ART FOR ALL THE CHILDREN

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APPROACHES TO ART THERAPY FOR CHILDREN WITH DISABILITIES

Second Edition

By

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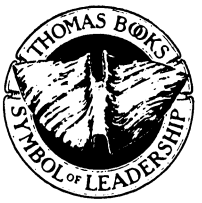

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This revised edition is dedicated to all of us who struggle with our own disabilities (especially C.P.P.). It is this triumph of the human spirit and the Creative Spirit in each of us that shines brightly in the darkest night that I wish to celebrate in this book.

FOREWORD

Once a month I meet with a group of mothers. We have been getting together regularly for a long time, first weekly, then bi-weekly, now monthly. Each of these mothers has a multiply handicapped child, along with one or more "normal" ones. They have inspired me, through their consistent determination, to find the best growth experiences for their disabled youngsters. I met them when they each brought in one of their children for individual art therapy. The youngsters have finished their treatment, at least for the time being. But for the mothers, parenting these children is a lifetime burden, full of fear for the unknown future.

In my own first experiences as an art therapist, I was asked to see what might be possible with children who had fairly severe disabilities. Hospitalized schizophrenics, institutionalized physically impaired, multiply handicapped blind, retarded, and deaf children—each of the groups described in Doctor Anderson's book. I recall vividly the skepticism, of those who knew the children better than I, about whether or not they would be able to use art materials appropriately or creatively. The doubts were enormous, as were the anxieties of other professionals about the possible negative impact of art activities.

Psychiatrists and child care workers worried that the schizophrenic children would become more psychotic and disorganized. Teachers and administrators feared accidents and injuries in those who were physically handicapped. Those in charge worried that the blind children would make terrible messes, that the retarded children would regress uncontrollably, that the deaf children would become confused and hyperactive. Happily, that was not the case. Children in each of these groups, treated as individuals and with appropriate adjustments for their disabilities, were able to create and to express themselves in art, well beyond even my fondest hopes. But it was an uphill battle at the time, and I remember it well.

Old attitudes die hard. Despite a new appreciation of the creative potential in the disabled person and of the value of art, there are many who have yet to learn. Although the situation has indeed improved since the first edition of *Art For All The Children* was published in 1978, there are still children who are excluded from both art and therapy, because they are

thought to be too handicapped to benefit from either. The creative adaptations throughout Doctor Anderson's book can make both growth processes possible for even the most damaged child.

Even if art and/or therapy are provided, they may still be offered in such a prescriptive and inhibiting fashion that the true self of the youngster cannot develop freely. Misunderstandings of behavioral, cognitive, and developmental approaches to art therapy can greatly limit what might be possible, given more depth and ingenuity. The many examples provided in this book by Doctor Anderson and her collaborators allow the reader to imagine ways of helping which vary tremendously, yet which consistently respect the child's uniqueness.

As Doctor Anderson states clearly and repeatedly throughout the book, a child with disabilities is—first and foremost—a child. Although art therapists have always worked with those whose problems are primarily social and emotional, relatively little attention has been paid to youngsters with cognitive, sensory, and physical impairments.

A heightened consciousness on the part of parents of children with disabilities, like the mothers with whom I meet, has led to significant legislation, described in detail by the author. Not only are school districts now required to provide appropriate educational programming for youngsters with handicaps; they are mandated to do so in a fashion which suits the needs of each individual child.

While art and other child therapists are accustomed to thinking in terms of individual needs, educators have most often taught and thought in terms of groups. The requirement for Individualized Educational Programs (IEPs) for each and every child with a disability has made possible more personally meaningful planning, a rich soil for the growth of programs in therapeutic art.

Fortunately, art therapy is one of the related services mentioned in the landmark legislation (PL 94-142), making it possible to educate the public and the schools about its benefits for exceptional children. While a child's primary disability may be something physiological, it is almost inevitable that emotional and social problems will accompany any major handicapping condition. They often interfere with the child's ability to take advantage of what the school itself has to offer. Almost always, they depress the child's self-concept, an area to which Doctor Anderson pays much attention.

This second edition of her book comes at a welcome time and with very helpful additions to the first. The time is ripe, because parents and teachers and therapists need to know what can be accomplished for the disabled through art therapy in order to press for its inclusion in a child's program. The book is full of useful information, not only about atypical children and

about development, but, most exciting, it contains many examples of actual art therapy programs with children who have disabilities, most of them in public school settings.

Doctor Anderson's invitation to those who have contributed case examples, methods of assessment, and modes of work with children, has added a great deal for the reader. Doctor Rosal's comprehensive chapter on different approaches to art therapy with children is especially helpful, as is Doctor Arrington's case study of a child who suffered sexual abuse. Doctor Anderson's modesty is reflected not only in having invited such contributions but also in her frequent references to those from whom she has learned and her acknowledgment that no single book can include everything on such a broad topic.

This second edition of one of the first books to focus on art for children with disabilities is a welcome addition to the literature for those in art and special education and in art therapy. Hopefully, friends and parents of the disabled will also learn of its existence, for it is through their efforts that more such opportunities may be made available to more such children. Perhaps, as is implicit in the title, authentic art will be possible some day for all.

J.A.R.

Judith A. Rubin is Clinical Assistant Professor of Psychiatry, University of Pittsburgh Faculty, Pittsburgh Psychoanalytic Institute. She is also the author of *Child Art Therapy: Understanding and Helping Children Grow Through Art* (2nd Ed.) (New York: Van Nostrand Reinhold, 1984), *The Art of Art Therapy* (New York: Brunner/Mazel, 1984), and *Approaches to Art Therapy: Theory and Technique* (New York: Brunner/Mazel, 1987).

INTRODUCTION

In The Decade since the first edition of this book was published there has been an enormous shift in attitudes toward children with disabilities and a tremendous explosion of information about children, art, art therapy, art education and special education. No longer are children with disabilities hidden and invisible. No longer is art therapy an unknown treatment modality.

Now all of us are likely to encounter daily at least one person with a disability. Now there are over 100 schools that offer courses in art therapy, and the American Art Therapy Association has given approval status to more than 25 academic, clinical and institute training programs in this country and Canada. Now there is a growing acceptance of the use of art to remediate learning and social problems, to facilitate growth, development and expression in all of us no matter what our age or disability.

And, yes, there is even some hard data research (Anderson, 1983; Anderson, 1988; Anderson, 1991; Anderson, Ash & Gambach, 1982) that supports what we who have been practicing art therapy have always known: **art is essential to the quality of life.** Art is also a major means to facilitate academic learning. Art is a means to help us express our inner chaos, to bring order and control over our inner turmoil as well as our outer chaotic worlds. Artistic activity is intrinsically healing, centering and strengthening. Art connects us all to ourselves and to our inner children no matter what our ages are.

The first edition of this book was written for art therapists, art teachers, special educators and other adults who had the responsibility for the art programming of children with disabilities. The field of art for children with disabilities has grown so much that one book cannot cover the necessary material. The focus of this revised edition is on approaches to art therapy for children with disabilities. It has been written specifically for art therapists in training and for in-service professionals in art therapy, art education and special education who have children with disabilities as a part of their case/class load. Another book geared specifically to approaches to art for children with disabilities and written for preservice art and special education teachers and undergraduate art therapy students is under development.

This revised edition is grounded in reality and research and based on

my own experience of three decades of work with children with visual impairments, hearing impairments, physical disabilities, mental retardation, learning disabilities and behavior disorders/emotional disturbance. I (and the other contributors) have tried to integrate research with practice and theory with reality. I hope that the outcome is a coherent whole and yet is so ordered that one can dip into its waters at specific points—or proceed through it in a linear way.

The first two chapters of the book lay a foundation in understanding disabilities and normal artistic development of children. These chapters are followed by an overview of four approaches to child art therapy buttressed with case material. These three chapters provide a knowledge base for the rest of the book.

Since Individualized Education Programs are a major means to avail children with disabilities of appropriate, meaningful and therapeutic art experiences, Chapter 4 is devoted to this topic. Also included in this chapter are several ways to assess children on their art skills. Finally, a segment focuses on the Miami, Florida, Dade County Clinical Art Therapy Program. As of this writing there were 15 art therapists working in public schools in Miami with learners who are seriously emotionally disturbed.

A detailed case of art therapy with a public school child is discussed in Chapter 5. This treatment was funded through legislation in California that is complimentary to Public Law 94-142 (now IDEA). If there is a healthier economy in this country in the years to come, I predict that more and more public school districts will have art therapists working with children who are disabled.

These chapters are followed by an extensive discussion of adaptative approaches to art for children with disabilities. I profoundly believe that art is indeed for **all the children.** So, one of the major goals in this book is to demonstrate the many ways that art can be adapted so that **ALL** children (with or without disabilities) can have a meaningful encounter with art. Chapter 6 covers in some detail many approaches to adapting art for children. Safety issues and health hazards related to art media are also covered.

The book concludes in Chapter 7 with a discussion of what research tells us about the effectiveness of the use of art to build more positive self-concepts in children. This information is followed by illustrations of ways to foster and encourage the development of a positive self-concept in children through appropriate art experiences. Chapter 7 also provides a model for sequencing art experiences into a coherent series that moves from simpler art experiences (and simple body concepts) to more complex art experiences (and more complex conceptual materials related to body concept). Additionally, each art experience discussed in Chapter 7 is followed by

suggested ways to adapt the activity for children with the six major disabilities covered in Public Law 94-142 (1975). This format is presented as a model to help the reader begin to understand specifically what needs to be adapted so that children with mental retardation, learning disabilities, behavior disorders, physical disabilities, hearing impairments and visual impairments can participate in the art experience.

I hope that the reader will have a better understanding of art therapy and how it can be used (in the best sense) to remediate academic, social and emotional problems of children with disabilities. With the information provided, I also hope that the reader will be better prepared to understand children, their art, their disabilities and how to adapt art to meet their needs.

As I complete this revised edition, I am reminded of the story of the building of a stone wall in the orient. In completing this structure, the laborers always placed one stone upside down to insure the wall had imperfections, for the gods would be angry if the stone wall were perfect. No human is permitted perfection. So I am very aware of my many stones in this work that are not perfectly placed. (I speak only of the parts which I have written.) I ask your tolerance and understanding. And *I know the gods will not be angry.*

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Public Law 94-142, 1975.

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Finally, I wish to thank my family, my family of choice and friends for their prayers, support and encouragement during the four years of my work on this book. (I Chronicles, XXIX:11–14.)

One can never pay in gratitude: one can only pay "in kind" somewhere else in life.
Ann Morrow Lindberg.

CONTENTS

ART FOR ALL THE CHILDREN

With regard to the use of non-sexist language, the author has throughout this book in the chapters, as well as segments in chapter 1, alternated the use of the pronouns he and she, her and him, and himself and herself.

Chapter 1

CHILDREN WITH DIFFERENT WAYS OF LEARNING ARE CHILDREN FIRST AND FOREMOST!

A DISCUSSION OF DISABILITIES

Introduction

Children with disabilities may have strange-sounding labels like osteogenesis imperfecta, athetoid cerebral palsied, multi-disabled, hearing impaired, socially maladjusted, and on and on, but mainly they are children. In fact, since 1975 there has been a trend (Kirk & Lord, 1975) **not** to label or categorize special children because such labels can become stigmas. Labels perpetuate negative and erroneous stereotypes about disabilities and mostly focus on what a child is unable to accomplish or do (Blandy, 1989).

Since the 1975 federal mandate (PL 94-142) to place children with disabilities in the least restrictive educational environment, two related approaches have emerged. These are the ecological and normalization approaches which are to some degree extensions of the mainstreaming concept.

In the ecological approach, children are viewed in terms of their abilities and how these interrelate with their sociocultural background, environs, and the significant persons in the learners' world. Teachers, counselors, and therapists are part of a team in equal partnership with the learner, and together they determine learning outcomes and set goals and objectives (Blandy, 1989).

Normalization is governed by the principle that underscores the "utilization of means which are as culturally normative as possible in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible" (Wolfensberger, 1979, p. 28). In normalization, art experiences would occur in a context that is as near the age norm as possible. The key here is a chronological, age-appropriate context in terms of art media used and art activities provided in a typical classroom environment (Blandy, 1989).

NOTE: Some material in this chapter has been taken from Daniel P. Hallahan and James M. Kauffman, *Exceptional Children: Introduction to Special Education,* 4th ed. Adapted by permission of Prentice-Hall, Inc., Englewood Cliffs, New Jersey; also, Kirk, S.A., *Educating Exceptional Children,* 4th ed., 5th ed., & 6th ed. Adapted with permission of Houghton Mifflin Company, Boston, MA.

Some art teachers and art therapists philosophically prefer not to know the details of a child's disability before personally having the opportunity to work with that child. Indeed, many would agree with Blandy (1989) that a normalizing and ecological approach is optimal in working with all children; however, there are some very good reasons to be aware of what disabilities a child may have. One reason is very pragmatic. Unless a child in a school setting has been assessed and his disabilities fall within those cited in Public Law 94-142, that child cannot qualify to receive special education services. Secondly, there are disabling conditions that require special interventions and assistance—and in some cases, unless the professional is knowledgeable about those conditions, the child might be physically or psychologically harmed or be placed in unsafe situations. This is especially true with children who are physically disabled, epileptic, and/or on medication. So it is best to be well-informed about a child's disability. Such information can insure the child's physical safety and enable informed planning of appropriate treatment modalities. This information may be confidential; art therapists and art teachers do have a "right to know" (Thorne, 1990) because they are responsible for the direct instruction and provision of services to these children. The individual child's classroom teacher can also be consulted by the art teacher or art therapist. Mainly, this should be done to check on medical issues, safety guidelines and possible allergies.

With these factors in mind, a discussion of the major categories of disabilities follows. The special education student or teacher may already know what all the labels and descriptions mean. The student or teacher of the visual arts, the art therapist, or regular classroom teacher, however, may not understand all these categories.

Who then are these children and what are the disabilities that they have? There are several ways to describe their disabilities—in fact, the variations in descriptions and definitions can cause some confusion and problems (Anderson, Ash, & Gambach, 1982). Therefore, for the purposes of our discussion here and elsewhere in this book, the definitions and descriptions that are included in the Regulations governing Public Law 94-142 and those that have been changed in the Individuals with Disabilities Education Act (IDEA) (PL 101-476 which is the reauthorization bill for PL 94-142) will be used.

> The term "children with disabilities" means children—
>
> (A) with mental retardation, hearing impairments including deafness, speech or language impairments, visual impairments including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities, and
>
> (B) who, by reason thereof need special education and related services. (IDEA, 20 U.S.C. Chapter 33 as amended by Public Law 101-476, 1990).

Recent trends in the field of professional special education and in disabled special-interest groups have resulted in determining that the terms *handicapped, handicapping condition, impairment* and *mentally* or *physically challenged* are inappropriate, euphemistic and unrealistic. These professionals and special-interest groups prefer to describe children as having a disability and/or to use the specific disability such as mentally retarded or emotionally disturbed (LIFE–CIL, n.d.; Research & Training Center on Independent Living, 1987). This trend in the use of descriptors for disabilities will be honored throughout this book. Further, the current way to use descriptors of disabilities is to phrase these descriptions so that they **follow** the words child, children, learner, person, and individuals. Thus, the term *disabled child* becomes **child with disabilities** or **child with mental retardation.** The reasoning behind this rephrasing is that the child comes first and then his disability descriptor. Attempts to honor this phrasing have been made throughout this book. However, there are instances when to do so would result in extremely awkward language, so there will be occasions where the descriptor of the child's disability does not follow but precedes the noun. This usage is not meant in any way to trivialize the child or to detract from the concept that the child is what is most important in our discussions. Because the following disabilities are most prevalent and likely to occur with greater frequency, this chapter will focus on children with the following six types of disabilities: mental retardation, hearing impairments, visual impairments, behavior disorders/emotional disturbance, physical disabilities, and learning disabilities.

Some information about ways art activities might be tailored for children having these disabilities is also included. More specific information about adaptations for art are further addressed in a chapter devoted solely to this topic (Chapter 6). Additionally, suggested art adaptions are included as part of every art activity discussed in Chapter 7. In reading the material that follows, please keep in mind that in spite of labels and descriptors, **children with disabilities are CHILDREN FIRST AND FOREMOST!**

CHILDREN WITH MENTAL RETARDATION

The term *mentally retarded* is defined in the regulations governing PL 94-142 (now IDEA) as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affects a child's educational performance" (PL 94-142, Reg. 300.5).

The American Association of Mental Deficiency (AAMD) uses four classifications under the general term *mentally retarded:* mild retardation with ranges of intelligence scores from 50–55 to about 70; moderate retardation

with ranges of intelligence test scores from 35–40 to about 50–55; severe retardation with ranges of intelligence scores from 20–25 to 35–40; and profound retardation with intelligence scores below 20 to 25. The AAMD emphasizes that several indicators of intellectual functioning should be used, including some provision for social adaptability (Grossman, 1983).

Identification

The majority of students in the retarded grouping fall into the mildly retarded category. It is only after they enroll in school that the retardation appears as they fall behind in school assignments. It is often not until the second or third year of formal schooling that these children are identified as being mildly mentally retarded, and the classroom teacher is often the first to suspect that a child has mental retardation.

There are two major means of determining mental retardation: individual standardized tests of intelligence and assessment of the child's ability to socially adapt. Students scoring two standard deviations below the mean on standardized intelligence tests are considered below normal in intelligence. There are two assessment tools of social adaptability widely in use: the AAMD Adaptive Behavior Scale (ABS) (Lambert et al., 1975) and the Adaptive Behavior Inventory for Children (ABIC) (Mercer & Lewis, 1978).

Causes of Mental Retardation

According to the AAMD, the causes of retardation fall into nine groups: "infection and intoxication, trauma or physical agents, metabolism or nutrition, gross brain disease, unknown prenatal influences, chromosomal abnormalities, gestational disorders, psychiatric disorders, environmental influence" (Grossman, 1983, p. 11).

Most children who fall into the mild retardation group are considered culturally-familial retarded, which means the condition is caused more by "poor social-environmental conditions" (Hallahan & Kauffman, 1988, p. 51) than heredity. This means that there is no evidence of brain damage, and the individual has been raised under conditions of poor nutrition and inadequate learning opportunities (Kauffman & Hallahan, 1988).

Moderate retardation is most likely caused by brain damage or genetic factors (MacMillan, 1982). Two more common genetic causes are Down's syndrome and phenylketonuria, although there are over 100 identified genetic disorders. Down's syndrome accounts for one to two births out of every thousand. Down's syndrome is caused by one added chromosome in the genetic code (47 instead of the standard 46). The result is either mild or moderate mental retardation (10 percent of all Down's syndrome children are moderately or severely mentally retarded) (MacMillan, 1982). Added