DOCUMENT RESUME

ED 203 615 EC 132 900

AUTHOR Roth, Ellen A.
TITLE Art Therapy to Promote Ego Development in Disturbed Retarded Children..
PUB DATE 80
NOTE 30p.: Paper presented at the Annual Conference of the American Art Therapy Association (11th, 1980).

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Art Therapy; Case Studies; *Emotional Development; *Mental Retardation; Psychotherapy; *Self Concept

ABSTRACT

The paper discusses the six major ego functions, ego disturbances in mentally retarded children, and case examples of the use of art therapy to promote ego development. Identified are the following ego functions: control and regulation of instinctual drives, autonomous functions, reality testing, object relationships, defense, and synthesis. The mentally retarded child is seen to develop maladaptive ego functions including an inability to control drives, delayed or deficient autonomous functioning, poor reality testing, impaired development of object relationships, primitive defense mechanisms, and inability to synthesize major ego functions. Six case studies are discussed to show the way that art therapy can help the retarded child develop appropriate ego functions. (DB)

Art Therapy to Promote Ego Development in Disturbed Retarded Children

Ellen A. Roth, M.F.A., ATR
Art Therapist
Western Psychiatric Institute and Clinic
University of Pittsburgh, School of Medicine
Pittsburgh, Pennsylvania

Introduction

This paper will discuss the use of art therapy to promote ego development in disturbed retarded children. The retarded child exhibits developmental arrests and regressions. He may have maladaptive ego functions resulting in emotionally disturbed behavior. Art activities promote ego development, and thereby aid in decreasing disturbed behavior. With a decrease in disturbed behavior, the child has a better opportunity to increase his intellectual functioning and adaptive behavior within the limitations of his retardation (Roth, 1979, 1980). For example, an eight-year-old may function as a three year-old in part because of emotional disturbance. Art therapy offers an opportunity to deal with emotionally disturbed behavior. As emotional disturbances decrease, the retarded eight-year-old may make intellectual gains, raising his mental age to four years.

The following sections of this paper are divided into three parts. Part I will briefly discuss six major ego functions. Part II deals with ego disturbances in mentally retarded children. Part III synthesizes the previous sections and illustrates through case examples the use of art therapy to promote ego development.

The child at birth cannot differentiate his body from the rest of the world. As the child grows and matures, he begins to perceive his body as distinct from the external world. During this separation-individuation process, beginning at age four to five months, the child gains a sense of himself as a separate entity (Mahler, Pine, & Bergman, 1975). Gaining this sense of self is the beginning of ego formation.

Ego, along with id and superego, are three psychological constructs postulated by Freud, designated as the three provinces of the human psychic apparatus. The id, which is unconscious, is the source of basic drives which are striving for discharge and gratification. The ego, which operates on a conscious and an unconscious level, maintains and regulates the individual. The ego mediates between the id and the superego. The superego, an unconscious mechanism, commonly referred to as one's conscience, develops as an outgrowth of an individual's having internalized parental prohibitions and moral values. Id, ego, and superego emerge in various stages of a child's psychosexual development (Freud, 1923/1949).

Erikson (1963) postulated a parallel relationship between Freud's stages of psychosexual development (oral, anal, phallic, etc.) and psychosocial or ego development. He referred to the stages of ego development as the "Eight Stages of Man," ranging from basic trust to integrity.

According to Erikson, at each stage of psychosexual or psychosocial development (i.e., ego development) the infant, child, adolescent, or adult must master the life tasks appropriate for that phase. The successful or unsuccessful performance of these tasks has implication

for future development. The successful resolution of each stage of tasks results in adaptive ego functioning. The unsuccessful resolution of tasks results in maladaptive ego functioning. For example, if the task solution is successful in the oral stage, basic trust is established. If it is unsuccessful, basic mistrust is the result, with a correlative impairment in ego functioning in the later stages of development. Similarly, if the task crisis at the anal phase is resolved, then autonomy is established. If the crisis is not successfuly resolved, then shame or doubt are the result, and so forth through the additional six stages of development.

Part I: Major Ego Functions

The ego has many functions, six of which will be briefly highlighted (Meissner, Mack, & Semrad, 1975). Included among them are: 1) control and regulation of instinctual drives. In this capacity, the ego mediates between id impulses and the outside world. The development of the ego allows the individual to delay the gratification of immediate wishes and urges, i.e., to postpone the discharge of instinctual drives. The ego is aided in this role by the evolution of 2) autonomous functions such as thought processes, language, and perceptual-motor organization. For example, if an individual can fulfill an instinctual wish by fantasizing, then urgent action may not have to be taken. Similarly, other intellectual processes, such as the ability to acquire knowledge, to figure things out, to memorize, to sequence, to imitate, and to anticipate consequences help the ego to regulate an individual's behavior.

3) Reality testing. This function of the ego is to objectively

evaluate the external world, to allow the individual to distinguish reality from fantasy. The ego also has the capacity to foster the individual's adapting to reality and "to form adequate solutions [to problems] based on previously tested justments of reality" (Meissner et al., 1975, p. 533).

4) Object relationships. This ego function is the capacity for mutually satisfying relationships with both objects and people.

5) Defense. This ego function is to employ defense mechanisms to combat anxiety.

6) Synthesis. Another major function of the ego is the capacity to unite the "various drives, tendencies, and functions within the personality," so that the individual can "think, feel and act in an organized and directed manner" (Meissner et al., 1975, p. 534).

This section highlighted major ego functions. A healthy child has adaptive ego functions and can cope appropriately with his environment. A retarded child may have maladaptive ego functions, and have difficulty coping appropriately with his environment.

The mentally retarded child suffers from intellectual impairment, and emotional and physical developmental delays. Not all retarded children, however, are emotionally disturbed. A retarded child who does not have the support systems to cope with his handicaps may develop maladaptive ego functions and exhibit emotionally disturbed behavior in different areas of ego functioning.

Part II: Ego Disturbances in Mentally Retarded Children

The American Association on Mental Deficiency (1961) defines mental retardation as "sub-average intellectual functioning which

originates in the developmental period, and is associated with impairment in adaptive behavior."

Mental retardation is a complex problem. There are two approaches to the conceptual definition of mental retardation. One is a biomedical model and the other a socio-cultural model. According to the biomedical model, mental retardation is caused by structural impairment to the brain. According to the socio-cultural model, mental retardation is related to the individual's inability to adapt to cultural norms of behavior. He/she is labeled retarded on the basis of an inability to learn and to adapt to the demands of society and to be self-sufficient. Causes for this inability may stem from developmental impairments, learning difficulties, or for other reasons.

Three percent of the population in the United States is mentally retarded. The "majority of the mentally retarded in the United States come from the lowest socio-economic group." They are the inhabitants of urban slums, and backwards rural communities. They are the poor (Cytryn & Lourie, 1975).

The mentally retarded child may not form early mother child bonds which are crucial for normal human attachments. The child may be slow in differentiating himself from his mother, a process that requires intact sensory, perceptual and intellectual mechanisms. Thus the child's entire emotional development is delayed. The child is dependent for a longer period of time; thus independence and autonomy are delayed. In disadvantaged homes, family cohesiveness is often absent. There may be no father. Mothers, grandmothers, and siblings raise the children in an unstable

environment. Parental roles are unclearly defined. Many care-takers may distort the infant's process of human attachment and object relations, retarding future personality development. A stable care-taking person is essential for healthy intellectual and emotional development.

Children suffering from socio-cultural mental retardation may not receive appropriate stimulation as infants, which impairs their intellectual development, or they may receive too much or inconsistent stimulation from a chaotic environment. There may be a lack of verbal stimulation resulting in poor language development, the basis of abstract thinking. Mentally retarded children may also be hypersensitive to sensory stimulation. For example, loud noises or bright lights may be very painful to them. Exposure to these things may stimulate hyperactivity, irritability or avoidance. A mentally retarded child who finds learning a slow and difficult process to begin with is further handicapped if he is hyperactive, resulting in restlessness and a short attention span. Irritability is reflected in a low frustration tolerance. Delaying gratification may increase the retarded child's anxiety which leads to disorganization and undesirable behavior.

On the other hand, some children screen out environmental stimulation to the point of creating a barrier between themselves and the outside world. They exhibit autistic-like behavior.

Mentally retarded children may also be aggressive and exhibit poor impulse control and destructive behavior, the result of brain damage or negative environmental influences.

Some mentally retarded children have difficulty tolerating

change. Any change in people or routine may be very disruptive to them, causing disorganization. These children need routines and predictability in their environment.. In environments where there is a lack of limit setting and poor role models, the retarded child may exhibit poor impulse control. He does not learn to sublimate aggressive drives.

The retarded child may also be emotionally neglected, receiving little encouragement or praise, resulting in a poor self-concept and poor body image.

Mentally retarded children may realize that they are different from other children and their siblings. This gives them a feeling of inadequacy and low self-esteem sometimes leading to depression or manifested in anti-social behavior. The mentally retarded child may lack originality in his play if he can play at all. His interactions with toys may be limited, repetitious, or stereotyped (Cytryn & Lourie, 1975).

To summarize Parts I and II of this paper:. The mentally retarded child may develop maladaptive ego functions.*

1. The child may not be able to control his drives and postpone gratification. He, therefore, acts impulsively and exhibits a low frustration toleration.

2. Autonomous functioning (e.g., thought processes, language, perceptual-motor orgnization) is delayed and deficient. The child has difficulty in the areas of acquiring knowledge, memory, speaking, and coordinating visual, motor and mental activities.

---

*The discussion of maladaptive ego functions (2-6) relies heavily on Henderson's paper.

The child may also have difficulty focusing on an activity and picking out what is relevant. Difficulty in focusing may result in distractibility and hyperactivity.

3. Reality testing may be poor. The child may not have an accurate perception of his environment or himself. He may not recognize or understand conventional social behavior. He may not be able to distinguish reality from fantasy. He may not recognize himself as a separate person with physical boundaries that differentiate himself from others. He may have a distorted body image.

4. Impaired development of object relationships may lead to unsatisfactory relationships with people. The child may be excessively dependent, lack flexibility, lack reflectivity, and lack the capacity to inhibit impulsive behavior. He may, on the other hand, exhibit avoidance behavior or be pathologically manipulative.

5. The retarded child, because of his inability to reflect, may employ primitive defense mechanisms such as avoidance "either into fantasy or into activity" (Henderson, 1975). The retarded child might also exhibit defenses in the form of impulsive behavior, obsessive stereotyped behavior, aggressive behavior or regressive behavior.

6. The retarded child may be less able to synthesize the other major ego functions "in the service of a stable and rewarding life pattern" (Henderson, 1975). Thus drives, thought processes, relation to reality, object relations and defense mechanisms are not fully integrated into an adaptive whole.

Part III: The Use of Art Therapy to Promote Ego Development

This section will discuss in general and illustrate through

case examples the use of art therapy to promote each of the six ego functions previously addressed. The case exmples are drawn from the John Merck Program for Disturbed Retarded Children, Western Psychiatric Institute and Clinic, University of Pittsburgh, School of Medicine.*

Art therapy provides an opportunity for creative self-expression which can be a very satisfying experience. An art product is a testimony to existence. I make a mark, therefore I am. Art therapy enables the non-verbal child to express himself in concrete form. It facilitates the verbal child's ability to talk about his feelings by either being able to refer to a finished product, or by providing a process which permits the child to visually focus on an activity while sharing his feelings.

In addition to the above, there are specific ways in which art therapy promotes ego development.

In terms of drives, art therapy offers an appropriate outlet for the expression of unacceptable impulses. It provides an opportunity for emotional release. For example, inappropriate sexual impulses as well as frustration and aggression can be sublimated through the use of art materials. Negative impulses such as punching and hitting can be channelled into positive experiences such as pounding and molding. The child learns that it is all right

*The John Merck Program provides a multidisciplinary approach to the treatment of disturbed, retarded children within a therapeutic milieu. Art therapy is one of several therapies that are offered in this program.

to pound clay, and he receives praise for this behavior whereas he may be punished for "pounding" another child. Thus the child learns that he can discharge his impulses in an acceptable manner and his physical activity becomes productive and rewarding.

Case #1: This case concerns a nine-year-old moderately retarded b who was incapable of controlling and regulating his basic drives. His behavior problems included greediness, inappropriate sexual behaviors, unpredictable aggressive outbursts, difficulty responding to limits, a low frustration tolerance, a short attention span and a tendency to tantrum. He rarely interacted with other children. When he did, it was in an intrusive, aggressive way (e.g., hitting, kicking, biting, scratching). He was an impulsive child who demanded instant gratification. He constantly sought approval or disapproval and frequently asked, "Do you like me?" He ate rapidly, often grabbing food from others. He exhibited much sexual curiosity and was known to grab at female staff members in their genital areas. He frequently asked of female staff members, "Will you marry me?", "Are you married?", or "Will you make marry on my lips?"

This child not only had tremendous oral needs but he was very confused about the relationship of sexuality and aggression. At the time of his art therapy diagnostic evaluation, he made five non-figurative drawings. All the ideas that he associated with these art products related to fish that were kissing, eating and/or killing one another.

As art therapy progressed, oedipal themes with violent overtones became prominent. Many of his oedipal fantasies remained

disguised in the form of animal stories. For example, in one drawing "two giraffes" were in bed sleeping. A "snake" awakened them and they killed the snake.

The opportunity to use art materials and to express disturbing thoughts in a supportive environment allowed this child to channel the inappropriate aggressive and sexual impulses that he exhibited toward staff and peers into a constructive experience. Art therapy helped him to recognize and deal with his intense emotional conflicts which he seemed neither able to fully understand nor control. He began to learn that his sexual and aggressive impulsiveness and his intrusive behavior were not acceptable to the staff, but that his uncontrollable feelings were acceptable in therapy when sublimated through art activities. Thus, at least in art therapy, he was able to control his drives. It would take, however, a longer period of time than that for which this boy was hospitalized (eight months) for this type of control to generalize and be maintained in all situations.

Because the retarded child experiences a prolonged infancy, he experiences deficits in sensory, perceptual-motor and intellectual areas (Wilson, 1977). Art therapy promotes these areas of autonomous ego functioning by expanding the child's sensory, perceptual-motor and intellectual horizons. Art materials with their range of textures and smells stimulate the senses. Art therapy requires that the child manipulate media and focus on whatever he is doing; thus perceptual-motor activities are coordinated. Talking about an art product stimulates the child's intellectual ability, memory, and imagination. Mastering the use

of art materials is a positive experience. As the child becomes increasingly confident with media, he may obtain a greater degree of mastery over his environment, without fear of failure. Successful resolution of an "art problem" (e.g., getting a clay figure to stand up straight) may lead the child to a greater realization of his ability and potential in coping with everyday experiences.

Case #2: This case concerns a seven-year-old non-verbal, moderate retarded boy who was delayed and deficient in all areas of autonomous functioning. His diagnosis was childhood schizophrenia with autistic features. This boy exhibited self-abuse, self-stimulation, tantruming behavior, episodes of staring into space and laughing or crying, a lack of peer interaction, a short attention span and a low frustration tolerance.

This boy initially responded to art materials in primitive ways. In most cases, his interactions with media were limited to touching, smelling, throwing, or submerging them in water. Frequently he did not interact with the art materials at all but instead walked around the room, touching and poking shiny objects, or he involved himself in non-art activities such as opening and closing a pencil box, or kicking a crayon around the room. His few attempts at drawing were limited to linear and curvilinear lines and dots situated at the bottom of sheets of paper (see Figure 1).

The approach used to get this child to interact appropriately with the art materials included: consistent exposure to the art materials on a weekly basis, insisting that he spend a portion of each session sitting in a chair with media in front of him, giving

him a great deal of support, and selectively reinforcing him with praise when he manipulated any medium appropriately. Initially the therapist also tried to ignore his self-stimulating in the form of touching shiny objects, but if no one interfered with this activity, he would do it for hours.

The therapist then decided to use his "pathology" to decrease his "pathology". He was told that he had to use an art material (e.g., make a drawing) and then he could spend a few minutes walking around the room, poking shiny objects. Then he had to sit down again. As his art work became more meaningful to him, there was an increase in the amount of time that he spent "on task", and a decrease in the amount of time he spent inappropriately. In other words, the art work was self-reinforcing. Also, he learned to use a variety of media appropriately (e.g., markers, clay, etc.). His scribblings evolved from a limited number of marks confined to a small area of a sheet of paper to full scale marks that filled a sheet of paper.

When this boy demonstrated the ability to make controlled marks, the therapist helped him to sustain this accomplishment and to prolong his attention span to a drawing task by linking it with the progress that he was making in speech therapy. By this time, after nine months of hospitalization, this boy had learned to verbalize 34 words.

Among these words were several nouns including "boy, duck, tree, key, and cup". The therapist assembled pictures of these various objects, glued them to paper, and printed the word below them. With verbal and physical guidance, the therapist showed him

how to draw the images that he had learned to say while using the pictures as references. Eventually he was able to draw some of the pictures spontaneously (see Figure 2). The boy was delighted with this activity. Perhaps because the drawing was now relevant to other aspects of his education in which he was making gains, he was motivated to concentrate. Hence, art therapy was effective in promoting his autonomous ego functions. It helped him to focus, to coordinate visual-motor and mental activities in the process of mastering new skills, and to reinforce his verbalizing.

In terms of reality testing, many disturbed retarded children have either poor body images or no concept of their body image. Art experiences can be used to reality orient a child in terms of his body image and spacial relationships. By talking about body parts and drawing pictures of people, or making models of figures or even "Humpty Dumpties," children learn about the interrelatedness of body parts. Tracing the child's body on a large sheet of paper is another way of orienting the child to his body image (Gitter, 1964). Thus the child learns that he has distinct physical boundaries.

"Reality shaping" is a technique that this therapist uses to help children develop concepts of both people and objects which they do not fully understand (Roth, 1978). This is a technique of using 2-D and 3-D models to develop a concept which a child initiates but inaccurately depicts on paper. For example, smeared lines identified as a tree do not represent a tree. Through a process of adhering a live branch to a sheet of paper and then painting a trunk, the child begins to grasp the concept of a tree. The live branch is then phased out as the child begins to reproduce the image from memory, showing that he has internalized the concept of a tree.

Case #3: This case concerns a five-year-old moderately retarded, non-verbal little girl whose reality testing was very poor. She had very little self-awareness. This child was isolated not only by her lack of ability to speak and to communicate, but also due to poor receptive language and a poor attention span. She was very withdrawn, exhibited no eye contact, and limited interaction with peers and adults. She manifested negativism in passive ways. For example, in her first art therapy session, she painted a lavish border of smeared colors around the paper attached to the easel instead of painting on the paper. Her approach was a deliberate attempt to avoid painting on the appropriate surface.

Art therapy focused, in part, on helping this child to develop a sense of herself as a person with a distinct body image. Techniques included learning to draw a human figure, looking at herself in the mirror, examining the bodies of dolls, tracing miniature dolls on paper, and making figures out of clay. Her human figure art work over a period of 13 months evolved from random scribbes (see Figure 3) to elaborate cephalopods which even included eyelashes and eyebrows. When therapy terminated, she was beginning to make more developed human figures by including a separate torso section (see Figure 4).

Paralleling her ability to draw a human figure was considerable interest in the form and function of both internal and external body parts and body elimination processes. She also used human figure drawings to deal with events that were emotionally significant to her. For example, after having two teeth pulled, teeth were emphasized in her drawings for the first time. Finally, as

she began to recognize herself as a separate person, she displayed a range of affect, showing both anger when she was frustrated, and pleasure when she was pleased with herself. (It should also be noted that concurrently she had learned sign language to communicate her basic needs.)

Thus, art therapy was successful in promoting this child's reality testing mechanisms. She developed an accurate perception of herself through greater awareness of her body parts and their inter-relatedness, and at the same time she exhibited an increase in self-confidence and self-esteem.

In terms of object relationships, "the psychologically healthy individual is able to establish and maintain satisfactory relationships with people, which in terms of ego functioning indicates generally satisfactory development of object relationships" (Henderson, 1975). Art therapy provides a means of communication and interaction with objects in the environment and with a supportive adult. If a child can become confident in the use of art materials, it may lead to freer interactions with other objects and people (Van Osdol, 19

A supportive therapist who shows a genuine interest in the child's art work and respects his comments will endear herself/himself to the child. The therapist sensitive to the child's art work and their associations "may gain insight into what the child does not understand about himself or his environment" (Van Osdol, 1972). The therapist may then help the child clarify a misunderstanding with a simple explanation. This positive relationship will help the child to trust in other adults.

Case #4: This case concerns a seven-year-old moderately retarded girl whose relationships with both objects and people were greatly

impaired. She did not interact appropriately with objects and her interactions with staff and peers were minimal. She exhibited tantruming, self-abuse, self-stimulation, bizarre posturing, and severe speech problems.

Over a period of two years and nine months, this child made gains both in terms of learning how to use art materials appropriately and in terms of relating appropriately to adults and peers. In art therapy, this was done primarily by having a range of materials available for her to use, allowing her to choose materials with which she wanted to interact, repeatedly showing her how to use media appropriately, teaching her how to draw and setting firm limits.

Her interactions with the art materials during the first year of treatment were characterized by a need to mess and to smear. She frequently finger-painted or engaged in water play. She often used the art materials inappropriately; for example, by distributing paint around the room or by throwing materials. Her behavior during the first year was frequently uncooperative, silly, self-abusive and generally difficult to manage.

During the second year of treatment, her interactions with the art materials were more appropriate. Her self-stimulation which consisted of waving her hand in front of her face as if she were striking the air, was easily re-directed into manipulating an art material. She made many, many drawings and paintings using this striking gesture, so that the art products were composed of dozens of dots. Although these art works were the product of a stereotyped gesture, the dots were not placed randomly nor was her selection of colors random. She mastered the use of many new two

and three-dimentional art materials and refined her control of familiar materials. For example, she learned to wipe a paint brush along the edge of the paint cup before painting so that excess paint would not drip onto the floor. Although her spontaneous mark making consisted of dots, she learned how to make controlled marks including horizontal and vertical lines and circles. These she would draw, however, only upon request. Thus, every week a portion of each session was set aside for structured drawing tasks. At these times, she was encouraged, for example, to make a page of just horizontal lines and she was not permitted to make dots. Her controlled mark-making was gradually channeled into the representation of faces. She practiced making the schema of a face with verbal support and physical guidance. This was expanded into a cephalopod. Other representational images from her environment followed. She also showed an interest in molding forms out of clay (e.g., snowmen, houses, animals) and in gluing wooden pieces to form structures.

During the last nine months of art therapy, this child continued to display significant gains. Her behavior became increasingly organized and self-directed. She exhibited independence in choosing art materials which she interacted with appropriately. Both her ability to conceptualize a variety of familiar images in her environment and her technical ability to represent them on paper expanded. She could draw several pictures upon request. These included a cephalopod, a house, trees, flowers and animals. Her spontaneous interactions with drawing and painting materials, however, continued to consist of making dots.

As this child's human figure drawing developed, she began to recognize a range of affective expressions and feelings. She differentiated between happy and sad feelings which she projected into her art products. Thus, she demonstrated an increased level of abstraction. She also learned to verbalize her own angry feelings and to say, "I'm mad." Hence art therapy helped this girl, who was initially reluctant to become involved with the world, relate appropriately to a range of objects. In structured situations, she showed the ability to inhibit her stereotyped behavior and to exhibit adaptive behavior. As her skills improved and she mastered the art therapy environment, she no longer exhibited outbursts and was able to relate to the therapist appropriately.

In terms of defense mechanisms, art therapy offers the aggressive child an opportunity to sublimate his impulses. As stated previously, asocial impulses can be appropriately channelled into a socially productive act. Art therapy could help to free the inhibited child from being so restricted. Allowing the inhibited child to have a series of successful experiences with crayons and markers may encourage the child to try materials that are more difficult to control, such as paints. As an over-anxious or inhibited child begins to loosen up and relax, he often becomes increasingly verbal. Art materials can also be used to help children who are afraid to reach out and touch things to be less tactile defensive. By having a range of materials to touch ane explore, the child will learn that there are pleasant things to feel, to combine, and to take apart. As a child works with shapes, textures, and densities, he gains a sense of form himself (Fitzgibbon, 1965).

Case #5: This case concerns an eight-year-old mildly retarded girl who was both inhibited and over-anxious. She manifested a speech delay and a nervous laugh. She exhibited poor peer interactions and over-reliance on adults. She was very sensitive to criticism. A major defense mechanism that this child employed was to perseverate on whatever she was doing if an adult showed approval of the initial activity. This was evidenced in art therapy. Her initial art work was characterized by controlled orderliness and a compulsion to repeat linear forms. For example, she would fill a sheet of paper with parallel lines (see Figure 5), or her name, or letters of the alphabet. Her human figure drawings had multiple legs. As long as she repeated lines, she felt secure in what she was doing and defended herself against risking failure or disapproval.

Art therapy focused on helping this child decrease her need to perseverate on linear forms and letters and to expand her pictorial imagery. This was done by initially encouraging her to use clay. Clay was chosen because it was a material with which she was not all that familiar and one that was different from drawing materials. Thus, she did not have any preconceived ideas about what she could make with the clay, or what she felt that she should make to gain approval.

A portion of each art therapy session was set aside for a structured clay activity. The therapist showed her how to combine and mold clay to make different forms. They concentrated on representing things that were part of the environment (e.g., people, tree, house, dog, cat, etc.). In each session, they made only

one of a kind. After four months of art therapy, when this girl returned to making drawings, she did not perseverate on linear forms. Rather, she made unique images which she associated with familiar places and objects (e.g., her home, bicycles, people) (see Figure 6).

Art therapy was successful in helping this child to be less defensive and more self-confident and independent. She acquired a sense of security in knowing that she could make something because she wanted to and not just for the sake of pleasing someone else. Her need to perseverate was eliminated and she was willing to take risks in making pictorial images. She was proud of her accomplishments. The opportunity to make choices and to master a new environment also served to raise her self-esteem. She became more assertive, active and verbal.

Finally, art therapy promotes synthetic ego functions. It offers the opportunity to give vent to drives; it requires that the child be aware of his surroundings; that the child coordinate perceptual-motor skills; that the child make contact with objects outside of himself, and that he be less defensive. All these experiences combine to help the child become increasingly organized and integrated.

Case #6: This case concerns a ten-year-old moderately retarded boy whose ability to synthesize his major ego functions was deficient. His behavior was characterized by hyperactivity, impulsiveness, inappropriate sexual behavior, enuresis and encopresis. He was an extremely disorganized child who manifested his anxiety in hair twirling, thumb sucking, and most dramatically in

rapid speech. His speech consisted of a rambling incoherent string of words which were in most cases irrelevant to the situation on hand. This pressure of speech also served as an emotional barricade to screen out verbal stimuli. When he talked continuously, he did not pay attention to others who may have been asking him to do things or directing him not to do certain things. By tuning out people, he could control his environment in a passive-aggressive way.

This child's initial art products consisted of scribblings and perseverative marks. He spoke rapidly and incessantly. His thoughts were irrational and scrambled.

Art therapy concentrated on helping this child slow down both physically and verbally. He was allowed to choose only one material to use at a time. It had to be put away before he could choose another. In this way, he was not overwhelmed by too many choices, and he could not impulsively go from one thing to the next. He was encouraged to focus on one theme at a time in his art work, and to begin another sheet of paper if he had a new idea. Thus, he learned to separate his thoughts and to concentrate on one pictorial image at a time. Over a period of two years, this process was effective in helping him to be more organized and coherent.

Several major themes appeared in this boy's art work. Initially his art products focused on his home and family relationships, particularly his fear of his father. The next theme to emerge included the art therapist as an essential member of the family unit, evidence of a growing relationship.

The third theme related to toileting. During a regressive phase, he began to produce bowel movements in his pants. As toileting improved, the focus of his art work centered on classroom activites. The fifth theme that appeared related to body parts. Finally, as his discharge approached, emphasis was placed on helping him to separate from the program by focusing on future oriented concerns such as a new school and new friends.

Art therapy was helpful in enabling this child to become more fully integrated. During art therapy sessions, he pulled together all of his inner resources. His anxiety and impulsivity decreased while his attention span increased. His language slowed down, and he became coherent. His thoughts became increasingly rational, focusing on reality-oriented concerns instead of T.V. commercials, and non-sensical "jibberish." As his art work became more meaningful to him, his verbal defenses decreased. Also, his relationship with the therapist helped him to have appropriate interpersonal relationships with other adults.

Conclusion

In addition to impaired intellectual functioning and slow development, retarded children may have mal-adaptive ego functions leading to complications in emotional development. Although there is a persisting controversy over whether retarded children exhibit emotionally disturbed behaviors that are different in kind from those of non-retarded children (Chess, 1970), it is clear that they do exhibit a range of primary and secondary psychopathology. It is also evident that the disturbed retarded child, like the disturbed non-retarded child, can benefit from art therapy treatment, which has shown to promote ego development.

References

American Association of Mental Deficiency. A Manual on Terminology and Classification in Mental Retardation (2nd ed.). American Journal of Mental Deficiency Supplement, 1961.

Chess, Stella. Emotional Problems in Mentally Retarded Children. In F.J. Menolascino (Ed.), Psychiatric Approaches to Mental Retardation. N.Y.: Basic Books, Inc., 1970.

Cytryn, L. & Lourie, R.S. Mental Retardation. In A.M. Freedman, H.I. Kaplan & B.J. Sadock (Eds.), Comprehensive Textbook of Psychiatry - II (Vol. 1). Baltimore: The Williams & Wilkins Co., 1975.

Erikson, E.H. Childhood and Society (2nd ed.). New York: W.W. Norton and Co., 1963.

Fitzgibbon, W.C. Therapeutic Arts for the Mildly Mentally Retarded. The Digest of the Mentally Retarded, 1965, 2 (1), 2-5.

Freud, S. The Ego and the Id. (J. Riviere trans.). London: The Hogarth Press LTD, 1949. (originally published, 1923).

Gitter, L.L. Art in a Class for Mentally Retarded Children. Bulletin of Art Therapy, 1964, 3 (3), 83-85.

Henderson, P.B. An Overview of Ego Psychology and Developmental Theory: Correlates in Child Psychiatric Diagnosis of Retardation Syndromes. Graduate Course in Mental Retardation, Western Psychiatric Institute and Clinic, 1975-1976.

Mahler, M.S., Pine, F., & Bergman, A. The Psychological Birth of the Human Infant. New York: Basic Books, Inc., 1975.

Meissner, W.W., Mack, J.E., & Semrad, E. V. Classical Psychoanalysis. In A.M. Freedman, H.I. Kaplan & B.J. Sadock (Eds.), Comprehensive Textbook of Psychiatry - II (Vol. 1). Baltimore: The Williams & Wilkins Co., 1975.

Roth, E.A. Art Therapy with Emotionally Disturbed-Mentally Retarded Children: A Technique of Reality Shaping. In B.K. Mandel, R.H. Shoemaker & R.E. Hays (Eds.), The Dynamics of Creativity, The Proceedings of the Eighth Annual Conference of the American Art Therapy Association. Baltimore: AATA, 1978.

Roth, E.A. Choosing an Appropriate Candidate for Art Therapy among Emotionally Disturbed - Mentally Retarded Children. In L. Gantt et al. (Eds.). Art Therapy: Expanding Horizons, The Proceedings of the Ninth Annual Conference of the American Art Therapy Association. Baltimore, AATA, 1979.

Roth, E.A., & Barrett, R.P. Parallels in Art and Play Therapy with a Disturbed Retarded Child. The Arts in Psychotherapy, 1980, 7, 19-26.

Van Osdol, B.M. Art Education for the MR. Mental Retardation, 1972, 10 (5), 51-53.

Wilson, L. Theory and Practice of Art Therapy with the Mentally Retarded. American Journal of Art Therapy, 1977, 16 (3), 87-97.

CAPTIONS

Figure 1 Curvilinear lines and dots characteristic of a basic lack of interest in using art materials.

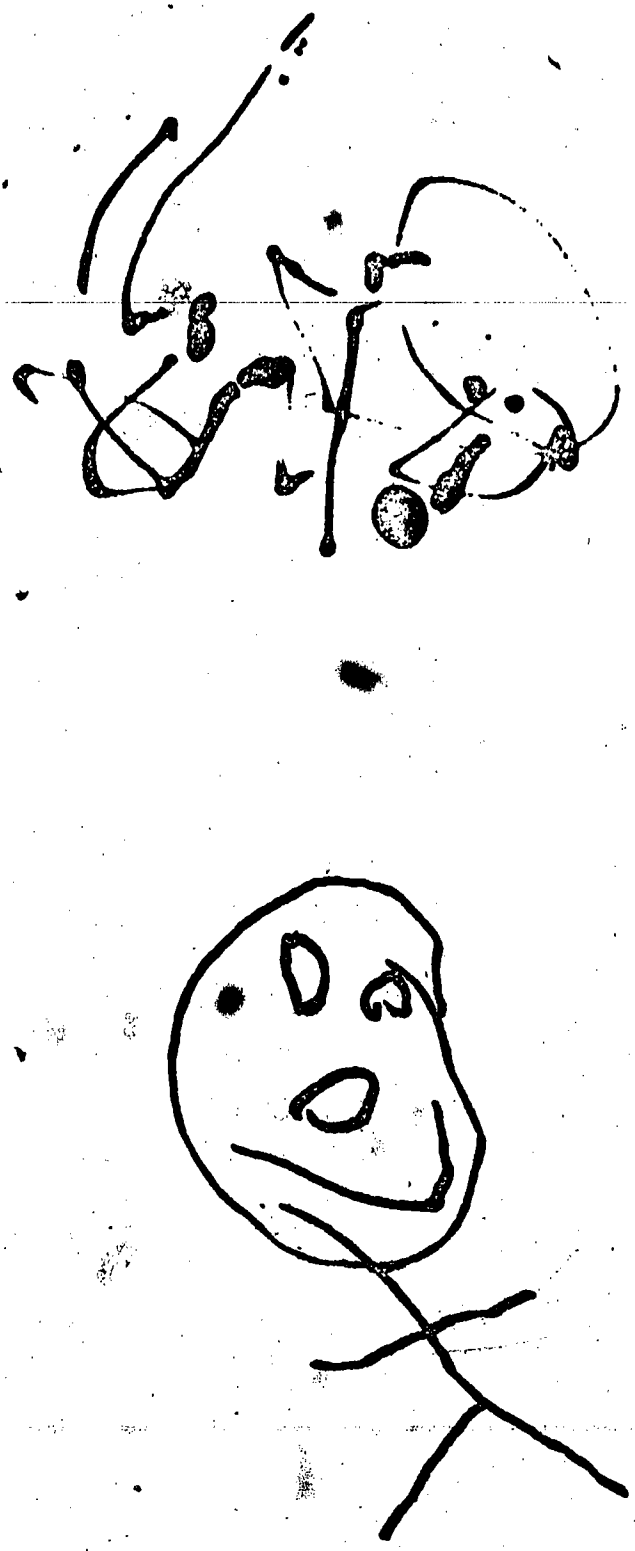
Figure 2 Human figure drawing identified as a boy. An image that the child learned to draw while using himself and pictures of a boy as references.

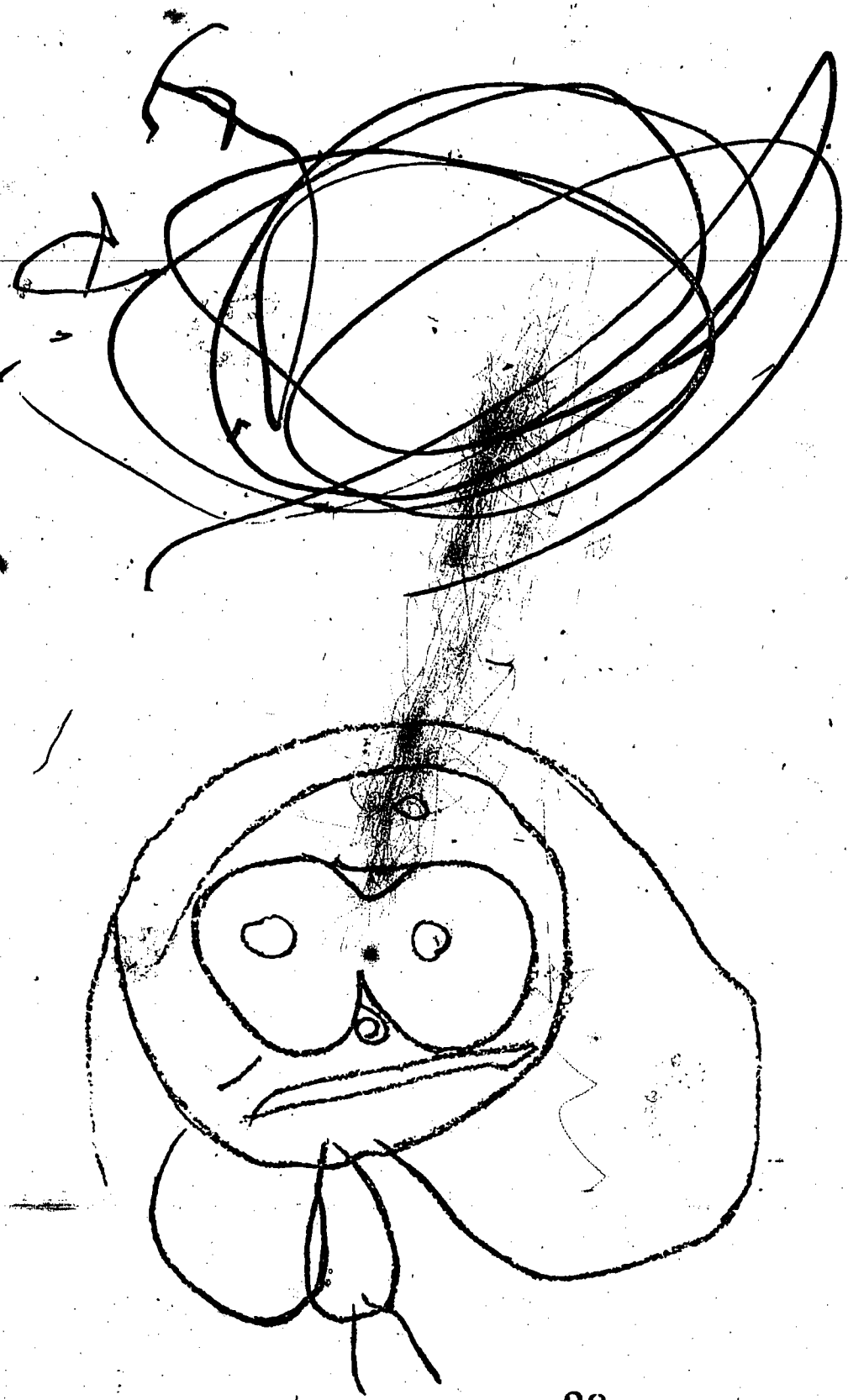
Figure 3 Random scribbling representative of the child's initial art work.

Figure 4 A developed human figure that includes a separate torso section, and the addition of glasses.

Figure 5 Parallel lines exemplifying a compulsion to repeat linear forms.

Figure 6 Drawing of a person after 4 months of art therapy where the emphasis had been on the use of clay revealing the absence of the need to perseverate on linear forms.





1