt), humanistic (Garai), and phenomenological

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[2]Margaret Naumburg, Dyamically Oriented Art Therapy: Its Principles and Practices (New York: Grune and Stratton, 1966).

[3]Edith Kramer, Art as Therapy with Children (New York: Schocken Books, 1971), p. xiii. The ego, in the psychoanalytic approach, is the part of the personality which is the mediator between the instinctual aspects of the individual and the demands of reality. Its main function is the perception of reality and the adaptation to it. The ego is said to be the executive of the personality because it controls action, selects those aspects of the environment to which it will respond, and decides which impulses will be satisfied and in what manner.

[4]Janie Rhyne, The Gestalt Art Experience (Monterey, California: Brooks/Cole Publishing Co., 1973).

(Betensky).[5] Elinor Ulman finds that, underlying all approaches or theoretical frameworks, is the recognition of the integrative nature of art, its ability to unite the opposing elements within the personality, such as impulse and control, fantasy and reality, aggression and love, conscious and unconscious. Art provides a means to understand the inner and outer world. Ulman states:

> Its motive power comes from within the personality; it is a way of bringing order out of chaos--chaotic feelings and impulses within, the bewildering mass of impressions from without. It is a means to discover both the self and the world, and to establish a relation between the two. In the complete creative process, inner and outer realities are fused into a new entity.[6]

Boundaries between approaches or psychological orientations are overemphasized; in reality they overlap. In actual practice it is hard to separate "art as therapy" and art in the service of psychotherapy; these approaches are not incompatible. Underlying them is the understanding that art is a means to alleviate emotional pain and promote psychological health.

Art therapy has traditionally been utilized only in psychiatric, educational, or rehabilitative settings. Its application in the medical hospital with the hospitalized child is relatively new. The hospitalized child, like all children, has need for expression, mastery, and ways of coping with stress. The young child in the hospital faces a great deal of stress--a variety of unfamiliar, unpleasant situations. Children are less tolerant of pain, frustration and trauma, and possess a limited knowledge of reality and reason. Boundaries between reality and fantasy,

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[5] E. M. Lydiatt, Spontaneous Painting and Modelling (London: Constable and Co., 1971): Joseph Garai, "The Humanistic Approach to Art Therapy and Creativity Development," (Mimeographed); Mala Betensky, Self-Discovery through Self-Expression (Springfield, Illinois: C. C. Thomas, 1973).

[6] Elinor Ulman, "Art Therapy: Problems of Definition," Bulletin of Art Therapy 1 (Winter 1961): 20.

reason and affect, conscious and unconscious are not clearly defined. Under the stress of hospitalization, fears and fantasies readily merge to distort the situation. For the ill and immobilized child, fantasies become more real; for example, castration may appear more feasible when the child's limbs are surgically attacked or rendered useless by illness.

The approach presented here is psychoanalytically-oriented. The use of art therapy in this setting draws to a large degree from the belief that the art process itself is integrative and healing. In a medical setting, where children are hospitalized for relatively short periods of time, art is not primarily utilized to bring into awareness unconscious fears and fantasies, or to promote verbal psychotherapy. Only the concrete, conscious aspects of the child's fears are discussed verbally; unconscious fears and fantasies are dealt with only through the art process.

The approach in this setting may be defined as one in which art is utilized to help the orthopedic child master trauma--feelings, fears and fantasies about an injury or consequent hospitalization and surgery. Mastery is a process of having attained a sense of control over one's fears and concerns. To attain mastery the child must move from his state of helpless passivity to one of activity. Through the active mastery of the art media and the ideas and feelings expressed in art, the child takes charge and, consequently, attains confidence to master the real world. The child ceases, even if only for the moments of the creative act, to be the passive victim of his fears and concerns.

Art is a wonderful form of expression through which to facilitate the child's active role in mastering trauma; the art therapy relationship provides a non-threatening atmosphere in which the child may explore consciously or unconsciously his fears and fantasies, verbalize those concerns,

or clarify misconceptions. The use of art in such a capacity will be discussed in depth, and illustrated and supported by case study material.

CHAPTER I: REVIEW OF LITERATURE

The Hospitalized Child

The state of being ill and hospitalized is stressful for most children.[7] The kind of reaction a child has to hospitalization is dependent on such factors as age, previous history of hospitalization or separation, level of emotional and cognitive development, and awareness and perception of the world. The type of illness and its consequent nursing, medical or surgical treatment will, in addition, determine the degree of emotional reaction to hospitalization.[8]

Much of the child's behavior must be understood in terms of the degree that hospitalization, illness and pain are charged with psychic meaning. The child will react with affects appropriate to his conscious fears and his unconscious feelings and fantasies concerning the experience. The issue of concern for one child may be separation from his family; fear of bodily mutilation may assume greater significance for another child. The following considerations are important in understanding the child's response to the experience.

Upon hospitalization the child experiences profound changes in his lifestyle. He is separated from the security of his home and family. The hospital is an unfamiliar environment--a world of bedpans, food served on

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[7] Madeline Petrillo and Sirgay Sanger, Emotional Care of Hospitalized Children: An Environmental Approach (Philadelphia: J. B. Lippincott Co., 1972); William S. Langford, "The Child in the Pediatric Hospital: Adaptation to Illness and Hospitalization," American Journal of Orthopsychiatry 31 (1961): 667-684.

[8] R. D. Becker, "Therapeutic Approaches to Psychopathological Reactions to Hospitalization," International Journal of Child Psychotherapy 1 (1972): 65-97.

trays, hospital gowns, and an array of new sights, sounds and smells. At home the child's needs are met by members of his family, but during his hospital stay he is cared for by strangers who must, on occasion, inflict pain as a part of medical treatment. This separation from his family may be perceived by the child as parental punishment for actual or imagined misdeeds,[9] or may be viewed as rejection and as an indication that he is unloved by his parents.[10]

During hospitalization the child may be subjected to anxiety-provoking diagnostic and surgical procedures. The threat and emotional stress aroused through such bodily interferences exist both in realistic terms and in their unconscious meanings. Thesi Bergmann and Anna Freud consider the effects of surgery, stating: "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, or deprived of a valuable part of his own self." In this threatening environment, "archaic fears and primitive anxieties" become confused with actualities and distort the issue. For example, surgery is often unconsciously confused with castration. According to Bergmann and Freud, the boy at the height of the "Oedipus complex" will most likely view the surgeon as a punishing castrator.[11]

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[9] Becker, "Therapeutic Approaches"; Thesi Bergmann and Anna Freud, Children in the Hospital (New York: International Universities Press, 1965); Emma Plank, Working with Children in Hospitals: A Guide for the Professional Team (Cleveland: The Press of Case Western Reserve University, 1971).

[10] A. Edelston, "Separation Anxiety in Young Children," Genetic Psychology Monograph 28 (1943): 3-95.

[11] Bergmann and Freud, Children in the Hospital, pp. 136-44. The "Oedipus complex", a psychoanalytic concept coined by Sigmund Freud, refers to the four to five year old child's wish for sexual possession of the parent of the opposite sex and the resulting rivalry with the parent of the same sex. The development of the "Oedipus complex" creates a threat for the boy. If he persists in his sexual attraction for his mother, he risks punishment by his father. Specifically, the boy fears his father will remove his penis. This fear is referred to as "castration anxiety." His fantasy is supported when the boy sees there

During illness and hospitalization, the child must often surrender his strivings for autonomy and is unwillingly forced into more immature patterns of response. R. D. Becker, Anna Freud and W. S. Langford emphasize this loss of independent function.[12] The child, having mastered significant stages of development such as independent eating, independent bowel and bladder control, and the ability to wash and dress, may find these advances in individuation frustrated or lost as he is forced into the passivity reminiscent of earlier development.

Autonomy may also be frustrated through the restriction of activity required during hospitalization, and the long periods of immobilization characteristic of many orthopedic conditions. W. S. Langford suggests that such decrease in movement and motor activity deprives the child of a valuable channel for emotional discharge.[13] In a study of orthopedic children subjected to long periods of immobilization, M. D. Schecter points out that lessened motility infringes on the child's ability to test reality and to obtain concepts of his body and self.[14]

In reviewing the literature concerning the child's behavioral reactions to illness, hospitalization and immobilization, it is important, first, to point out that which is normal. According to Anna Freud, many children

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are those (girls) who have no penis. The girl appears castrated to the boy. While such a paradox is normally resolved in most homes, it becomes a basis for emotional disturbance where unusual circumstances intensity the dilemma. This area is further discussed in Sigmund Freud, New Introductory Lectures on Psychoanalysis, trans. J. H. Sprott (New York: W. W. Norton and Co., Inc., 1933), p. 120-122.

[12]R. D. Becker, Therapeutic Approaches"; Anna Freud, "The Role of Bodily Illness in the Mental Life of Children," Psychoanalytic Study of the Child 7 (1952): 69-82; W. S. Langford, "The Child in the Pediatric Hospital."

[13]Langford, "The Child in the Pediatric Hospital."

[14]M. D. Schecter, "The Orthopedically Handicapped Child: Emotional Reactions," Archives of General Psychiatry 4 (1961): 247-253.

react to hospitalization and illness by withdrawing from the outer environment. These children refuse toys, food and affection. Through this withdrawal from the object world, the child's energy is concentrated on the body and its needs; this process is normal, and is beneficial for recovery.[15] The hospitalized child may become demanding, irritable, depressed or have occasional nightmares; these are also normal reactions. In a study of orthopedic children, M. D. Schecter found depression and occasional nightmares to be prevalent during hospitalization.[16]

Thesi Bergmann and Anna Freud have studied the orthopedic patient's reactions to the restriction of movement. The orthopedic child is often faced with traumatic situations such as traction, immobilization in a cast, an amputated limb, etc. Bergmann and Freud, however, note that in many cases the visable and concrete nature of the orthopedic disability and the devices for treatment often help to allay the child's anxieties and enable him to view his treatment more positively. It was observed that the child confined to a plaster cast for an extensive period of time "explodes" with motor activity upon its removal. Irritability, uncooperativeness and aggressive outlets such as temper tantrums or abusive language often appear in orthopedic patients when ambulation resumes or when a cast is removed, and are considered normal reactions.[17]

Bergmann and Freud distinguish between those children who openly express anxiety and resentment through angry and aggressive reactions, and,

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[15] A. Freud, "The Role of Bodily Illness."

[16] M. D. Schecter, "The Orthopedically Hospitalized Child."

[17] Bergmann and Freud, Children in the Hospital.

in contrast, those who submit to medical procedures and immobilization calmly, exhibiting cheerful, cooperative behavior. Unfortunately, the latter are often praised as the "perfect patient." Cooperative behavior often masks overwhelming feelings and fantasies; the child utilizes all his energy to defend against such feelings. According to Bergmann and Freud, it is predominantly in the latter type of patient that various quasi-pathological reactions and after-effects are observed (e.g. regression, wetting and soiling, eating and sleeping disturbances, school phobias and learning difficulties). In such instances, the child's defenses are not strong enough to cope with the anxiety; the child consequently reacts with a neurotic outbreak.[18]

Those who exhibit extreme degrees of anger and hostility during hospitalization, manifested in destruction of property, kicking, biting, bullying, and uncooperativeness, are often found to have disturbed relations with their mother or are involved in family conflict, as noted by Petrillo and Sanger.[19]

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[18] Bergmann and Freud, Children in the Hospital, Regression refers to the act of returning to an earlier level of adaptation; to express emotional and social needs and outlets appropriate to an earlier age level. A school phobia is the refusal to attend school on a regular basis because of pervasive anxiety and somatic complaints, and is often related to anxiety about separation from mother or home.

[19] Petrillo and Sanger, Emotional Care of Hospitalized Children.

Art Therapy with the Handicapped Child

While a wealth of literature is available dealing with the drawings of orthopedic children,[20] little has been written about the use of art therapy with orthopedic children in the medical setting. The literature concerning art therapy with the physically handicapped child, however, is helpful in working with this population. The physically handicapped child, similar to the orthopedic child, is often faced with immobilization and the consequent physical limitations.

Judith Rubin's work concerning art therapy with the handicapped child is particularly significant. She recognizes the importance of providing the handicapped child with opportunities to function as independently as possible, since he is so often dependent on those around him. In art the child has an opportunity for choice and decision-making; art gives him a way to be in charge of a medium or tool that he may control in any way he chooses. To facilitate independent functioning, the art therapist, according to Rubin, must provide a broad choice of media and allow the child to select a preferred media from those available. She must, at times, be flexible and imaginative in order to adapt the art materials to the needs of the child, and to do so in such a way that he is in maximum

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[20] See L. Centers and R. Centers, "A Comparison of the Body Images of Amputee and Non-Amputee Children as Revealed in Figure Drawings," Journal of Projective Techniques 27 (1963): 158-165; Victor Lowenfeld and W. Lambert Brittain, Creative and Mental Growth (New York: Macmillan Publishing Co., 1975); Karen Machover, Personality Projection in the Drawing of the Human Figure (Springfield, Ill.: C. C. Thomas, 1949); Donald Uhlin, Art for Exceptional Children (Dubuque, Iowa: Wm. C. Brown Co., 1972); O. Weininger, G. Rotenberg and A. Henry, "Body Image of Handicapped Children," Journal of Personality Assessment 36 (1972): 248-253. This literature deals with the orthopedic child's body image and its projection in drawings. The authors note the presence of distortions, exaggerations and omissions in the figure drawings of orthopedically handicapped children.

control. In addition, Rubin advocates an openness to the use of other expressive modalities such as play or drama.[21]

There is often a greater need for adult intervention with the handicapped child. Rubin points out, however, that such intervention need not take the form of telling the child what to do or how to do it, but "in being understood, and being helped to articulate their unique creative strivings."[22] According to Edith Kramer, the therapist often acts to support the child's ego, helping him perform those functions he cannot do alone due to emotional or physical handicap. The therapist actively participates in the child's creative adventures, clarifying, guiding and supporting the child's strivings without imposing her own style.[23]

Mastery through Art

> True mastery of life's tasks depends on a disciplined freedom, whose model may be found in the artistic process.[24]

Much of the feeling and emotion are inaccessible to language. According to Suzanne Langer, art functions to objectify feeling so that it might be understood.[25] There is much evidence in the practice of art therapy that by objectifying or giving form to feeling, the creator is able to gain a sense of control over such feeling. Judith Rubin and Edith Kramer emphasize the child's ability to learn to control the real world through

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[21]Judith Rubin, Child Art Therapy: Understanding and Helping Children Grow through Art (New York: Van Nostrand Reinhold Co., 1978).

[22]Ibid., p. 239.

[23]Kramer, Art as Therapy with Children.

[24]Elinor Ulman, "Art Education for the Emotionally Disturbed," American Journal of Art Therapy 17 (October 1977): 14.

[25]Suzanne Langer, "The Cultural Importance of the Arts," Aesthetic Form and Education, Edited by M. E. Andrews (Syracuse: Syracuse University Press, 1958): 4-5.

active mastery of materials, tools and the concepts and feelings expressed in art work. Through this mastery of symbolic expression, the child learns to master reality and life's developmental tasks.[26]

Because art partakes of the realms of both reality and fantasy, the child can experiment with the impossible symbolically without fear of real consequences. The child is able to "gain symbolic access to and relive past traumas, and can rehearse and practice for the future."[27]

Similarly, Kramer observes art's ability to facilitate the child's move from passivity to activity, providing him with an opportunity to take an active role in reliving an experience that was passively endured. Kramer states: "The child who makes a picture of himself in the doctor's hands usually shows himself as helpless before a terrifying powerful figure." Hence, art provides the child with a means to present life's "truthful images."[28] Rubin also recognizes the value of art in dealing with trauma that is ordinarily too difficult to assimilate, stating that "giving form to the feared object brings it under one's own symbolic control."[29]

In relation to experiences that are particularly frightening and anxiety-provoking, however, the child may attain a sense of mastery by renouncing his helpless state and becoming the aggressor in art or play. In Beyond the Pleasure Principle, Sigmund Freud recognizes the child's emergence from the passive to the active role in his play that represents

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[26]Rubin, Child Art Therapy; Kramer, Art as Therapy with Children.

[27]Rubin, Child Art Therapy.

[28]Edith Kramer, "Art Therapy and Play," American Journal of Art Therapy 17 (October, 1977): 8.

[29]Rubin, Child Art Therapy.

assimilation of unpleasant or frightening experiences. S. Freud states: "If a doctor looks down a child's throat or carries out some small operation, we may be quite sure that these frightening experiences will be the subject of the next game."[30]

According to Anna Freud, who has studied the mechanisms of defense in depth, this process is known as "identification with the aggressor." With this mechanism, the child defends himself against his fear of attack, and against the helpless anger that results, by identifying with the aggressive characteristics of the threatening object. By assuming the characteristics of the aggressor, or by imitating his aggression, the child temporarily renounces his state of helplessness and himself becomes the person who makes the threat. As a result, he is helped to master the experience. This identification reflects both the actual situation and the fantasies and feelings aroused as a result.[31]

According to Kramer, identification with the aggressor is temporarily helpful, particularly because the child turns his aggression and anger against the outside world rather than inward. Kramer acknowledges the benefits of this defense in the art of children. The child who attempts to master a situation by identifying with that which is feared (and perhaps at the same time admired) turns his aggressions outward and preserves his energies for artistic expression. Identification is beneficial and stabilizing. By forming visual images of the aggressor's characteristics, the child

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[30]Sigmund Freud, "Beyond the Pleasure Principle," Standard Edition 18 (1920): 17.

[31]Anna Freud, The Ego and the Mechanisms of Defense (New York: International Universities Press, 1966). The defense mechanisms of the ego are ways of dealing with anxiety by distorting, hiding or denying reality. They develop as a means of controlling or holding in check the impulses or affects, which, if expressed, may arouse such anxiety and conflict.

brings his fantasies into the realm of the ego, thus gaining greater control.[32]

Kramer describes the paintings of many boys concerned with defense against castration anxiety. These paintings, reflecting the use of identification with the aggressor and the accompanying fantasies of power, are of a destructive and aggressive nature. They abound with phallic representations such as whales, sharks, wild animals, battleships and swords. According to Kramer, whales and sharks often express identification with a castrating or devouring aggressor. Forms such as octopuses reflect a fantasy of possessing many penises and also serve to defend against the castration fear. These images in the child's art function to strengthen his defenses and, according to Kramer, will, with maturity, lead to more realistic expression of masculine prowess without excessive aggressiveness.[33]

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[32]Kramer, Art as Therapy with Children.

[33]Idem, Art Therapy in a Children's Community (New York: Schocken Books, 1977).

CHAPTER II: METHODOLOGIES

Art Therapy with the Orthopedically Hospitalized Child

The Setting

A major children's hospital is the setting for the art therapy internship from which this work emerged. The hospital is devoted to the diasnosis, research and treatment of major medical problems in children, newborn to approximately eighteen years of age. It houses a two-hundred-fifty bed inpatient facility and numerous out-patient clinics and services.

The internship took place on the orthopedic unit of the hospital. Orthopedics is concerned with the treatment of congenital and acquired injuries to the mechanical framework of the body. Children with afflictions such as cerebral palsy, spina bifida, scoliosis, bone infections, dislocated hips and fractures are commonly seen on the unit. The length of hospitalization for the orthopedic patient may be as short as two days or, in a few cases, as long as several months. Multiple hospitalizations are necessary for patients requiring cast removal or physical therapy.

The patient popluation of the orthopedic unit usually ranges from twenty to twenty-five. Private rooms are available for children who risk contracting or passing infection. Semi-private rooms are shared by two children, and the four wards on the unit accomodate as many as five children in each.

The hospital atmosphere is warm and cheerful. The rooms have many windows, and are sunny and bright. Children's art work adorns the walls of the rooms; toys fill the window ledges and bedside tables. Bulletin boards, murals and windows, decorated by the children or staff, colorfully line the halls.

A spacious room on the unit serves as a schoolroom and playroom. It is equipped with a sink, large tables, and cabinets for art supplies, toys and educational materials. During the morning hours a school program is maintained for children who are absent from their regular schools during long periods of hospitalization. In the afternoon the room serves as a playroom where organized group activities are available for all children on the unit. Immobilized children are taken to this room in their beds; others attend in wheelchairs, carts or on foot.

The art therapy program was developed within the existing pediatric play program known as Child Life. The Child Life Department comprises seven play therapists, a director, and numerous volunteers and students. Each Child Life therapist maintains a therapeutic play program in a designated area, such as orthopedics, neurology, general medical or the outpatient clinics.

The tenets of developmental psychology and play therapy form the basis of the department's philosophy. Child Life attempts to meet the emotional and psycho-social needs of the hospitalized child and his family through play and other recreational activities. It aims to maintain normal development during the stress and trauma of hospitalization. It attempts to provide the child with a positive growth experience, enlarging his capacity to cope with the hospital environment and subsequent new environments.

The Child Life therapist and the art therapist are an integral part of the hospital team; they work with medical staff, social workers, psychologists, clergy and educators in an effort to provide total health care for the child. The art therapist can contribute valuable information concerning a patient's behavior and the emotional variables in his illness and hospitalization. The therapist's efforts to maintain or facilitate psychological

health in the child will expedite the physician's goal of faster physical recovery. The physician is primarily concerned with medical treatment and will often overlook or be unaware of the emotional aspects of the hospitalized child's care. The therapist must often "educate" medical staff, sharing knowledge and skills in order to broaden understanding of the developmental and psychological aspects of the child. Small workshops or seminars may be conducted for medical staff covering various aspects of working with the children. Through interactions with the art therapist, medical staff can gain a greater understanding of and respect for the usefullness of art therapy. The emotional care of the hospitalized child may then take a parallel, rather than secondary, position to medical treatment.

Certain aspects of the medical setting create obstacles to maintaining a successful art therapy program. The most significant of these problems is the lack of privacy for the patient and the frequent interruptions by medical staff. Privacy and freedom from interruption are important factors in any therapeutic environment if the patient is to openly explore his psychological parameters. In the medical setting, however, these factors are difficult to maintain. The child is hospitalized primarily for medical treatment; psychological care usually takes a secondary position. It is not uncommon for physicians or physical therapists to remove a child from an individual or a group art therapy session for a medical procedure or a physical therapy session. Art therapy sessions are occasionally interrupted by technicians for blood tests, x-rays, and other procedures. These distractions interrupt the flow of the therapy session, and diminish the feeling of safety and neutrality that the therapist works to establish. The art therapist must consult with medical staff in order to schedule her sessions with the child so that the chances for interruption are lessened.

If the session is interrupted for a minor medical procedure, however, the therapist's presence is often helpful and supportive to the child and may stimulate discussion of fears about medical procedures, which then can be dealt with in the therapy.

It is also difficult to maintain privacy when the child shares a room with other children. An art therapy room, offering privacy for individual sessions, is not available on the orthopedic unit. Art therapy sessions are consequently held in the child's room, often in the presence of others. Some children may be reluctant to talk about their concerns in the presence of other children or family members. Conversely, others may find comfort and support in the presence of roommates who share similar experiences at the hospital, or family members from whom they are separated during the hospital stay. In the latter cases, roommates or family members are encouraged to work along with the child.

The Art Therapy Program

The philosophy and structure of the Child Life Department provide an ideal framework for the development of an art therapy program for the orthopedic child. The department's staff offers support and enthusiasm for the use of art therapy; at the same time, they provide the degree of independence necessary to explore and test its use.

In the orthopedic setting, art therapy may be utilized in a variety of ways: to promote the acceptance of a handicap and to build self-esteem; to encourage family interactions or socialization with other children; to facilitate emotional release; to provide the handicapped child with an opportunity for pleasure and joy through the sensory-motor experience. This study focuses specifically on the use of art to promote mastery of

fears and fantasies concerning an injury, hospitalization or surgery.

Illness and hospitalization are stressful and are sometimes traumatic for the child. He is separated from the familiarity of his home and family and is thrust into the unfamiliar and often hostile environment of the hospital. The child must submit to anxiety-provoking diagnostic and treatment procedures and is further forced into passivity by the immobilization resulting from disease or injury or by the variety of devices required for treatment. The child feels helpless and impotent. Tensions increase in this anxiety-arousing atmosphere. Fears and fantasies, shaped by conscious and unconscious factors, arise in the child.

The child can be helped to master his fears, fantasies and sense of helplessness by relinquishing passivity and utilizing art as a means to move into activity. Through the art process, the child has an opportunity to express his feelings; as he forms images of those feelings, he gains a greater sense of control over them. The child takes charge of the art media and the process; he is actively doing something to and with materials. He experiences a kind of power and mastery over the symbolic world--mastery that can be transferred to real life situations. He is able to relieve inner tensions as well as create aesthetic forms.

The therapist serves to facilitate and enhance this move to activity. She provides materials and establishes an environment in which the child feels both freedom and safety. In the hospital environment the child has little choice or control over what is done to him; it is consequently important for the therapist to provide the child with an opportunity for control and independence. This is best done by allowing the child to choose his own materials and projects, to establish his own pace, and to explore in his own way. The therapist, therefore, learns to trust the child's ability to

choose materials that are best for him, and to trust the child's natural tendency towards growth and integration. The therapist provides the encouraging, supporting framework within which the child is free to choose, to express and to explore. To prescribe materials or topics would only force the child back into his role of passivity and dependency.

If independent functioning through choice and control is to be attained, the therapist must make materials available in such a way that the child is maximally free to obtain and use them. Most children on the orthopedic unit are immobilized and are unable to explore the shelves and cabinets of an art therapy room; the art therapist must consequently bring the materials to the child. For example, for individual sessions a large tray of art materials is taken to the child's room and placed at bedside where he has a view of and easy access to its contents. The tray contains materials such as tempera paints, finger paints, watercolors, crayons, chalks, markers, scissors, glue and paper in a variety of sizes and colors. In addition, the child is verbally informed of other available materials and encouraged to ask for whatever he desires.

Trays and props are arranged for the child in traction or prone in bed so that he can comfortably use the art materials. Paints are poured in plastic jars and arranged in a tub that is placed on the child's bed. Plastic aprons and trays are available so that the child can explore messier materials such as clay, plaster, or fingerpaints. Such materials are never discouraged because of difficulty in clean-up or fear of soiling the bed. Rather, they are encouraged because they afford an opportunity to develop sensory manipulative powers in the child who may be handicapped in other realms.

The orthopedically hospitalized child may face many physical limitations

in the use of art materials. The art therapist must use her imagination to adapt materials and space to the individual needs of the child, and in such a way that the child has as much control as possible. For example, a child unable to control a brush may find a sponge a better tool for painting. This means that the art therapist must remain open to the use of media and tools in a variety of ways, as well as accept and encourage any genuine effort in art, no matter how crude.

The immobilized child often needs assistance from the adults in his environment. The art therapist often functions to support the child's ego, helping him with those aspects of his work that he cannot perform alone.[34] The orthopedic child most often needs help with the actual manipulation of materials. The child who has use of only one hand or the child prone in bed may need help mixing paints, gluing, cutting, or holding an object while it is painted. The therapist must be careful not to foster too much dependency in the child, however, or allow the child to use his handicap to solicit more help than is necessary. When help is genuinely needed, it is important that the child make verbally explicit what the therapist is to do, so that he remains in control. The therapist must be cautious not to impose her own ideas or style, as in telling the child what to do or how to do it. Rather, she must lend empathy and support to the child's own creative endeavors.

The role of the art therapist in supporting the ego is exemplified in the case of Joey, a child whose treatment for a bone infection required an I.V. in his left hand and restriction to a wheelchair. Over a period of several art therapy sessions, Joey created a large Easter egg by covering a balloon

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[34] See page 7 for discussion of support of the ego.

with the plaster-coated gauze used for orthopedic casts. The construction of the egg was a difficult task for a child with the use of only one hand. Joey required assistance in dipping the plaster-coated strips in water, placing them on the balloon, and holding the balloon while they were smoothed. Later, he needed help in mixing paints and holding the egg as it was painted. In each instance, Joey maintained full control over the project; assistance was provided only after he had given explicit verbal directions.

In addition, the therapist acts as an "extension of the ego" when she provides external control for the disturbed child with a poor sense of internal control.[35] The child with emotional difficulties preceding hospitalization or the child overwhelmed by fears and concerns related to his illness or hospitalization may display poor impulse control, his behavior and use of art materials may be ruled by aggression and destructiveness. The therapist can intervene to set limits, provide structure, and guide the child in his use of the materials. Structure and limits are conducive to the development of self control; by internalizing the controls the therapist offers, the child achieves greater powers of self-regulation.

Because the immobilized child needs more individual attention, group work is frequently difficult to conduct. Art therapy groups are also difficult to establish due to the rapid patient turnover and the difficulty in scheduling the groups around each child's medical treatments. Most art therapy on the orthopedic unit is consequently done on an individual basis.

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[35]Kramer, Art as Therapy with Children.

Small groups are occasionally organized in the ward rooms, where the children's beds can be pushed together. The children may choose individual projects, but often the group chooses a common material or project, such as clay or making puppets.

It is important that the therapist remains open to the use of other expressive modalities such as drama or play, as Rubin advocates in Child Art Therapy. If the child is to have a sense of control, he must be free to choose the form of expression best suited to him at any given moment. He may, at times, prefer a modality other than art. In the hospital setting, for example, the child will often achieve mastery by becoming the doctor in play. Through his identification with the aggressor in play, the child is able to move from a state of passivity to one of activity and control in an effort to master his fears and helpless anger about hospitalization.[36] Hospital play materials such as doll-size hospital beds, x-ray machines, wheelchairs, gurney carts, dolls, and actual medical supplies such as plastic syringes and bandages are utilized to facilitate the child's play. The child about to receive a body cast may attempt to deal with his anxiety by playing doctor and applying a cast to a doll; in the same manner, the child who intensely fears shots may administer play shots to the therapist, to a doll or to his stuffed animals.

Art and play may often be combined, as in the creation of masks or puppets for use in play or drama. One child who was fearful of doctors and medical procedures created a plaster mask of "Dracula" and donned the mask when doctors approached to "scare them away."

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[36] See pages 9-10 for discussion of the defense identification with the aggressor.

As has been emphasized, a successful art therapy program in a hospital setting must stress independent functioning through choice and control by the child. With a sense of control, the child will begin to master his feelings and concerns. The use of art therapy and the process of mastery is exemplified in the following case studies of Darrell and Jeff. Each case study addresses the use of art to facilitate mastery of a specific fear stimulated by hospitalization. Darrell utilized art in an attempt to master his fear of further bodily harm that was stimulated by his injury and the consequent need for surgery. Jeff was helped to master his overwhelming fear of rejection and desertion and to establish greater impulse control.

CHAPTER III: RESULTS

Case Studies

Darrell

Darrell, a nine-year-old black boy, was admitted to the orthopedic unit of the hospital with a lacerated right thumb. According to the story related by Darrell and his brother Larry, the boys were playing in the kitchen at home when Michael (Darrell's father's girlfriend's son) held a kitchen knife to Darrell's throat and, attempting to push Michael out of the way, Darrell swung his hand into the knife, severely lacerating the thumb. Darrell was taken to the emergency room of the hospital late that evening, where his hand was examined and temporarily bandaged. Because surgery would be required to repair the muscle and nerve damage that resulted, Darrell was admitted to the orthopedic unit that night.

Information concerning Darrell's personal and family history was obtained by the medical staff at his admission, and through my interactions with Darrell, as well as his father and brothers who were often present at the hospital. Darrell and his brothers, Larry, 11, and Jeremy, 7, were born near Atlanta, Georgia. While living near Atlanta, Darrell experienced his first hospitalization after an uncle hit him in the head with an automobile jack. Darrell's parents became divorced when he was five years of age, at which time the father and children moved to Chicago and the mother remained in Georgia. The children have visited their mother only a few times since their separation from her; according to the father, they would be allowed to visit her more often but never ask to do so. The father's girlfriend, Rosalyn, and her children, Michael and Belinda, are apparently present a

great deal in the home.

Darrell was hospitalized for a period of five days, Tuesday evening through Sunday afternoon. Surgery was not performed until Friday; such a long waiting period undoubtedly increased Darrell's sense of anticipation and fright. It was during this waiting period that Darrell was seen in two individual art therapy sessions and one group art therapy session.

I met Darrell the morning after his admission to the hospital. I approached him in his room where he sat alone, tearful and frightened-looking. Immediately upon introduction, Darrell began to speak with a quiet, whimpering voice, saying that he missed his mother and wished that she were with him in the hospital. He continued to explain how sad it made him feel that his parents had divorced and that his mother had remained in Georgia. When questioned why he was in the hospital, Darrell recounted the story of his injury, and expressed his fright over the incident and his consequent hospitalization. I asked Darrell if he would like to work with art materials while he was in the hospital. He brightened considerably, and replied eagerly that he would enjoy doing so.

I was surprised that Darrell had immediately expressed such intense feelings of sorrow and pain to me, a total stranger. This child apparently thirsted for a listening ear to whom he might express his troubles. In response, I offered Darrell an opportunity to further express his ideas and feelings through art and the therapeutic relationship.

When I returned to the room with a variety of art materials, Darrell's father and brother, Larry, were present. Darrell asked if Larry might join us in the art session, and I readily consented. A large table was set up in the room with all art materials visible and available so that the boys

might choose their own media and proceed. Their father was occupied with admission procedures, and when finished, he chose to sit in the far corner and read the newspaper. He interacted very little with the boys and showed no interest in their art work.

Both boys chose tempera paints and 12" X 18" white paper for their first pictures. Larry began with a painting of "Superman" that was quickly executed. After watching his brother for a few moments, Darrell began a similar painting of a robot or a "super villain." The figure has large box-like shoulders and head, a squared mouth with bared teeth, and is surrounded by a cape bearing "S's," which represent "super-villain." Hands and feet are absent. The villain or robot is equipped with a control box in the upper torso area that, according to Darrell, controls his action. While painting the figures, the boys eagerly discussed the knifing incident of the night before and Darrell's previous hospitalization in Atlanta. Darrell expressed no direct anger about either incident. Rather, he expressed affection and concern for Michael, the aggressor, and a wish that he would visit during the hospital stay.

Darrell's picture, however, suggests underlying feelings of anger, and seems to represent a compensation for feelings of inadequacy and fear specifically related to the knifing incident with Michael. When looking at the picture, one is immediately aware of the feeling of anger reflected in the squared mouth and bared teeth. The villain's aggressive-looking stance and angry appearance suggest the use of identification with the aggressor, as discussed by Anna Freud and Edith Kramer.[37] By identifying with the characteristics of the aggressor, Darrell may have defended against

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[37]See pages 9-10 for discussion of identification with the aggressor.

feelings of anger and fear in being the passive victim of such an aggression. Just as Darrell controls or denies his anger through his gentle, compliant behavior, the villain's action may be controlled by the box in his torso. Even if turned on, the villain appears unable to move ar attack, lacking hands or feet. This helpless demeanor seems to further reflect Darrell's feelings of inadequacy and fright.

For their second picture, both boys chose markers and 12" X 18" white paper as their materials. This time Darrell initiated an ocean theme, and Larry responded with a similar drawing. Darrell's drawing comprises the following: a small open boat on the water's surface; a submarine; several sharks with prominent fins and teeth; an octopus, also equipped with teeth; and a whale emerging from a cave in the lower left of the picture. The picture was carefully planned and drawn slowly with a blue marking pen; no other color was added. The submarine is of particular interest because of its detail and the time Darrell spent in its creation. It contains a door, a window, a periscope, a circle and cross motif, and a heart bearing the words "I love you."

Darrell's picture, with its abundance of phallic-aggressive representations, is reminiscent of those discussed by Edith Kramer as reflecting identification with a castrating aggressor.[38] Again, Darrell may have been struggling to assert strength and to compensate for his fear by identification with such forms. The presence of teeth in all creatures perhaps reflects a castration fear displaced from the penis to the nearly lost thumb. As Kramer points out, the octopus may reflect a fantasy of possessing many penises, again a defense against castration. In addition to the fears of mutilation stimulated

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[38] See page 10.

at the time of the accident, Darrell undoubtedly faced similar fears in anticipation of surgery. The benign-looking whale emerging from the cave may symbolize the therapist, observing the turmoil that surrounds.

The submarine in Darrell's picture seems to symbolize home and a wish for his mother. With its door and window, the submarine is reminiscent of a house. The addition of the heart bearing "I love you" seems to support its connection with the need for his mother. The circle and cross, early forms in the child's drawing development, may also be linked to such nurturance needs.[39] The stress of hospitalization intensified Darrell's need for his mother. As stated earlier, Darrell was separated from his mother around the age of five, a vital age marked by the emergence of Oedipal strivings.[40] His parents' divorce and his consequent move to Chicago with his father may have intensified feelings of guilt and fears of castration during the Oedipal period; and such a separation may have hindered the normal course of resolving the conflicts of that period.

Larry's picture depicts a large blue whale being struck by harpoons. A hat rides above the whale's yellow spout of water. The picture also contains a seal balancing a ball on its nose, a red submarine, and a torpedo, which resembles a syringe, aimed in the submarine's direction. Larry used tempera to add color to the drawing. The paint was carelessly applied and smeared in places. When asked to create a story about his picture, Larry said that a man had been devoured by the whale, and that his hat was

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[39]Refer to Donald Uhlin's Art for Exceptional Children, pp. 96-113. According to Uhlin, the circle is symbolic of the child's tie to his mother. If the child is separated from his mother, he will desperately attempt to identify with her, thus, the emphasis on circular forms. The cross form, Uhlin states, represents the Oedipal dilemma and establishment of sex role identification.

[40]See footnote 11 on page 2 for discussion of the "Oedipus complex."

riding above the spout of water. The harpoons, thrown by men not drawn in the picture, killed the whale, allowing the man within his belly to escape unharmed.

Larry's pictures seem to reflect a regression, as is evidenced by the quality of execution (i.e., the careless application and smearing of paint) and the chosen themes. Although my contacts with Larry were few in number, he seemed to be of above-average intelligence and normal development. I feel that Larry was capable, therefore, of more mature levels in his art work. Such a regression may have been stimulated by a strong identification with Darrell's helpless situation. The devouring whale in Larry's picture suggests an identification with his brother as a passive victim; the harpooning of the whale to allow the man to escape may reflect fantasies of rescuing his brother.

Clearly, the boys seemed to identify strongly with each other and drew a great deal of support from their relationship. This need for support may have grown from their mutual lack of mothering. Identification was particularly evident in their reciprocal sharing of themes in painting and drawing, and in the similarity of their pictures.

The boys showed great interest in the use of art materials. The creative experience seemed to bring pleasure and feelings of accomplishment and esteem, as was evidenced in their enjoyment of the process, and pride in their products. They expressed delight in being able to choose their materials freely, commenting that they had never been offered such an opportunity at home or school. Darrell was able to manipulate the media very well using only one hand. Because he is left-handed, the bandaged right hand did not hinder his use of the materials.

As I became more acquainted with the boys during this first session, I perceived my role as one of encouraging and supporting their expression. In such a short-term therapeutic intervention it was not realistic to deal with many of the issues that became apparent in Darrell's art work. Thus, I chose to rely to a great extent on the integrative aspects inherent in the art process to help Darrell achieve a sense of mastery.

In the third picture, Larry covered a small (6" X 9") sheet of paper with daubs of tempera of many colors and folded the paper to create a design he designated as a "butterfly." As with his previous work, this picture was quickly executed. Darrell watched and, fascinated, created a similar butterfly design. His picture, however, was done slowly and carefully.

Upon completion of the butterfly picture, Larry left the room to explore the unit and Darrell continued with a picture of a house using markers on a 12" X 18" piece of white paper. When questioned, Darrell said that the house represented his home. The heart symbol with the words "I love you" and the circle and cross motif that appeared on the earlier drawing of the submarine were again drawn on the house. A fruit-bearing apple tree stands to the right of the house. The front door, initially forgotten, was added upon his discovery of its absence.

The picture seems again to reflect Darrell's wish for the return of his mother. The presence of the heart, the circle and cross motif, and the fruit-bearing apple tree that also suggests nurturance, support such an assumption. The initial absence of the door perhaps symbolizes Darrell's failure to keep channels of communication open with his mother. If he does not ask to see her, he has, in essence, closed the door to the mothering he longs for.

While drawing the house, Darrell expressed concern about a nightmare

which had recurred the night of his admission to the hospital. According to Darrell, the nightmare had previously occurred several times, and he attributed it to a frightening movie that he had seen with his father. He was eager to describe the dreams, and as he spoke, he rapidly colored the house and tree with the markers, an action that reflected his anxiety. In the dreams, a man pursued and attempted to kill Darrell. In one dream, the villain broke into his home, and Darrell's father was unable to kill him. In another dream, Darrell "cut the man up," but the pieces rejoined and the man continued to pursue him. I suggested to Darrell that he draw a picture of the nightmare in the hope that, by doing so, he might conquer the villain symbolically. He resisted such an idea, however, saying that it was much too frightening to draw.

Darrell related another dream that occurred on the night of his admission, following the frightening nightmare. In this dream, Darrell appeared as an older man who owned and controlled the hospital. He described this as a pleasant dream.

The recurring nightmares suggest guilt and anxiety, undoubtedly over feelings of anger towards his father, and serve as punishments for having such feelings. Perhaps Darrell feels that his father is responsible for the separation from his mother, thus stimulating anger towards him. The inability of Darrell's father to destroy the villain in the dream may symbolize Darrell's feelings that his father cannot provide for all his needs, again arousing anger and fear. Castration anxiety and fears of punishment and abandonment were probably heightened by the knifing accident and Darrell's consequent hospitalization, stimulating the recurrance of the dream upon hospitalization.

The second dream, in which Darrell takes on the role of owner of the hospital, reflects further use of identification with the aggressor. By

taking an active and controlling stand in the dream, Darrell denied his helpless, passive state and his fears about hospitalization.

Later that afternoon, Darrell attended an art group in the playroom where playdough and other art materials were available for use. Larry, as well as two of Darrell's and Larry's friends from school, attended. Seemingly depressed and tired, Darrell interacted minimally with the other children in the group. He created three round discs out of playdough and engraved a happy, a sad, and an indifferent face in the discs. He then chose tempera and 12" X 18" paper to paint a picture of a red and a black flower. First, the red flower was painted on the left side of the paper; then, the black flower was painted on the right. A vertical black line down the middle of the paper separated the flowers. Finally, using chalks on 12" X 18" paper, Darrell drew a picture of a house similar to the one he had drawn in our earlier session.

The playdough discs seem to reflect contrasting feelings of happiness and sadness. Similarly, the tempera painting suggests anger, symbolized by the red flower, and separated from the sadness or depression that is represented by the black flower. It seems that Darrell's anger about the separation from his mother is hidden behind a wall of depression. Darrell's previous pictures, as well as the recurring nightmares, have pointed to such feelings of anger. The underlying depression evident in his art and behavior is undoubtedly linked to his need for mothering, which was again expressed through the second house drawing.

The following day, a second individual session was held. Darrell used tempera on a 12" X 18" sheet of manilla paper to paint a black linear design with small daubs of red and green. The picture was folded in half and rubbed to create blending of lines. The finished picture looks confused

and has a monsterous and depressive quality. Darrell did not want to talk about the picture, and quickly laid it aside. He did, however, begin to discuss his fear and concern about his surgery, which was to be performed the next day. Holding his bandaged hand against his body protectively, Darrell stated that the doctor would not repair his thumb, but, rather, intended to cut it off. I acknowledged Darrell's fears and we discussed his expectations about surgical procedures. I offered him some general information about some of the procedures that he would be undergoing, such as anesthesia, the repairing of the thumb, and recovery. Darrell was very concerned about the initial pre-operative shot, the part of the surgical procedure that he would be awake for.

Darrell's picture seems to reflect this fear and anxiety over the imminence of surgery. His confusion concerning surgery--the fear of losing his thunb--may suggest fear of castration. Perhaps Darrell unconsciously feared the loss of his penis, and had displaced such a fear to his severed thumb. Also, Darrell had already been the passive recipient of two major injuries. He undoubtedly mistrusted the surgeon, fearing that he, also, would inflict further injury. Although I could not address the fear of castration directly in therapy, I could express my trust that the surgeon would indeed repair his thumb and not cut it off, as Darrell feared.

Surgery was performed the following day and, unfortunately, Darrell was taken to the operating room early, before his father or I had arrived at the hospital. According to medical staff, he was extremely frightened and belligerent upon receiving the pre-operative shot.

Several bedside visits were made following surgery. Darrell seemed to experience much pain and wept often. Since he was unable to draw,

with the intravenous apparatus on his hand, Darrell and I sat and talked about his previous fears concerning surgery. Relieved that the worst was over, Darrell spoke about returning home and to school. He even expressed a wish to visit the hospital again. In spite of his fears and pain, Darrell seemed to have many positive experiences through art and interactions with others. He was discharged two days following surgery.

Concluding remarks

Art is the medium through which Darrell could express many immediate and long-term concerns and fears. Major issues which became apparent included: the trauma of the knifing incident and resulting arousal of fear of further bodily injury; hospitalization and separation from home and family; recurring nightmares; the longing for a more nurturing home environment. Darrell readily utilized the art and the ensuing discussions to express these concerns.

Although Darrell's short-term hospitalization did not allow enough time to explore many issues that became apparent in his art, he was helped to deal with the immediate concerns about the injury, surgery and recurring nightmares. The creative experience allowed Darrell an opportunity to actively master his fears by attaining control over the media and over the ideas and feelings expressed in his art.

Darrell utilized the defense of identification with the aggressor to master his fears of the injury and surgery, as was evident in the drawings of the robot and ocean creatures, and in his dream. Such a defense proved beneficial, as Darrell could gain strength through identification, and a sense of control by forming images of his fears. By using such a defense, he was able to externalize feelings of anger and aggression. Although

anger was denied behaviorally, it was close enough to the surface to manifest itself in his art.

The pleasurable aspects of the creative process were, in themselves, therapeutic for Darrell. He delighted in the use of art materials and expressed feelings of pride in his art work.

It seems that the depression which manifests itself in Darrell's art and behavior is linked to an early separation from his mother and an apparently distant relationship with his father. Separation at such a crucial age may certainly have contributed to an unresolved "Oedipal complex," thus intensifying fears of castration in the hospital and stimulating the recurring nightmares. Such a separation deprived Darrell of a nurturing, mothering person; his art reflects his wish for such a relationship. Darrell does not, however, seem to take personal responsibility for having such a wish fulfilled, evidenced in his not requesting to see his mother. Such areas of conflict require further exploration, but were not within the realms of our short contact.

The therapeutic relationship eased much of the trauma of hospitalization. Through my supporting and understanding attitude, Darrell was better able to express his fears and concerns. I facilitated the use of art materials and, in many instances, encouraged Darrell's verbal expression of conflict. Although I could not address Darrell's unconscious fears directly, I could offer information and demonstrate a trust of the surgeon's actions.

Darrell's creative endeavors could not eliminate the nature of his problems. They could, however, for the duration of the creative act, give him a sense of mastery over his conflicts. For those moments, Darrell was an active conquerer, rather than a helpless victim of his fears.

Jeff

Jeff, an eight-year-old white boy, was admitted to the orthopedic unit with Legg Perthes Disease.[41] Hospitalized twice at the children's hospital in the earlier stages of the disease, Jeff returned a third time for further treatment that involved daily physical therapy sessions and traction. When he was not in physical therapy, Jeff was required to spend most of his day prone in bed in traction. He was, however, allowed some freedom of mobility with a wheelchair to attend group activities.

Little is known about Jeff's personal history. His parents are divorced, and a custody struggle occurred during the divorce because neither parent wanted to assume responsibility for Jeff's care. According to the hospital charts, both parents openly expressed to him their disdain and apathy, and they showed no involvement or concern with his hospitalization. When he was admitted to the hospital, Jeff was living with his father, stepmother and stepsister, but in his entire month's stay he was never visited by family.

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[41] Legg Perthes Disease is the necrosis and eventual replacement of the osseous nucleus of the femoral head. It occurs predominantly in boys four to eight years of age. The course of the disease is two to three years, and is characterized by four stages: 1. Stage one lasts two to four weeks and involved a low grade inflammatory reaction in the joint area. 2. Stage two, or the necrosis stage, lasts six to eighteen months. The bone dies and becomes soft. This is the crucial stage in that if the child bears weight on the hip, the head will become deformed. 3. The regenerative stage lasts one to three years. During this time the femoral head revitalizes, new bone and cartilage begin to appear. 4. The final stage is the reappearance of normal bone. The child is intermittantly treated with bedrest and traction during the course of the disease. The use of a hip brace or crutches may be prescribed, depending on the type and degree of deformity. Physical therapy is utilized to restore range of motion. Ernest Aegerter and John A. Kirkpatrick, Orthopedic Diseases (Philadelphia: W. B. Saunders Co., 1968).

Management of Jeff's behavior during previous hospitalizations was a difficult task, according to hospital staff who worked with him. Psychological care was recommended by the staff, but their suggestion was ignored by his parents. Prior to his hospitalization, Jeff was involved in a special education program; according to the teacher who worked with Jeff during his hospital stay, he has many learning difficulties, including poor reading and writing skills.

During the later three weeks of Jeff's hospitalization he participated in six individual sessions and four art groups. Individual sessions were held at bedside while Jeff was in traction, and art therapy groups were attended in the wheelchair. A variety of art media was taken to Jeff's bedside so that he could choose his own materials.

At our first meeting, I entered Jeff's ward to find him thrashing from side to side in his bed, talking loudly to himself. Upon introduction, I asked him if he would like to make Valentine's Day cards from the materials that I had brought with me. Eager to do so, he chose construction paper, glitter and glue to make the valentines. Jeff aggressively and carelessly cut heart shapes from the red construction paper, only to reject them and throw them aside, saying that they were "dumb" and that he hated them. He devoured the materials, asking for more and more paper and pouring glitter profusely. Responding to his loss of control and apparent desire to fail, I intervened to provide the external controls and structure Jeff needed to complete the valentines.[42] Rescuing several of the rejected hearts, I helped Jeff trim the edges so that he might proceed. I then helped him to control the amount of glue and glitter he applied. With this

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[42] See pages 7, 17-18 for discussion of the art therapist's role as an "extension of the ego."

structure, Jeff was able to complete four or five valentines for children on the unit, and was quite proud of the finished products.

Throughout this session, Jeff wavered between loud, angry demonstrations and affectionate, calm gestures; such action seemed to reflect his intense ambivalence towards me. Ambivalence was also directed to the children for whom he made valentines. He expressed affection for these children but, almost immediately, denounced them because he feared they would not reciprocate with valentines.

In addition, Jeff exhibited great difficulty in separation at the close of the session. He attempted to keep me in the room by holding on to my clothes and the art materials, and refusing to surrender them. He demanded that I allow him to keep the materials in his room rather than return them to the cabinet for the other children's use. I suggested that perhaps he had difficulty in sharing the materials with the other children; Jeff readily acknowledged that he wanted them all for himself. I allowed him to keep some paper and crayons in his room and told him that they could be returned at our next meeting.

In this first session, I began to formulate many ideas concerning the dynamics of Jeff's emotional difficulties and their relation to hospitalization. It is apparent that Jeff possessed poor self-esteem, as was evidenced in the repeated rejection and destruction of his art work. His great hunger for love and attention was symbolized by his devouring attitude with materials. Yet Jeff feared rejection and desertion from others, and this fostered his great ambivalence. His difficulty in allowing me to leave at the close of the session was perhaps stimulated by a fear that I might not return. The wish to keep the art materials expressed his need for a "transitional object"

to keep in my absence.[43]

For our second session, held early the following week, I again brought a variety of materials to Jeff's bedside. He chose watercolor paints and 8" X 10" paper and, propped on one elbow, painted a red heart on the left side of the page and a snowman on the right. Expressing discontent with these forms, he carelessly covered them with daubs of red and orange paint, creating a "snowstorm." Jeff added that it was a "huge snowstorm" with many people stranded in it. When I asked what would happen to the people, he replied that they would all die, including myself, as I was also in the storm. I asked Jeff where he himself was in the picture, and he designated himself as a circle at the edge of the storm, saying that only he would survive the catastrophe. Then he began to cover the paper with black paint in pressured, smearing motions. The picture, according to Jeff, had become a "mess of mud" in which all the people would drown.

I felt it necessary to give structure to Jeff's chaotic direction and, in part, to let him know that I accepted him despite his messiness, I suddenly asked him if he had ever played in the mud. He replied that he had not, and asked if I had. I answered that my brother and I had once played in some muddy rain-filled holes in our yard and had washed ourselves afterward in a large tub in the basement. Fascinated, Jeff wanted to portray this in a series of pictures. With watercolor paints and 8" X 10" paper, he created a picture of a girl and a boy covered with mud. The girl, painted in red, and the boy, in orange, are crudely executed stick-like figures. Black paint was added to represent the mud. A small yellow figure,

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[43] D. W. Winnicott, "Transitional Objects and Transitional Phenomena," Through Pediatrics to Psychoanalysis (New York: Basic Books, 1975). The "transitional object" is usually a blanket or soft toy that the infant endows with special significance. The object is symbolic of mother and soothes the child during periods of separation from her.

designated as the mother, was painted on the male's shoulder.

In a second picture, the children are portrayed in the tub. Quickly painted, the picture is comprised of: a bathtub represented by a green circular shape with extended legs; two sexually undifferentiated figures in red at either end of the tub; a splash of blue paint that represents the bath water. The picture is an overhead view of the bath tub, but the legs of the tub are visible, extending outward.

In the last picture of the series, the children are portrayed clean. The figures are one-dimensional, sexually undifferentiated and purple in color. When he finished, Jeff expressed pride in the pictures and wanted to preserve them. They were stapled together to create a storybook.

At the close of the session Jeff again had separation difficulties and expressed the need to keep the art materials in his room. Increasingly aware of his fear of desertion, I felt that it was important to establish consistency in the therapeutic relationship. At this time we agreed to have regular art sessions, and I told him when I would return for the next session.

This series of pictures seems to poignantly portray many of Jeff's inner difficulties. In the first picture, the heart may symbolize the therapist; its form had been transmitted from the previous session in which valentines were made. The snowman may symbolize Jeff. The snowstorm that covered these symbols seems to represent Jeff's chaotic fears of desertion. In the fantasized catastrophe all would be destroyed and he would be left alone. Jeff portrayed himself as a grandiose figure outside of the storm's destruction. Underlying the grandiosity was, perhaps, his fear of desertion. Considering what is known about Jeff's family life, it is no wonder that such fears were intensified during his hospitalization. Jeff undoubtedly viewed his hospitalization as a further rejection, and as proof that those he loved had deserted

him. These feelings are portrayed in the storm's catastrophe.

The aggressive smearing of black paint that represented mud may have served to conceal or deny the earlier core conflict, the fear of desertion. Similarly, Jeff's aggressive and manipulative behavior on the unit seemed to protect underlying hurts and fears.

With the story from my childhood, I offered Jeff a theme which served to contain his affect. I provided him with the external controls he needed to turn to more creative work. Although crude in execution, the subsequent three pictures reflect more control than the first painting of the snowstorm. The portrayal of the mother on the male's shoulder in the picture of the mud-covered children is of interest. Perhaps this symbolizes Jeff's feelings about his mother, small and faint because provides little mothering and is absent much of the time.

Jeff's behavior on the unit was difficult to manage. He was often boisterous and aggressive with staff and the other children. On several occasions he intentionally hurt other children, helpless in their beds, by pulling their traction or pinching and poking them. Recalcitrant to his own treatment plan, Jeff was often found out of traction while in his bed, performing stunts deleterious to the healing of his legs. His behavior angered the medical staff, and many found Jeff "impossible" to work with. Midway through his hospitalization, a medical psychologist was called in to assess Jeff's difficulties and to advise the staff concerning an effective treatment plan. Several staff meetings were held to coordinate efforts to handle Jeff's behavior. Consistency was advocated: Jeff was assigned a primary nurse with whom he would have daily contact. Regular art therapy sessions and group activities were recommended.

Jeff attended several art and play groups during the early stages of our relationship. He had great difficulty sharing materials or toys with the other children, and often announced that a shared project or toy was to be his alone. He needed considerable structure in his use of art materials and he showed little self-direction, as was reflected in his continual need for assistance and his requests that a project be done for him. In games, he displayed a constant need to win.

Several group sessions were organized for a few of the boys of Jeff's age on the unit, and Jeff took part. During one such group, the boys requested that clay be used. Although I was uncertain about Jeff's ability to control the clay, I consented and provided each child with several pounds of clay. Jeff smeared, pounded and smashed his clay against the table. He added water to it and deviously smiled and laughed as he squeezed it through his fingers. Jeff was aggressive with the other boys, taking their clay and threatening to throw it across the room. I firmly intervened and set limits as to how he could use the clay and the amount of water that he could add. With such external control, Jeff settled down and constructively devised a plan for a clay city that he wanted to build in a future session. During clean-up, he showed genuine affection and concern for another boy, helping him wash his hands at the sink. The two left the room together, talking and laughing.

Jeff often showed an initial inability to control the use of materials, as well as aggressive behavior around others. In this incident, the clay seemed to stimulate fecal associations, evidenced by his squeezing and smearing motions and devious laughter. With the aid of an external ego--my limit setting and structure--Jeff gained a sense of behavioral control and assumed appropriate relations with others. Moreover, he became constructive and

creative. Group activities were therefore important in building trust and a sense of esteem in Jeff.

Jeff gradually began to internalize the controls I offered him. In one individual session held near the end of his hospitalization, Jeff displayed this increasing ability to control himself as well as others. Crayon drawings and scribbles were made during this session. In his first drawing, Jeff used purple crayon and 12" X 18" white paper and quickly drew a full figure. The figure has a circular head with a smiling face, an oval torso with three buttons, one-dimensional legs, feet and arms, and circular shapes for hands. The figure is surrounded by a series of broken lines forming a square. The second picture, in purple crayon on 12" X 18" white paper, portrays a smiling face enclosed in a square frame. Orange and brown color was added to the four corners of the frame and enclosed in black.

While initiating a third picture, Jeff hid his paper from view and asked me not to watch. He asked me to draw a picture too; I agreed and worked on a drawing at his bedside table. He worked slowly and when he finished he wrote my name at the top of the paper and presented the picture to me. In multi-colored crayons on 12" X 18" white paper, Jeff had drawn a large fish bowl containing three fish and a George Washington cherry tree. A human figure with squared head, fish in hand and no legs was located to the left of the large fish bowl. When asked who the figure was, Jeff initially identified the figure as myself, but a few moments later described it as "crippled, dumb, and bald." He did not want to talk about the picture.

Jeff then initiated several scribble drawings. He created a spontaneous scribble and began to fill the areas with different colors. I suggested

that he make a scribble, find an image within, and outline it with a dark crayon. To demonstrate, I made a scribble and outlined a rabbit within it. Hesitantly, Jeff tried my method by taking a scribble that I had begun and, also drawing a rabbit. Pushing the drawing away, he insisted that we return to his method of scribbling, and he continued to fill the areas in with color.

In this session, all Jeff's pictures represent attempts to control, contain or isolate affect. The broken-lined enclosure, the frame, the fish bowl, and the scribbles are all symbolic of this attempt to control by establishing boundaries. The bits of color enclosed in the frame and the color added within the boundaries of the scribbles may be symbolic of the affects and impulses that Jeff attempts to control. During this session, Jeff clearly displayed more control in his drawing and his behavior.

The drawing of the fish bowl is Jeff's most detailed and organized work. Because he refused to discuss the picture, its meaning is vague. Perhaps the fish bowl represents the hospital environment, enlarged because of its importance to Jeff. Jeff may view the hospital as a place of protection where he is observed, nurtured and accepted. The cherry tree, drawn within the fish bowl, may further symbolize the hospital; trees similar to this one had been drawn by the children in honor of Washington's birthday in an evening playroom activity. The figure may represent myself; I, in a sense, protected and watched over Jeff. The description of the figure as "crippled, dumb and bald," however, seems to reflect Jeff's feelings about himself. The fish, held in the figure's hand, is perhaps symbolic of Jeff.

Jeff attempted to distance and control me by hiding his pictures from view, by insisting that I draw and follow his scribbling method, and by refusing to

discuss his pictures upon completion. The need to control his environment seems to relate to Jeff's intense ambivalence: he craved attention desperately, but when he succeeded in securing it, he was unsure of its permanency and of what to do with it. By distancing and controlling those around him, Jeff may have defended against his uncertainty and possible disappointment.

During a play session later in the week, Jeff suggested that we fill the unit's bathtub and, kneeling at its edge, play with a variety of plastic toys. Although his play centered around acts of destruction, for example, sinking boats and killing a whale, Jeff continued to display control over his behavior. Little splashing or impulsivity occurred. A car was sunk but its passengers survived, according to Jeff, because no water could get in. When the tub was drained, Jeff announced that the turtles that we had played with would die without water. I responded that perhaps they were also land turtles and could live outside the water. Jeff decided that his turtle would live and, hesitantly, that mine would too.

The nature of Jeff's destruction fantasies in his water play are distinct from those expressed in the earlier snowstorm catastrophe. Destruction was not total in the latter case; for example, the passengers in the sunken car survived, although their environment was potentially dangerous, because the water could not get in. As he demonstrated in the encapsulated pictures, Jeff seemed to express a need for protection or defense against a potentially disappointing environment. By allowing my turtle to live, Jeff may have been expressing an increasing trust that I would not desert him as all had done in the previously depicted snowstorm.

Jeff began to show some improvements in his behavior on the unit. He was less aggressive with the other children and pursued friendships more

readily. Medical staff noted greater compliance in treatment and less ambivalence in relationships.

In the last few days of hospitalization, Jeff again became aggressive and disruptive. When he discussed his feelings about leaving the hospital and returning home, Jeff said that he could not wait to leave, that he hated the hospital and would miss no one. This behavior undoubtedly defended against an underlying uncertainty and anxiety about returning home, and his sadness in leaving the hospital.

Concluding remarks

Jeff's emotional difficulties seem to originate in the uncertainty of the relationships in his home environment. Clearly hospitalization intensified Jeff's fears and chaotic feelings. Apparently, his parents have openly expressed a lack of love to Jeff; it is no doubt that he lives with the fear that they will desert him. Many children from stable, loving homes view hospitalization as desertion by parents; one can imagine that Jeff, amidst such instability, would fear that his parents would not return to take him home. His parents never visited or called during his hospitalization, further intensifying his fear of desertion.

In our earlier sessions, Jeff's aggressiveness, lack of controls, poor self esteem and intense ambivalence were pronounced. All seemed to be related to the underlying fear of rejection that, further stimulated during hospitalization, caused Jeff to lose control over his behavior. Through the creative experience, Jeff poignantly communicated many of his concerns and conflicts. By actively externalizing his ideas and feelings in his art work, Jeff slowly began to build a sense of mastery over his impulses and fears.

During these earlier contacts, Jeff required a strong external ego to help him achieve control over his behavior and the use of art materials. With my limit setting and structure, Jeff could channel his energies into more creative work. The art process provided a model through which Jeff could gradually internalize such controls. Near the end of his hospital stay, he clearly displayed a greater sense of internal control and was, thus, free to achieve further mastery on his own. Such control was exemplified in Jeff's encapsulated drawings and scribbles, as well as his need to exert control within our relationship.

Much of Jeff's progress may be attributed to the support, acceptance and consistency he experienced in the therapeutic relationship and in relationships with other staff on the unit. Of great importance in my work with Jeff was the establishment of consistent, defined contacts. Because Jeff's life at home is filled with uncertainty, he lacks a sense of consistency in his view of those in his world. With consistency in the therapeutic relationship, Jeff began to build a sense of trust; ambivalence became less pronounced. Although initially sadistic and aggressive with staff and other children, Jeff showed more appropriate interactions later in his hospitalization. Self esteem was bolstered by such positive interactions.

Jeff's case beautifully exemplifies the importance of the team approach in dealing with the emotional aspects of hospitalization. It was necessary for all staff--medical and psychological--to work together to help Jeff build a sense of trust, feelings of esteem, and greater control over his behavior and, in doing so, to further his medical treatment.

The progress Jeff attained through art therapy during his hospitalization was a beginning. It was hoped that he would receive further psychological

help upon his return home, but it was doubtful that the parents would agree to or carry out such a suggestion. Amidst the uncertainty of his home environment, Jeff needs continued support to further conquer his many difficulties.

CHAPTER IV: CONCLUDING REMARKS

This work demonstrates the usefullness of art therapy with the orthopedically hospitalized child. It shows conclusively that, through the art process and the therapeutic experience, the child can be helped to master the stress and trauma evoked by separation from home and family, pain, real or imagined body injury and immobilization. The case studies exemplify a few of the fears and fantasies and the feelings of impotence that arise in the hospitalized child. They demonstrate the benefits of the use of art to facilitate the child's move from helpless passivity to a state of activity in an effort to gain control over feelings and impulses that are stimulated by the hospital situation. Further, the case studies exemplify the importance of the patient/therapist relationship to provide a non-threatening atmosphere in which the child may explore his fears and fantasies and clarify misconceptions.

The successful use of art to facilitate mastery in the hospital setting has affirmed the assumption that healing qualities are inherent in the art process. It has also confirmed trust in the child's natural ability to make choices and decisions that are best for him, without underestimating the importance of the adult's role in nurturing and supporting the child's creative urges.

This work touches on only a few of the many aspects of work with the orthopedically hospitalized child. Areas of further investigation within the presented topic might include more specific aspects of the therapist/patient relationship (e.g., issues of dependence/independence, or dealing with the irrational feelings that arise in the therapist working with the

immobilized child), and the difficulties of short term intervention in the medical setting.

The possibilities and potential for the use of art in the orthopedic hospital setting are vast. Further investigations into the many uses of art in this setting are warranted. For example, an area of further research might be in the potential use of art to promote acceptance of a handicap or improve body image in the orthopedically hospitalized child. Art's use in such a capacity would be highly beneficial for the handicapped child.

There is a great need for the art therapist's unique skills and offerings in this setting. Much enthusiasm is being generated as the benefits of art therapy with the hospitalized child are recognized. Its use will, hopefully, continue to grow as more and more hospitals open their doors to the art therapist.

REFERENCE LIST

Aegerter, Ernest, and Kirkpatrick, John A. Orthopedic Diseases. Philadelphia: W. B. Saunders Co., 1968.

Becker, R. D. "Therapeutic Approaches to Psychopathological Reactions to Hospitalization," International Journal of Child Psychotherapy 1 (1972): 65-97.

Bergmann, Thesi, and Freud, Anna. Children in the Hospital. New York: International Universities Press, 1965.

Betensky, Mala. Self-Discovery through Self-Expression. Springfield, Illinois: C. C. Thomas, 1973.

Centers, L., and Centers. R. "A Comparison of the Body Images of Amputee and Non Amputee Children as Revealed in Figure Drawings." Journal of Projective Techniques 27 (1963): 158-165.

Edelston, A. "Separation Anxiety in Young Children," Genetic Psychology Monographs 28 (1943): 3-95.

Freud, Anna. The Ego and the Mechanisms of Defense. New York: International Universities Press, 1966.

Freud, Anna. "The Role of Bodily Illness in the Mental Life of Children." Psychoanalytic Study of the Child 7 (1952): 69-82.

Freud, Sigmund. "Beyond the Pleasure Principle." Standard Edition 18 (1920).

Freud, Sigmund. New Introductory Lectures on Psychoanalysis. Translated by J. H. Sprott. New York: W. W. Norton and Co., 1933.

Garai, Joseph. "The Humanistic Approach to Art Therapy and Creativity Development." (Mimeographed.)

Kramer, Edith. Art as Therapy with Children. New York: Schocken Books, 1971.

Kramer, Edith. "Art Therapy and Play." American Journal of Art Therapy 17 (October 1977): 3-11.

Kramer, Edith. Art Therapy in a Children's Community. New York: Schocken Books, 1977.

Langer, Suzanne. "The Cultural Importance of the Arts." Aesthetic Form and Education. Edited by M. E. Andrews. Syracuse: Syracuse University Press, 1958.

Langford, William S. "The Child in the Pediatric Hospital: Adaptation to Illness and Hospitalization." American Journal of Orthopsychiatry 31 (1961): 667-684.

Lowenfeld, Victor, and Brittain, W. Lambert. Creative and Mental Growth. New York: Macmillan Publishing Co., 1975.

Lydiatt, E. M. Spontaneous Painting and Modelling. London: Constable and Co., 1971.

Machover, Karen. Personality Projection in the Drawing of the Human Figure. Springfield, Illinois: C. C. Thomas, 1949.

Naumburg, Margaret. Dynamically Oriented Art Therapy: Its Principles and Practices. New York: Grune and Stratton, 1966.

Petrillo, Madeline, and Sanger, Sirgay. Emotional Care of Hospitalized Children: An Environmental Approach. Philadelphia: J. B. Lippincott Co., 1972.

Plank, Emma. Working with Children in Hospitals: A Guide for the Professional Team. Cleveland: The Press of Case Western Reserve University, 1971.

Rhyne, Janie. The Gestalt Art Experience. Monterey, California: Brooks/ Cole Publishing Co., 1973.

Rubin, Judith. Child Art Therapy: Understanding and Helping Children Grow through Art. New York: Van Nostrand Reinhold Co., 1978.

Schecter, M. D. "The Orthopedically Handicapped Child: Emotional Reaction." Archives of General Psychiatry 4 (1961): 247-253.

Uhlin, Donald. Art for Exceptional Children. Dubuque, Iowa: William C. Brown Co., 1972.

Ulman, Elinor. "Art Therapy: Problems of Definition." Bulletin of Art Therapy 1 (Winter 1961): 10-20.

Ulman, Elinor. "Art Eduction for the Emotionally Disturbed." American Journal of Art Therapy 17 (October 1977): 13-16.

Weininger, O., Rotenberg, G., and Henry, A. "Body Image of Handicapped Children." Journal of Personality Assessment 36 (1972): 248-253.

Winnicott, D. W. "Transitional Objects and Transitional Phenomena." Through Pediatrics to Psychoanalysis. New York: Basic Books, 1975.

Additional Resources

Axline, Virginia M. Play Therapy. New York: Ballantine Books, 1947.

Azarnoff, Pat, and Flegal, Sharon. A Pediatric Play Program: Developing a Therapeutic Play Program for Children in Medical Settings. Springfield, Illinois: C. C. Thomas, 1975.

Benjamin, Alfred. The Helping Interview. Boston: Houghton Mifflin Co., 1969.

Erikson, Erik H. Childhood and Society. New York: W. W. Norton and Company, Inc., 1963.

Freud, Anna. Normality and Pathology in Childhood: Assessments of Development. New York: International Universities Press, 1965.

Hammer, Emanuel F. The Clinical Application of Projective Drawings. Springfield, Illinois: C. C. Thomas, 1978.

Kernberg, Otto. Object Relations Theory and Clinical Psychoanalysis. New York: Jason Aronson, Inc., 1976.

Lidz, Theodore. The Person: His and Her Development Throughout the Life Cycle. New York: Basic Books, Inc., 1968.

Lindsay, Zaidee. Art and the Handicapped Child. New York: Van Nostrand Reinhold, Co., 1972.

Moustakas, Clark E. Children in Play Therapy. New York: Ballantine Books, 1973.

Peller, L. E. "Libidinal Phases, Ego Development, and Play." Psychoanalytic Study of the Child 9 (1954): 178-198.

Schaefer, Charles E., ed. Therapeutic Use of Child's Play. New York: Jason Aronson, Inc., 1979.

Walder, Robert. "The Psychoanalytic Theory of Play." Psychoanalytic Quarterly 2 (1933): 208-224.