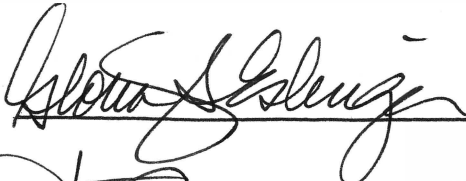
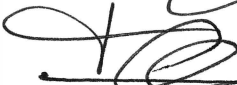



Healing Through Expressive Arts: A Path  
to Success for Children with ADD and ASD

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### Abstract

This paper explores the relief expressive art therapy offers children with Attention Deficit Disorder (ADD) and Autism Spectrum Disorder (ASD). The paper defines expressive art therapy, it's evolution, and how expressive art therapy aids communication, builds social skills and creates a supportive community for children with these diagnoses. In addressing children's emotional needs expressive art therapy can have an impact on the child's behavior and ability to learn. Current research and case studies are presented that support expressive art therapy's efficacy with children with ADD and ASD.

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## **Healing Through Expressive Arts: A Path to Success for Children with ADD and ASD**

### **Introduction**

Art is a universal language. Throughout the ages, art has conveyed emotions and ideas. Art has united people through image, crossed language barriers, and time to document significant events. The power of art is not limited to a small section of our population but is available to all. It can offer a mode of communication for those who struggle to be heard. Art can build communities and a common language. The mere creation of art can have the effect to sooth and comfort those in distress (Rogers, 1993).

Art facilitated in a proper environment can be therapeutic. Expressive art therapy is a therapeutic modality that specifically can aid children who suffer from learning disabilities, primarily autism spectrum disorder (ASD) and attention deficit disorder (ADD). These conditions are being identified earlier in childhood than in the past. Families and educators struggle to find pathways to reach these children. Art and expressive art therapy interventions can provide a path out of isolation for many children.

This paper creates a road map to greater healing through expressive arts. Citing many studies with children in various circumstances demonstrates how the use of expressive art along with therapy can offer relief and possibly hope for families and educators. Definitions of ADD and ASD are provided along with current statistics about how pervasive these disorders have become. Children with ADD and ASD often struggle with depression and anxiety further exacerbating their isolation. This paper explains how expressive art therapy has improved the lives of children here in the United States and in other countries as far away as Russia. Expressive art therapy also aids communication, improves behaviors and social skills by creating

a creative community for children coping with ASD and ADD (Rogers, 1993). This paper also offers insight into these claims by citing casework completed during practicum that supports these findings.

### **What is Expressive Art Therapy?**

Art therapy is an emerging field that began as a hybrid of psychology and art. Art has long been considered a universal language art can convey emotions and thoughts. This made art an easily accessible medium to use in the field of psychology. Early on the uses for art therapy were many and it was often used as a mode of rehabilitation for those who were recovering from other physical illnesses. There were many in the psychology field that regarded art as a tool to be used along with traditional methods used in therapy (Malchiodi, 2003).

Much of what we know today about how art works began with pioneer art therapists. Margret Naumburg, often recognized as the “Mother of Art Therapy,” according to Malchiodi (2003). Naumburg points out the idea that artwork is the manifestation of the artists psychic experience and reflects what is internal. She suggested that the creations of her patients were symbolic communications of their unconscious, conveying thoughts and experiences (Malchiodi, 2003). Her work came out psychoanalytical practice and would become the foundation for art therapy (Malchiodi, 2003).

Edith Kramer, another pioneer of art therapy took a different approach to art therapy. Kramer’s view was that “art as therapy” was applied more directly while she was working in therapeutic schools (Malchiodi, 2003). This approach suggested that the act of making art was more therapeutic than interpreting the images produce by the individual (Malchiodi, 2003). She felt that the children she was working with could channel their destructive and aggressive emotions into the art rather than acting upon those emotions (Waller, 2006). Kramer hypothesized that the child expressing negative emotions through the use of art would allow the child to gain control over these emotions (Waller, 2006).

The field of art therapy grew to encompass both Naumburg and Kramer's work. Art therapy used in clinical setting became widely recognized after therapists began using it to enhance traditional methods of therapy. As the field of expressive art therapy expanded, many approaches were directly influenced by various psychoanalytical theories (Malchiodi, 2003).

Today, art therapy has many applications and can be used with many populations. It has been applied to work with the elderly as well as children and families. Art therapy has been a therapeutic tool when working with soldiers returning from combat suffering from PTSD. Art therapy has been used worldwide and has evolved to encompass education and the medical field, even though the roots are in psychology. Anywhere psychology or psychoanalytical theory can be applied, so can art therapy (Malchiodi, 2003).

Many of these approaches to art therapy rely heavily on art assessment. After using assessment tools, the therapist interprets the art based on the images produced (Malchiodi, 2003). During the late 1950's child psychologists Jean Piaget and art educator Viktor Lowenfeld, found interest in children's art. Lowenfeld gathered artwork from children of different ages and created a system designed to assess child development bases of graphic development (Shore, 2013). He felt that the images produced by children directly reflected the child's cognitive development. Piaget and Lowenfeld based art assessment on the developmental drawing scale that defined this method. This scale was designed to determine the cognitive and emotional development of children. The art therapy done at this time had many limitations for application and many argued that interpretation must be done on a case-by-case basis (Malchiodi, 2003). This approach excluded children with physical limitation to produce art that could be easily interpreted (Rogers, 1993).

Another approach to art therapy was on the horizon. Expressive art therapy evolved from the idea that making art is therapeutic (Rogers, 1993). This idea took a much broader approach to art therapy and included all of the arts, writing, drama, dance and music along with visual art forms (Malchiodi 2003). The combining of one or more forms of art to help the client achieve self-awareness and encourages emotional growth. This method of intervention appeared to offer the best outcome, taking the pressure off the client to produce art that requires interpretation. This approach to art therapy offered a creative outlet for difficult emotions, allowing the client to create a visual language. This approach also allowed for the client to explore creative ideas (Malchiodi 2003).

Expressive therapy continuum (ETC) is defined as:

Kagin and Lusebrink (1978) first proposed the expressive therapies continuum (ETC), a model for understanding expressive arts therapy. Initially, the ETC was designed to focus on art therapy, but in later work the model has been extended to all art forms used in art therapy (Lusebrink, 1990, 1991). The ETC integrates information from neurological research on how the brain processes imagery with theories of sensory-motor development, cognition, psychosocial behaviors, and self-psychology (Malchiodi p. 109). ETC expresses four levels of experience. The first being, Kinesthetic/sensory, this refers to how the person interacts with the art form in an exploratory way. The physical act of using the materials and what that feels like is the goal. The outcome is not important here, the experience of working and creating with the medium is the focus. Next is the perceptual/affective level, at this level the person attaches emotions to the art and the process and gain self-awareness. This stage allows the client to emote with in the creative framework. Cognitive/symbolic is the next level, at this stage a client seeks meaning in the act of making art or the art produced in the



session. The client creates a visual language and access to deeper insight (Malchiodi, 2003). Last is the creative level, which refers to the integration of all the levels, using the art process and attaching meaning to the art produced. Not all clients will achieve this level and is not necessarily important, because there is therapeutic value in all the levels. These levels were designed to evaluate the progress of art therapy, allowing the therapist the ability to recognize the need for exposure to new art mediums or combining different art forms and encouraging self-actualization (Malchiodi, 2003).

Another forerunner in the expressive art therapy approach is Natalie Rogers. Her father, famed psychologist Carl Rogers, largely influenced her work (Rogers, 1993). Carl Rogers took a humanistic approach to psychology (Rogers, 1993). This approach would develop into what it now known as person-centered therapy (Rogers, 1993). Carl Rogers idea was that if a person felt safe and comfortable in the therapeutic environment, they would be able to explore difficult emotions freely and be able to achieve a greater level of emotional healing. The focus is the person and how they are experiencing the moment. The person-centered method allows the client the ability to emote in a self-directed manner and achieve deeper emotional healing. He felt that if the client was approached with unconditional positive regard and empathy the client would have the ability to self-actualize (Rogers, 1993).

Natalie Rogers used these principles and applied them to art therapy, believing that if a client feels comfortable with the therapist and the focus is not on the artistic outcome or an interpretation of the work, the client is able to emote through the art and the use of the art materials (Rogers, 1993). She argued that a client uses their mind, body and emotions when creating art and this has the ability to lead to greater personal insight, hence allowing the client deeper self-exploration and communication (Rogers, 1993). The client is able to create a visual

language while experiencing emotional relief brought on by the art process itself. According to Rogers (1993):

As our feelings are tapped, they become a resource for further self-understanding and creativity. We gently allow ourselves to awaken to new possibilities. With each opening we may deepen our experience. When we reach our inner core, we find our connection to all beings. We create to connect to our inner source and to reach out to the world and the universe (p.4)

Rogers's work transformed the art therapy community. Her methods could be applied to many populations from the very young to the very old. Because her approach incorporated the use of all of the art forms it could be used with anyone regardless of their limitations, physical and cognitive (Rogers, 1993). This approach of using a variety of art forms combined with creating a therapeutic environment let expressive art therapy reach a broader range of clients.

### **Autism Spectrum Disorder**

Autism spectrum disorder (ASD) appears to be more prevalent than previously thought (Zachor, 2012). It was once considered rare, is now identified much earlier due to medical advancement and changes in the way children are diagnosed with ASD. Early identification can happen as young as twelve months of age (Zachor, 2012). Researchers now recognize the characteristics of ASD earlier as a result of changes in the way ASD is assessed. These changes occurred by not only assessing cognitive development but also by assessing social interaction and motor skills. This evolution of assessments for ASD has allowed more children to receive earlier interventions which appears to yield the best possible outcome. If ASD is detected during early brain development current interventions can be applied giving the child the best chance of retaining the ability to learn new skills (Zachor, 2012).

How ASD occurs is still being researched though more is known today in regard to etiology. Currently ASD is considered highly heritable, although the specific gene that causes it has yet to be identified (Zachor, 2012). These brain abnormalities are complex and vary from person to person and this is why it is considered a spectrum disorder (Zachor, 2012). The range of impairment varies greatly from person to person ranging from severe impairment to what is considered high functioning. The DSM5 divides them into three levels. The DSM5 states that “severity is based on social communication impairments and restricted, repetitive patterns of behavior.” Individuals who would be deemed severely impaired or level three according to the DSM5 require very substantial support (p. 52, 2013). Level two requires substantial support and level one requires support. Some brain structures effected have been identified and they include enlarged white matter, variations in myelination, and impaired connectivity between brain

regions (Zachor, 2012). Since these brain abnormalities cannot currently be corrected, this disorder is considered lifelong. According to Zachor, (2012) p. 9

Studies considering performance on perceptual tasks using fMRI emerging in the literature suggest a role for perceptual differences to affect motor outcomes. The link may be in the impact of perception and action upon the child's ability to anticipate, gather information, and respond accordantly during a daily activity.

Although Autism is a spectrum disorder and the degree of impairment varies from child to child, general areas of deficiencies have been identified (Zachor, 2012). Those include cognitive and behavioral problems, repetitive movement or speech also known as echolalia. Many children on the spectrum also struggle with hyperactivity and impulse control issues. These children also appear to lack imaginative play and these individuals are unable to mimic social interaction as they perceive it. Recent research suggests that motor skills play a role in the expression of ASD, however it is not currently used as diagnostic criteria (Zachor, 2012).

There are pervasive characteristics of ASD that appear to limit the child's ability to make social contact, hindering their chances of having peer support or a network of friends (Epp, 2008). These children tend to withdraw from social situations, largely due to their inability to empathize with others. They do not comprehend how others feel and cannot grasp that other people perceive situations different than they do. Thus, they do not understand the emotions, thoughts and attitudes of others. Children with ASD also have sensory issues that may limit their ability to cope with overstimulating environments. They also have difficulty with transitions and have trouble moving from one task to another (Epp, 2008). When a child with ASD is asked to change their routine or asked to participate in a noisy environment, this may affect the child's ability to comply to the request or behave in a socially acceptable manner (Epp, 2008).

### **Attention Deficit Disorder**

The presence of ADD amongst school age children appears to be on the rise. Recent research indicates that how ADD is assessed and diagnosed has changed over the last twenty years (McGough, 2014). McGough states that combined with adult assessments of ADD varying from that of children may contribute to this finding.

There are many variables to consider when assessing for ADD, for this reason the disorder is often first recognized in children when they begin school. Teachers will recognize the symptoms and recommend an assessment. There are currently more interventions for these children and not all are medication. However, when applied along with medication seems to yield the best results (McGough, 2014).

To clarify, ADD falls under the same heading as attention-deficit/hyperactivity disorder (ADHD), they are considered the same disorder for diagnostic purposes and differentiated by the presence of hyperactivity (McGough, 2014). As early as 1907 the symptoms were recorded and historically ADD was regarded as a result of physical brain damage (McGough, 2014). There was an assumption that trauma during childbirth caused the brain damage, this would result in the child's inability to control behavior (McGough, 2014). Doctors determine that the defect was in the brain after observing children after the flu pandemic of 1918 (McGough, 2014). These children exhibited the same inattention and impulse control issues as those who were believed to have suffered other brain trauma (McGough, 2014).

During the 1930's, Dr. Bradley administered amphetamines to children with ADD after a procedure designed to assess for possible brain lesions. The drug was intended to alleviate headaches post procedure. What he found was the stimulant had a paradoxical effect on these

children. Instead of alleviating the headaches caused by the procedure, the amphetamines appeared to have a calming effect allowing the children the ability to focus. He reported significant improvement in the children's behavior as well as an improvement in their ability to learn (McGough,2014). Later he would discover that this outcome was not limited to children with ADD and the amphetamines had the same effect on general public. However, this would become the first medications used to treat ADD and they are similar to medications used today (McGough, 2014).

During the 1950's doctors determined that ADD was a developmental delay and that children would grow out of their symptoms by the time they reached adulthood (McGough, 2014). This was a long-held belief that would not be challenged until the 1990's. In the 1980's, two subtypes were identified, ADD and ADHD, the difference between the two is the presence of hyperactivity. During this time certain criteria was established to aid in diagnosis. In order to understand the disorder better, many longitudinal and phenomenological studies were conducted. These studies revealed that there was a clear genetic link and that many of these children would continue to struggle with symptoms into adulthood, hence adult ADD was recognized.

Although medical advancements would provide a biological reason for the presence of ADD in an individual, careful assessments and clinical history are still the only way to determine if the disorder is present (McGough, 2014).

There are many psychosocial risk factors that increase the severity of the disorder (McGough, 2014). Those include but are not limited to, family conflict, low socioeconomic status, economic stress, the absence of a parent or caregiver, and foster care placement. Research suggests that a resolve in family conflict can increase the child's ability to manage their symptoms. Family conflict likely stems from the child's inability to stay on task, the child's

response to discipline, and their overall lack of compliance. There is also an estimated 30% chance that one parent may have ADD further exacerbating the conflict (McGough, 2014). This combined with other risk factors decreases the odds of a positive outcome.

There are other prenatal risks for ADD such as maternal smoking, preeclampsia, toxemia, premature birth and low birth weight (McGough, 2014). The link between children with ADD and maternal smoking is still not entirely understood, research suggests a mother with ADD is more likely to smoke during pregnancy and so the presence of ADD in her child may be due to the genetic risk factor rather than the mother smoking (McGough, 2014). Many claims have been made in regard to diet and the incidence of ADD. That perhaps a diet high in sugar or food additives could be the cause of ADD. However, there is no substantial evidence that confirms this theory. There have been studies that indicate increased serum lead levels can impact the incidence of ADD. Further research indicates a strong probability that ADD is highly heritable and yet most research suggests that a positive outcome is most likely influenced by a number of factors, some of which are biological, and some are environmental.

Assessments are often not done until the child enters school (McGough, 2014). Often ADD is not detected in children prior to attending school due to age appropriate behavior before the age of five (McGough, 2014). Educators often recognize a child's inability to stay on task and are the first to identify impulse control issues; this often leads to the assessments (McGough, 2014). The parent or parents of the child are asked to complete a rating scale; completing surveys regarding the child's behavior and academic performance. Next a clinician will interview the child to determine the level of impairment. Medical records, family history and academic records are often used to assist the assessment. Care must be taken to determine the presence of other psychiatric disorders; most children with ADD have at least one other disorder. Some of the

disorders commonly associated with ADD are disruptive behavior disorder, learning disorders, anxiety and depression. About thirty percent of children who suffer from ADD report struggles with anxiety which can exacerbate their ability to focus and stay on task. Gaining this knowledge is an important step that must be taken if medications are being considered.

There appears to be many similarities between ASD and ADD. Most notably is that there seems to be a genetic link and this may be why these disorders occur. Another similarity is that these disorders begin in the brain. There are many stigmas that seem to exist surrounding ASD and ADD as well. Perhaps it is because on the surface it may appear as a behavioral issue or the lack of effective discipline. It seems that often parents are blamed for their child's inability to cope or stay on task and this can cause frustration for both parent and child. Educators are often undertrained in these areas and are ill equipped to deal with the struggles of these children.

Both of these groups of children struggle socially. Without peer support and proper interventions in place the outcome does not look promising. However, expressive art therapy may offer an alternate route to finding relief for anxiety. These interventions could create a social network where they might feel free to express themselves. Most important, expressive art therapy could give them a means of communication that they might not have otherwise. Current studies designed to assess and measure these outcomes.



### **Literature Review**

Expressive art therapy has offered relief to many children in various situations from schools to hospitals. The use of expressive art therapy as an intervention offers relief in many ways. One of the ways expressive art therapy works is it gives the child a place to communicate difficult emotions. Many children with these cognitive and behavioral obstacles often feel misunderstood and isolated. It is often a challenge for children with these disabilities to convey their struggles particularly to those who are not experiencing them. Both ADD and ASD seem to have a built-in barrier to communication. Another way expressive art therapy works with these children is that it creates a community. This community offers the children a chance to share ideas and thoughts. This also gives them an opportunity to build a social network and practice their social skills. Many children who have been diagnosed with ADD and ASD have behavioral issues that hinder their ability to make social contact. Without a social network many find it difficult to identify appropriate social skills. Expressive art therapy provides a format for them to share their experiences through the art and the activity of making art. The positive outcome of expressive art therapy as an intervention can also come from the act of making art (Rogers, 1993). Creating art allows the children a chance to try different art mediums without an expected outcome. When the net result of the art making process is not important and the child can create without these restrictions the child is given the chance to gage their success by the experience alone and this in turn can build confidence.

Kostyunia found that a recent Russian study conducted whereby art therapy administered in the form of mandalas suggested that children who were experiencing anxiety had difficulty with communication and rarely took the initiative towards communication (2016). The study also

identified that these children lacked motivation to learn and a general lack of compliance was reported as well. The study was designed to determine whether or not the art therapy program aided children with their anxiety and behavioral issues. First the study surveyed students to identify their level of anxiety prior to the study. Next the children were asked to complete mandalas choosing colors that correspond with specific emotions creating a form of communication. The study revealed that in fact the expressive art therapy had reduced their anxiety and their communications skills had improved. The students in the study also reported that they felt more accepted by the other children who participated in the art therapy program and looked forward to the activity for the social construct (Kostyunia 2016).

The data collected from the study revealed that more often creating the mandalas had a soothing effect on the students who participated, and their anxiety had diminished (Kostyunia, 2016). Data also suggested that attitudes and behavior in regard to school had improved (Kostyunia, 2016). The conclusion recommended that this was an effective method to reduce anxiety and can be used by teachers, social workers, and psychologists to prevent anxiety disorders in children and adolescence (Kostyunia, 2016).

Another study conducted in Sweden was done to determine if expressive arts had an impact on children who were hospitalized (Wickström, 2005). The research behind the study revealed that children who had been hospitalized for illness or injury benefited from having play therapy and expressive arts available to them. They found that there was a measurable increase in their pain tolerance. Also noted that the children who participated reported an improved sense of well-being as opposed to the control group.

Wickström's study was designed specifically to see if non-directed expressive arts offered relief from emotional pain, crying, decreased communication, and sleeplessness, often associated with children who are hospitalized (2005).

The study was conducted over a three year period with children ages six to nine. The criteria for participation in the study was based on three groups in order to measure the outcome more accurately. The first group consists of children who had visited the play therapy unit for the first time, the second group was children who were hospitalized for more than a week and the last group of children was determined by the child's age. The therapist did not give directives to these children, they were allowed to choose the type of play or expressive art they desired. The therapist recorded dialog and methods of play as well as art materials used. The study was designed to take a broad look at the effectiveness of expressive art on children undergoing painful procedures, being away from home and how they communicate their experience (Wickström, 2005). To assure validity there were three levels used, the first level was done with feedback during the expressive art session, confirming the child's understanding and thoughts (Wickström, 2005). The second level was the children's stories, what the child conveyed during the session. The third level was connecting the data gathered to previous studies (Wickström, 2005). The children were allowed to visit the play therapy unit at their own discretion and were not given any directive, they were encouraged to try any or all of the art mediums available. The children who were confined to their bed were visited by the therapist who would bring them the art supplies they desired (Wickström, 2005).

The resulting themes that were expressed was fear, powerlessness, and longing (Wickström, 2005). The children were found to spontaneously describe themselves through their artwork. The data also showed that the more often the children visited the play therapy unit the

more they disclosed and began attaching meaning to their expressive art objects (Wikström, 2005).

A child age six, with leukemia created a series of masks, he explained that he wore certain masks for certain medical procedures (Wikström, 2005). He also reported to the therapist that the masks helped him feel less scared and that he felt they protected him (Wikström, 2005). Another child, age seven, who suffered from diabetes created a doll and a bag for the doll to wear (Wikström, 2005). She explained that the bag must be carried with doll at all times because it held her insulin injection (Wikström, 2005). During the creative process the girl talked about her struggles with being insulin dependent (Wikström, 2005). A child age 9, who suffered from impaired renal function visited the play therapy unit every day (Wikström, 2005). He created the same diorama each visit, he created a seascape with a boat and green lawn with flowers. He expressed that his family had a summer home on a lake and wished he could be there instead of the hospital. These results are examples of how expressive art therapy allowed the children to communicate their experience and find relief in the art making process (Wikström, 2005). The conclusion was that the study may have lacked a systematic approach to evaluate the outcomes, however, the flexible nature of expressive art therapy was valuable to children in this type of environment (Wikström, 2005). Expressive art therapy can be regarded as a tool for children who are hospitalized (Wikström, 2005).

The two studies reflect the therapeutic nature of expressive art therapy. They also demonstrate how diverse the applications of expressive art therapy can be. Although both studies were designed to look for certain outcomes they both aided communication and emotional relief. Children with ADD and ASD often experience anxiety and what might be considered an enjoyable experience by children who do not have these diagnoses can often feel overwhelming. The

children in both studies had used the art as a communication tool, conveying their experiences.

Expressive art therapy has the ability to create a positive experience for these children.

### **Expressive Art Therapy and ADD and ASD**

Further studies have been done that indicate how effective expressive art therapy can be when practiced with children who have a diagnosis of ASD and ADD. These studies were conducted in a variety of settings. The result of these studies supports the use of expressive art therapy with these children. These results also suggest that perhaps expressive art therapy should be as an intervention commonly used in schools.

#### **ASD Interventions**

The study of the efficacy of expressive art therapy for children with ASD appears to be happening more frequently (Schweizer, Knorth, & Spreen, 2014). Recently a study that gathered data from eighteen previous studies and compared them in order to produce empirical evidence to the effectiveness of art therapy when used as an intervention with children with ASD.

Electronic searches were performed including studies done from 1985 until 2012 (Schweizer, 2014). These studies primary target was a certain population (Schweitzer, 2014). Studies were included in which

- Children up to 18 with normal and high intelligence with ASD were subject of research;
- Art therapeutic interventions with the aim to stimulate change in behavior and skills of children diagnosed with ASD;
- Art as a means of expression was described in relation to a change in behavior or skills of children diagnosed with ASD.

The studies considered for this compilation were limited to visual art as an intervention and followed the four main categories of the Context Outcome Art Therapy (COAT) model, context, outcomes, therapeutic behavior, and art as a means of expression (Schweitzer, 2014). After compiling and comparing the data gathered from the eighteen studies it was determined that in fact art therapy as an intervention for children with ASD did offer relief (Schweitzer, 2014). The children who participated in the art therapy interventions experienced relaxation and improved their communication and social skills (Schweitzer, 2014). The research suggested that the children experience more flexibility and improvement in their behavior (Schweitzer, 2014). They also improved their self-image and their learning skills (Schweitzer, 2014). The final recommendation was that the topic needs more study, however, it appears that expressive art therapy is an effective intervention for children with ASD (Schweitzer, 2014).

Another research study was conducted to evaluate the outcome of an art therapy group to improve social skills of children with ASD (Epp, 2008). One of the ideas behind the study was that art therapy offered children with ASD a way to solve problems using a visual medium (Epp, 2008). That perhaps this format allowed these children to be less literal and have a means of concrete self-expression (Epp, 2008). The study implemented using The SuperKids model (Epp, 2008). The model uses group therapy sessions with approximately six children of a similar age and social skills (Epp, 2008). The parents and teachers of the children were surveyed after two months of observation to determine a baseline for social skills and behavior (Epp, 2008). The questionnaires were designed differently for the parents and the teachers (Epp, 2008). There were four categories to measure positive social behaviors, cooperation, assertion, self-control, and responsibility (Epp, 2008). The problem behavior categories measured for externalizing problem, which include poor temper control and aggression (Epp, 2008). Also measured for

internalizing problems such as anxiety and sadness and third, hyperactivity and impulse control (Epp, 2008). The program was structured so that the children had more than one opportunity to practice social interaction with the other children participating (Epp, 2008). The participants of the study all attended a mainstream classroom, and many attended public schools along with attending the SuperKids program (Epp, 2008). The children were evaluated at the end of the program that lasted seven months, From October to May during the 2004/ 2005 school year (Epp, 2008). Other than responsibility all of the categories saw an improvement (Epp, 2008). The two categories that showed the most significant positive change were assertion and internalizing behavior (Epp, 2008). The study concluded that children with ASD can benefit from group therapy and the use of art therapy is an effective format to learn social skills (Epp, 2008).

### **ADD Interventions**

Children with ADD have a number of challenges that often prevent them from participating in group activities. According to Safran art therapy groups serve many functions, they give the children who have ADD a format to encounter and correct issues of impulsivity and attention. Expressive art therapy groups also provide an opportunity for them to practice their social skills (Safran, 2002). These interventions also allow the children a chance to communicate otherwise difficult emotions (Safran, 2002). The group approach is very beneficial because it creates a community of children with ADD who have many shared experiences (Safran, 2002). The eight-week program works to teach the children healthy boundaries and appropriate behavior in a social construct (Safran, 2002). The groups are constructed around a specific age range and usually consist of approximately six to eight children (Safran, 2002). The hour-long sessions are conducted and structured with a set of rules that are established for the groups needs and can vary from group to group (Safran, 2002). The rules are then reviewed each session



(Safran, 2002). The directives are not as structured and often the art is used more as a talking point (Safran, 2002). The children start the first session with an individual drawing to introduce themselves to the group, they work independently while working to establish boundaries (Safran, 2002). Gradually the group works their way to creating murals together which has many challenges for this population (Safran, 2002).

The therapist observed many that many of these children were hyper focused and had difficulty stopping (Safran, 2002). She also noted that they used the entire paper, often covering the surface with overlapping images or working right through the paper (Safran, 2002) The therapist suggests that this is a manifestation of their ADD (Safran, 2002). One of the children worked the paper so much that the drawing was destroyed, other children pointed out this fact which helped him become aware of his aggression (Safran, 2002). The therapist points out that interpreting the child's artwork is usually counterproductive and that most of these children were willing to share their stories explaining the images to the group (Safran, 2002). Another observation was that drawing held their attention and the images helped the children remember information about each other (Safran, 2002). The one consistent rule was that the children were not allowed to make negative comments about the other children work (Safran, 2002). The therapist found that this helped the children be more supportive of each other's efforts and created a community of support (Safran, 2002).

The therapist allowed the children to develop ideas, collaborating as a group when making decisions about the content of their work (Safran, 2002). She noted that at times the children would run into design problems and need to stop and talk about the best way to move forward which became a way for them to use the social skills they had learned throughout their participation in the program (Safran, 2002). Over time the groups almost always had to deal at

some point with conflict resolution usually because children with ADD are often not self-aware and need to learn to be aware of others (Safran, 2002). According to Safran:

The art process had provided an avenue for growth and self-awareness. The children's art expressions became "a container for feeling...and the expression through art has an inherent therapeutic value" (Malchiodi, 1998). (Safran p. 115)

The therapist states that the children were able to convey difficult emotion through the art making process and they were able to support each other creating a community for them to practice their social skills and find support (Safran, 2002).

## Case Studies

### After School Program

This research is further supported by practicum work completed. One of the sites used to complete these observations was an after school program. The program was funded and facilitated by the Salvation Army and the Housing Authority of Superior. These two agencies provided children with a meal or snack, help with homework, weekly bible lessons and exposure to activities that might not otherwise be available to many in this population. The group of children were age's kindergarten through eighth grade and ranged in attendance of twenty five to thirty children daily. Most of the children came from a single parent families or blended families and many were from a lower socioeconomic background. It was available to all children but mainly consisted of children who lived in public housing, although there were a few church members and a few home-schooled children as well. The children were picked up after school at their school and dropped off at the Peter Rich community center. The children would first eat a small meal or snack and then those with homework would get help as requested. The children who did not have homework or completed their homework early were able to choose an activity. These activities included playing appropriate games on the computer, playing board games or participate in expressive art therapy. Most children's parents picked them up around five pm often they were returning from work.

Many of the children struggled with mental health issues ranging from PTSD to ADHD. The children were often excited to be done with school for the day which would create delays while the facilitators of the program attempted to feed the children and keep them on task. The standard disciplinary action was to remove the child from the group, giving them a chance to

regulate their behavior. This method was not very effective with the children in the group who were coping with ADD and ASD. Many times, they reported sensory overload due to the commotion created by excited hungry children. Sometimes, weather permitting the children were brought to the park nearby and asked to walk or run around the block in order to expel their pent up energy. This seemed to create more anxiety for the children with ASD and appeared to have the opposite effect on the children with ADD.

### **Brady**

Brady, age ten, started attending the after school program after he went to live with his grandmother. Both of his parents had issues with drugs and his mother was incarcerated at that time. Brady reported he did not like living with his grandmother because she had many rules and worked and because of this she made him attend the after school program. His grandmother reported that he had been living in the car with his mother before she was arrested. She also said that he had missed a lot of school and that when he did attend he was very disruptive in class. Brady's teacher had suggested to his grandmother that he should be assessed for ADD. His grandmother reluctantly agreed to the assessment but adamantly refused to consider medication. She reported her struggles with keeping him safe and that he would sneak out of the house at night and go to the skate park. She said that on more than one occasion he had been brought home by the police because he was at the skate park after curfew. His grandmother expressed her concern but had felt she had run out of options.

The first session was an activity that all the children were to participate in. Each child was given a line drawing in the simple shape of a head with no features or details. The children were asked to draw a self portrait and provided markers and crayons. Brady reported that he didn't know how to draw and that it was unfair that he was required to participate. He

went back and forth to the art supplies several times but did not complete the task. He then accused another child of taking his markers and a conflict between the two began. The facilitator of the program, Brad, asked both children to remove themselves from the room. He then sent them both to separate places away from the rest of the children.

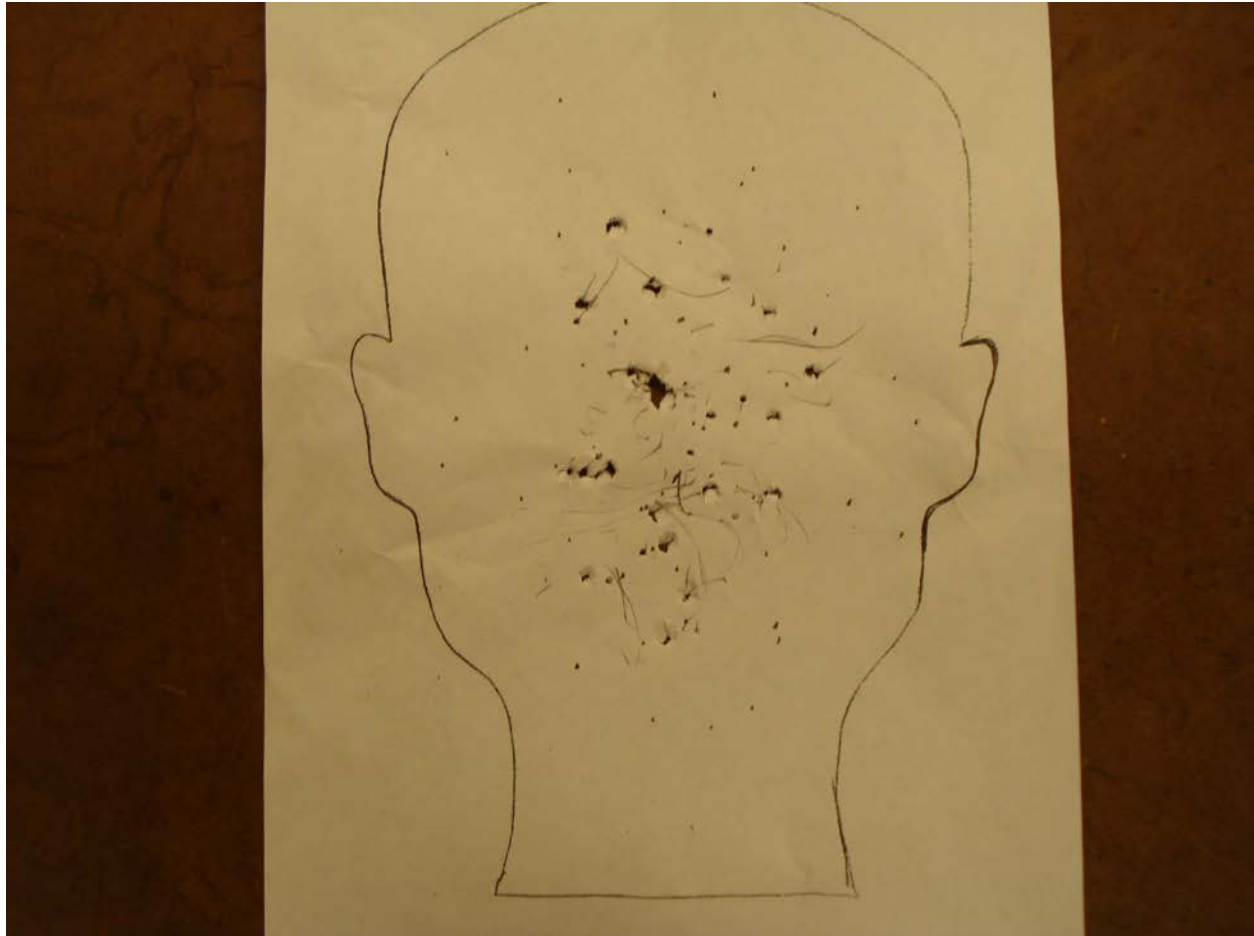
When I approached Brady, he had poked many holes in his paper head. He was crying and had explained that he just wanted to go outside. He appeared relieved when he was told that he was not required to do anything more to his drawing and could turn it in as is. After the children finished their drawing they were released to do other activities.

As the weeks passed a small group had formed that were interested in the art activities. Brady began participating regularly. At first, he would complete the task right away and leave the group. The children were given a directive of creating a superhero. The superhero needed to have a name, a superpower and a purpose. The children were allowed to use any of the drawing supplies. Brady chose pencil and drew a very detailed figure, he reported that his superpower would be invisibility so that he could sneak around people and know what they were doing. He said that it would also be useful because the bad guys could not see him and get to him. This may suggest that he feels powerless in his current situation. He then asked if his superhero could have more superpowers, he explained that the ability to fly would be an important ability to have because you would be able to get anywhere fast. This thought created a dialog amongst the children and they all came to the conclusion together that all the superheroes can fly in addition to their other unique superpower.

A week later Brady brought a notebook to the art session. He shared with the group the drawing inside, some of which had a very dark theme which concerned the facilitator Brad. Brady explained that he had taken the notebook with him when he went to visit his dad and that

he was glad he had it because his dad wasn't home most of the time and he didn't have cable television. His grandmother reported that his teacher suggested he carry the notebook with him, so he can take art breaks when he is having trouble staying on task or experiences agitation in the class room. She went on to say that drawing was part of his individual education plan (IEP) for his ADD and that he did not seem to be spending as much time in the focus room at school for disrupting class. She said that he had just started taking medication and hoped that he kept on doing better. The beginning of the next school year the self-portrait activity was done again. This time Brady volunteered to pass out the head template, he also explained to the new children attending about the art group and how fun it can be. He drew a self-portrait that closely resembled Sponge Bob SquarePants and pointed this fact out. He said he didn't know he could draw.

This is a clear example of how Brady found relief drawing and how he became part of a community of children with similar interests. More importantly, his communication skills had improved greatly. His tumultuous life had created insecurities whereas expressive art therapy gave him confidence and a way of coping and feeling empowered and connected.



*Figure 1 Brady age 10 self portrait*

### **Katrina**

Katrina, age ten, has been diagnosed with ADD when she began first grade. She is currently on medication and has an IEP at school to help her regulate her behaviors and her mood. The directive for the first session is to create a self-portrait using the head template. She chose to work only in pencil and frequently reported that she did not know how to draw. Although she finished her self-portrait she refused to have it photographed. The next session she attended was an open drawing session. She asked for someone to tell her what to draw, it was explained to her that she could draw whatever she wanted to. She seemed very angry and then scribbled in pencil. She explained that is was the best she could do and that she didn't understand what she was supposed to do. At this point another child explained that she could do whatever

she wanted to and show her what they had drawn. She appeared frustrated and left the group. She attempted to participate in the following weeks. The directive for the art activity on this day was to identify colors that would represent emotions such as anger, happiness, sadness, and bored. These colors were then to be used to color a heart outline to convey how the child was feeling on this day. Katrina chose blue for sad, brown for angry, red for happy and green for bored. She also used two shades of pink and did not identify emotions to go with them. When she was asked about her heart she explained that she started it wrong and didn't understand the directive. This reaction could suggest that when she is feeling insecure about her work she claims she doesn't understand. With prompting she reported that the color red makes her happy and that she is trying to be happy, but her brother won't let her. She then said that she isn't as sad as she used to be, but she still is sometimes. She went on to say that her art work did not turn out and that she didn't want it. This is first time Katrina has not taken her art home.





*Figure 2 Katrina age ten*

The next day there were only three children participating in the art activity, so Katrina decided to join the group. She conveyed that the art activity from the day before was hard and hoped to do something easier. The directive was to create a story based on a character. The character would be derived from answers to questions the children provide. Favorite color, a food you don't like an activity you like to do, and a location. Katrina added a gift you don't want. They were then asked to draw this character and then write a story using the information. Her drawing was very detailed, and she appeared to carefully color it in with markers. This is her character story:

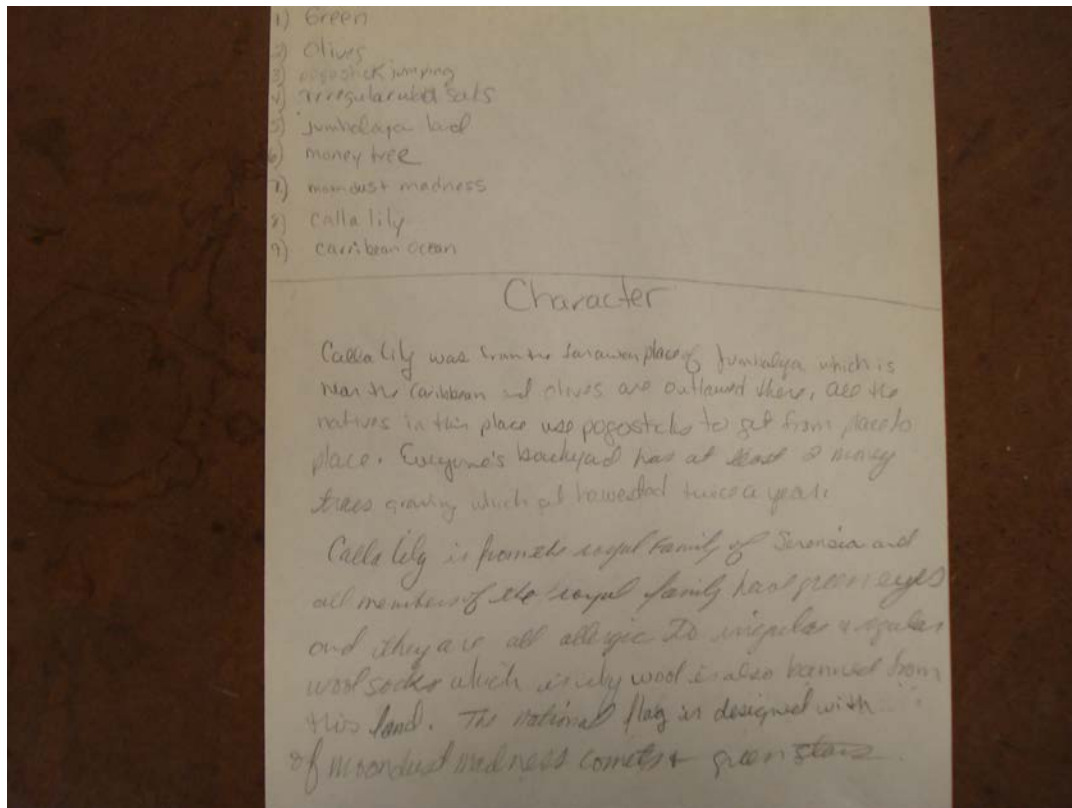
Calla lily was from the faraway place of jumbalya which is near the Caribbean and olives are outlawed there, all the natives in this place use pogo sticks to get

from place to place. Everyone's back yard has at least two money trees growing which are harvested twice a year. Calla lily is from the royal family of Serensia and all the members of the royal family have green eyes and they are all allergic to irregular and regular wool socks which is also banned from this land. The national flag is designed with moon dust madness comets and green stars.

She conveyed that she really liked this activity and hoped they could do it again. Katrina appeared to be more relaxed with the art activity than she had been in the past, perhaps because the activity allowed her to express her feelings. The directive for the activity allowed the children to make up questions that revealed thoughts and opinions and put that information in a creative context. The children were then able to express themselves without a pre-conceived expectation of how the story should be told. The group expressed that they all enjoyed the activity, laughed at all the stories and had many suggestions for future activities. Katrina continued to participate in the expressive art group and on a few occasions asked if the group could participate in an activity that she designed. The themes she chose involved stories derived from questions and the participation of the other children. The support she received from the other children appeared to be having a positive impact on her confidence.



Figure 2 and 3 Katrina's character and story



The Montessori school model was originally designed by Maria Montessori in 1898. She had visited a “insane” asylum and found interest in the children being housed there and she noticed that they were not being stimulated or learning anything. She developed a model for teaching these children who were considered unteachable. Her method developed over the years and the methodology is still based on the three main principles today, teaching academics, teaching life skills and modeling social skills. For the children ages three to six years old. These children can choose from six different curriculums areas (McKenzie, Zascavage, 2012).

The first is practical life and everyday living activities such as taking care of the environment, for example sweeping and gardening. Taking care of self by washing hands and getting dressed. Deportment and courtesies, being respectful in words and actions. Developing and perfecting fine and gross motor skills, pouring and cutting (McKenzie, Zascavage, 2012).

Second is sensorial activities, this is refinement of the senses which includes most learning that involves the five senses. It also includes tactile experiences and material manipulation. Third is math activities, this includes hands on explorations of shapes and sizes to learn geometric concepts. Fourth is language activities, some of which are learning phonetic sounds of letters and spelling simple words using movable letters. Fifth is cultural and peace activities. Some things in this curriculum would use maps and globes. Also experiencing cultural elements by learning about other countries. Sixth is art, music, drama, and physical activities. The development, appreciation and exploration of these activities.

The Montessori method also focuses on the way in which a child learns. This method also delineates between the types of learning a child experiences. Starting with discrimination learning, this focus is on how things are separate, for instance letters and numbers and being able to differentiate between the two. Factual learning is the retention of what is concrete, facts that

can't change. Rule learning is self-regulation and how actions and behavior impact learning and environment. Procedural learning is identifying the sequence of things and actions. Conceptual learning usually takes place during the ages of six to twelve years old (McKenzie, Zascavage, 2012).

The main focus for this method is critical thinking and how a child can cognitively approach learning taking independent steps to gain knowledge of themselves and their environment. This education model seems to parallel expressive art therapy, both allow children to learn and explore through participation.

### **Lakeview Montessori School**

Lakeview Montessori School is a school for children six years old and younger. There were three children who attended kindergarten for half of the day and the rest of the children were in attendance full time. At the time of this case study there were no children attending under the age of two. The day was structured, and the children were encouraged to be independent and had responsibilities. Some of these included cleaning up after themselves after playing and eating. The children also had other duties that rotated from child to child on a schedule. Lynn was the facilitator of the school.

### **Landon**

Landon, age 5, attended kindergarten for the first half of his day. He had an assessment the previous year and had a diagnosis of ASD. Lynn reported that Landon was high functioning although he may not be receptive to the expressive art therapy process as he appeared to be struggling with the transition from full time at the Montessori School to public school for half a day. She went on to say that he often arrives from kindergarten agitated and or crying and sometimes will not take off his shoes or jacket for up to an hour. She said that his behavior had

deteriorated over the first four weeks of school and that his mother had been called repeatedly by Lynn and where he attends kindergarten. Lynn reported that she hoped expressive art therapy might help him adjust but that he did have sensory issues that may make the art making process difficult for him. Landon watched the other children in the art group and sometimes joined in the conversation the children were having but expressed that he did not want to participate until the day the group made soap ghosts. It was flu season and there had been a discussion about washing hands and how important this was to stay healthy. The directive was to make a soap ball using water and soap flakes, the soap is to be squeezed into a ball, this ball of soap was then covered by a washcloth and tied on with a cotton string. Next the children were allowed to paint their ghost with fabric paint. Landon watched most of the children make their ghost but was still concerned about making the soap ball, he reported he didn't want to touch it. When it was his turn he forcibly squeezed the soap together and expressed surprise when the soap ball became smaller. Once the soap ball was made, he reported that he needed to rinse his hands because he did not like how they felt with the soap on them. He said he wanted to paint the face of the ghost with fangs. He expressed that he enjoyed making his soap ghost and wanted to be in the art group. Landon attended art group for the next few sessions and did not show any sign of apprehension. The day that the group was going to make window clings Landon was late arriving from kindergarten. He appeared very agitated and expressed disappointment that art group had started without him. The activity was to apply colored glue from squeeze bottles to the premade heart outline. Landon applied the glue heavily and it poured out of the outline. He appeared frustrated and began purposely over filling his heart. At this point he said that he had ruined it and asked to start over. He was told that when all the other children had completed one the extra outlines were available for children to make more. At this he started to cry, and Lynn asked him

to leave the art table. When he stopped crying he approached the table and asked if he could make another window cling. He began by using the color blue and squeezed a small amount at a time. While he did this, he would stop and let the glue spread out and he would explain how he did it wrong the first time. It appears that Landon's desire to make the window cling was strong enough for him to return again. Lynn explained that Landon asked her frequently when art group was happening and expressed concern about missing a day and not getting to participate. It appears that perhaps making art was helping him with this transition from kindergarten to Montessori school. Landon continued to participate in the art sessions although his sensory issues appeared to sometimes hinder the execution of his work. His inquiry about the art group may suggest that having art group when he arrived from kindergarten helped him adjust to the change in the environment.

### **Theo**

Theo, age three, attends full days and his brother Peter, age five, attends half days and half his day in kindergarten. Peter was assessed a year ago and diagnosed with ADD. Theo's mother and Lynn have speculated that Theo may have ADD, however he is young and could be emulating his brother's behavior. Theo seems always in motion and often moves from one activity to the next without cleaning up after himself and Lynn must repeatedly remind him to put things away when he is done. Theo's first day in art session prompted many reminders to only draw on his paper. He pointed out that he wanted to share by drawing with other children. Theo also seems to overconsume the art supplies and Lynn asked if the children could be limited to a set amount of paint for example. Theo made a soap ghost and proceeded to cover it with fabric paint. It was pointed out to him that because of so much paint it might not work for washing hands. Theo responded with a smile. The ghosts were put on a drop cloth to dry

overnight. Theo continued to handle his ghost and repeatedly needed to wash the paint off his hands. When his mom arrived to pick him up, he went to get his ghost to show her and once again was reminded that it was wet with paint. The next week the children were to create a mural on a roll of paper taped to the wall. Theo explains that he is very excited to draw on the same drawing as the other children. He is reminded to only work in his space on the paper. Theo's drawing is a series of scribbles that starts to encroach other children's drawings. He then attempted to draw a circle around his drawing and said that he would keep his drawing in the circle. Theo does appear to be working on his impulse issues and it seems the art process is making him more aware of this. He often expresses his desire to make art and seems to be trying to follow the rules. He has been more responsive to the other children's protests when he has behaved inappropriately. This may suggest his desire to be included in the group.





*Figure 4 Theo's mural*

### **Observations**

The children who participated in the expressive art therapy interventions all reported that they enjoyed making art even if it was not always easy. The children I worked with during this time shared many funny stories real and imaginary. They also supported each other and sometimes there was conflict and overstepped boundaries, however it was my observation that they all learned something about themselves and each other. The children built a community completed some amazing art in the process.

### **Conclusion**

Expressive art therapy is an effective intervention for children with ASD and ADD. Expressive art therapy is a format for learning effective coping as it allows for self-expression

which enhances communication. Increased communication skills allow for children to connect to one another, share ideas, thoughts and creativity. Expressive art used in conjunction with other interventions appears to yield success for children who are diagnosed with ASD and ADD. The research suggests that expressive art therapy can be used in many environments where children, especially those with ASD and ADD might feel most vulnerable. The suggestion that expressive art therapy be a mainstream intervention for schools and hospitals is valid and a few of the studies presented suggested just that. In order to empower the children of the future they must be offered the best chance to reach their full potential. Expressive art therapy can lead the way.

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