The Uses of Doll Making in Art Therapy with Children:

Four Case Studies

Jennifer Topp

A Research Paper

in

The Department

of

Art Education and the Creative Arts Therapies

Presented in partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montréal, Quebec, Canada

February 2005

Your file Votre référence
ISBN: 0-494-13246-9
Our file Notre référence
ISBN: 0-494-13246-9

Abstract

The Uses of Doll Making in Art Therapy with Children:
Four Case Studies

Jennifer Topp

The purpose of this study is to examine how doll making can be used as a therapeutic tool in art therapy. The literature review will cover the historical uses of dolls, prior research where art therapists used dolls as part of the therapy and an overview of the issues faced by children in hospitals. Four case studies will follow. The cases will include the process of the child making the doll and the context within which it was created. The four children were seen in art therapy in a hospital setting for several months. The children worked on issues of self-esteem, anger, sibling relationships, physical illness, and sexual abuse. The discussion will examine the similarities and differences of the doll making experiences of the children and suggest ideas for further research on this topic.

Acknowledgements

First of all I would like to thank Suzanne Lister for her insights and her tireless editing. My thanks to Dr. Kapuscinska, and the Behavioural Pediatrics team for their wisdom for accepting me as a part of their team. My gratitude and admiration for my fellow classmates Branko, Heather, Jenne, Janet, Sarah, Sheila, Shoshanna, Sora, Véronique B, Véronique S. They have all contributed to this paper in some way through finding resources, being excited about the project, or being guinea pigs for the doll making. My gratitude extends to Bonnie Harnden, for being an excellent role model and for her unwavering support. I would like to thank the children who participated in this study. My thanks to my sister Cathy, who has always been a good role model. Lastly I would like to thank my husband Roderick, for keeping the computer running smoothly, for his patience and for his belief in me and all my endeavors.

Table of Contents

Table of Contents (continued)

List of Figures

The Uses of Doll Making in Art Therapy with Children: Four Case Studies

Dolls and doll making have played a part in history since humans began creating art objects. Materials used to make dolls have spanned clay, stones, sticks and rags to plastics. Dolls take human form, or represent our animal friends. In ancient times the doll was a talisman, a symbol of good luck, fertility or imbued with special powers to protect the one who carried the doll (von Boehn, 1929/1972). It is only recently in the history of dolls that they have been the playthings of children.

The purpose of this research is to examine the relationship between children and the dolls they create. Stitching is a symbolic activity that requires patience and concentration. It is intrinsically different from the painting and drawing of a usual art therapy session because it is more structured and time consuming. Additionally as dolls have the potential to lend themselves to a representation of self, I wanted to discover how the children viewed themselves as portrayed through this medium. An essential component to working with children is the idea of play. Finally, I wanted to investigate how they would play with the dolls they created. Four case studies of children in a hospital setting show a glimpse into the time I spent with them observing the dolls they made in therapy. As this is a qualitatively-based study it was important to incorporate my own process, thoughts, and interpretations of the child's creative endeavors with doll-making and playing. The dolls became a shared activity between the child and me, making my point of view necessary. This project is an exploration of the interaction between children and their dolls.

Therapeutic uses of Stitchery

Textile arts have been used for centuries as a way of remembering family members. The quilt traditionally told the stories of the family and was passed down to the next generation. The quilt is the keeper of memories especially for the women of the family. In recent times a quilt project to remember the victims of AIDS has been created. The AIDS quilt (AIDSquilt.org, 2004) is an example of how textile arts can be used therapeutically. Over 45000 squares have been created by loved ones of someone who has died of AIDS. At first the quilt was a politically charged piece where people put names and faces to those who had died in an atmosphere where AIDS was not discussed. Later it became a powerful symbol of the number of lives lost to AIDS. In another setting, art therapist Frances Reynolds (2000, 2002) studied the way in which quilt making and other textile arts could be therapeutic to women suffering from depression and chronic illness. After interviewing women about their experiences with needlecraft activities Reynolds found the women derived numerous benefits from the art making. The women coping with depression gained a sense of relaxation from the stitching and enhanced self-esteem through mastery of the techniques (2000). The women also benefited by gaining a sense of control from stitchery. "Some aspects of the needlecraft activity seemed to allow the experience of autonomy and choice, which may be particularly valued when personal decision-making or control were limited in other facets of life" (2000, p. 111). This would be an important feature to consider in working with children dealing with physical ailments or illnesses. Children need to experience autonomy and this is often difficult if a child is dependent on medical treatments for their survival.

Doll making has been introduced to a variety of populations in art therapy. A variation of doll making is the more common use of puppetry and puppet making, especially within a drama therapy and play therapy context. Lani Gerity (1999) introduced puppet making to adult patients who had survived childhood traumas and who exhibited dissociative characteristics. The use of the puppet allowed the patients to examine their body image, and let them explore how they related to the world. The puppets allowed for narratives to be created where the individual can stay safely in the metaphor of the story. Gerity included a case study of a woman who made numerous puppets to represent various mental states and significant persons in her life. Some of the participants discovered that "sometimes the puppets spoke more openly and honestly than they were comfortable with" (p. 35). One participant suggested making a place for the bad puppets so the women could discard the difficult part of their personality in the puppet. The participants soon forgot their resistance to using the puppets. The puppets permitted the patients to discuss painful events while maintaining a sense of distance. The author concluded the experience of the participants: "These puppets with all the narratives and attached metaphors of growth and change would then be internalized and carried around like transitional objects; things of their own making that made them feel whole and happy, not alienated, not dissociated" (Gerity, 1999, p. 120).

Play Therapy

An essential part of working with children is the notion of play. The child first begins to explore the world through play. A child will have a complete sensory

experience of an object such as tasting, touching, or throwing it through play. Schaefer (1983) discusses the developmental stages of play and what the child can gain cognitively through the play. The three stages are sensorimotor play or experiential play, the second is symbolic or pretend play, and the third type of play is the game. The pretend play is an integral part of doll play where the child can use an object to stand in for a person in their lives or for themselves. Play can be a window into the inner world of a child. According to Irwin (1983) play reveals much about the child. The therapist can observe through pretend play "the child's view of him or herself" and the roles they assume, how the child views others, the internal state of the child including the "worries, wishes and conflicts", and also the way in which they view the world "including intellectual capacities and problem solving abilities" (pp. 149-150). How a child plays with the art materials, how they approach the activity and the materials can be indicative of their inner states. An art therapist gathers a great deal of information from the non-verbal cues of the client as they work with the materials.

Virginia Axline (1969) developed a method of play therapy based on the client-centered work of psychologist Carl Rogers. This approach presumes that the client has the capacity to work through their issues and to grow emotionally. The therapist is a facilitator of this process, reflecting the inner states of the client and allowing the client to be themselves in the therapeutic setting, with no pretenses or agendas. Axline states that "since play is his natural medium for self-expression, the child is given an opportunity to play out his accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment, confusion" (p.16). The child is limited only by certain rules of respect and

safety in the play therapy setting. This allows the children to be themselves, to feel in control, and to explore. It is a way of approaching the sessions where the therapist has an open mind, allowing the child to bring any issues to the session. Cattanach (1999) discussed the role of the therapist in a play therapy setting. The therapist and child play together in their special space. The therapist assists children in playing out their imaginary or actual worlds, in whichever way the children see fit. The therapist provides and maintains the frame while allowing the child to explore. Introducing new materials to the children opens up the possibilities for them to consider and allows them to play. "When the child plays with toys and other materials and narrates a story with the objects or dramatizes the play the child is distanced from their reality world". "It is a paradoxical process because we can come closer to the issues that concern us through the distance created by the processes in the play" (Cattanach, 2003, p.36). The child is not conscious of this process and is therefore more natural in their play, revealing more about their inner world.

Bettelheim (1987) advocated for play and its importance for children. Play gives children the opportunity to explore their world and to work out problems. Bettelheim encouraged parents to take an active role in the play of children. Doll play according to the author is not just for girls but boys benefit from this activity as well. Bettelheim postulated "if parents could see how eagerly boys use dolls and doll houses in psychoanalytic treatment to work out family problems and anxieties about themselves, they would be more ready to recognize the value of doll play for both sexes" (p.40). Bettelheim also discussed the emotional involvement of parents in the toys of their

children. If parents make the toys for the children, both the child and the parent will view the toy as having a certain special-ness adding a depth to the play experience of the child. The child making his/her own doll would invest more in the doll and thereby give it more significance in the eye of the child.

Play can be used therapeutically by a variety of professionals working with children. Play can be used to assist children in a non- threatening and entertaining way. The authors Billig & Weaver (1996) wrote about dolls that were created for children undergoing amputation. The children were either in the process of an amputation or were born without limbs. They were paired up with a doll resembling the child. The doll was fitted with a special prosthetic to simulate the prosthetic limb the child was to receive. The medical professionals working with the child could then demonstrate to the child how to use and wear their new prosthetic limb. This special doll also added an emotional and not just technical component to the treatment of the child. The child was given a doll just like them, at a time when most children in that particular situation would feel that they were different from others, thus giving the child an ally. The dolls were also used to educate siblings and classmates about body image, amputations and the potential physical limitations of the child.

Together these authors show that play can be utilized for a variety of reasons. Play can be used as a teaching tool, or as a natural form of communication for children. It is revealing about the way in which the child views the world. Children are uninhibited in play, allowing their inner most thought and feelings to be expressed in a safe forum. Children learn and assimilate information through their experiences in play.

Therapeutic Uses of Dolls

Since the time of Anna Freud (Sinason, 1988) psychotherapists working with children have been using dolls to help the children communicate their thoughts and fears. Sinason (1988) used dolls and stuffed animals in psychoanalysis to help children deal with issues of sexual abuse. In play the children were able to reenact scenarios and show what had happened to them, and to help them disclose the abuse to the therapist. Ferenczi as cited in Sinason described how the trauma of sexual abuse caused children to act like dolls, frozen and unable to move on their own, being easily manipulated by the person in control. The child seeing a doll that was easily manipulated could invoke the helplessness the child felt during the abuse. However, this scenario would be different than the original abuse because the children would be in control of the doll and could examine what happened at their own pace.

Children must sometimes work through not only physical damages but also emotional ones. Munro-Smith (1996) used doll making in art therapy with a neglected twelve-year-old girl. The girl exhibited behaviour problems in school and had a chaotic family life. Her mother had many children to take care of as a single mother and was also expecting another child. The girl was unkempt and she frequently acted out at school. Munro-Smith felt that the structure of doll making would be beneficial to the girl. She made two dolls during the course of the therapy with the help of the art therapy intern. She made an angry doll and one to resemble Rapunzel from the fairy tale. The client, after making her angry doll "played with it briefly, sadistically, tied its legs in

knots, knocked it on its face, and poked it with the needle" (p.32). After making the Rapunzel doll, the girl finally chopped off the doll's long hair in an effort to destroy the doll. The girl knew that she could not live in the fairy tale and she needed to destroy the fantasy. According to Munro-Smith, the girl was able to express her hateful feelings towards the angry doll instead of her new sibling, who took the attention of her mother away from her. Thus, one of the advantages to doll playing is that clients are able to express anger towards the dolls and have the power to be able to destroy what they create.

Vollmann (1997) wrote of her experience with dolls in art therapy. The author created numerous dolls of her own in childhood and also continued creating dolls in adulthood. She introduced the technique to the children and adolescents she was treating in art therapy. She found that many of the children responded well to the doll making activity. One case in particular was with a fourteen year old boy with gender identity disorder and separation anxiety. Vollmann wanted to work on issues of body image with the boy but was hesitant about having him do a body trace drawing of himself or any activity directly related to his body. The author reasoned "my previous experiences of doll making with patients had demonstrated their powerful potential for fostering self-identification and the projection of issues that were 'too hot to handle'" (p.81). The client made a series of dolls where he examined his family members, himself and his place in his family unit. Craig, the client, created a doll that could be seen as a self-portrait doll. He created a wire doll with what looked like a mirror frame for the head. The author commented that the doll was a manifestation of his critical self-image and

fears of what others thought of him. The author successfully introduced the doll making activity to the adolescent boy, allowing him to create and later play with dolls where he was able to express his concerns and insecurities about himself. The use of doll making to distance the client from his conflicts provided a way to "open him up and protect him simultaneously" according to Vollmann (p. 85). Dolls provide a vehicle for projecting oneself onto an external object, where clients can examine their issues from a safe distance and remain in the metaphor during the play.

Children in hospitals can benefit from doll play as well as other children. The hospitalized child can benefit from the comfort and familiarity of dolls in what can be at times a frightening experience. Barbara Sourkes (1995) wrote about her experiences as a psychotherapist with children in hospital for life threatening illnesses. Sourkes goes into great depth about what hospitalized children experience in their lives including treatments, the family life and their perceptions of their disease. In addition to the verbal therapy, Sourkes used play and art to assist the children to express their thoughts and feelings. Sourkes created a booklet with Karen Josephson called "My Life is Feelings" (n.d.) as a therapeutic tool for working with these children. The book featured a teddy bear going through a range of emotions during the course of treatment. The teddy bear belonged to one of the patients that Sourkes saw in therapy. She created the story specifically to help him through his stay at the hospital. Sourkes worked with stuffed animals, suggesting to the children that the animal suffered from the same illness as the child. "For a child who is receptive to this form of play, the identification with the animal and the projective process do not take long to establish" (p.14). The child is able

to discuss his/her feelings about their illness through the third party of the stuffed animal. The stuffed animal became a living character that existed in between the child and therapist. The children were able to demonstrate procedures or explain treatments to the animal, thus creating a sense of mastery over the illness and the treatments for the child.

Another study examined the use of dolls in a hospital setting presenting the dolls to all children and not just those who were gravely ill. Gaynard, Goldberger, and Laidley (1991) described a Child Life project in which children newly admitted to hospital were introduced to dolls. Each child was presented with a stuffed doll without any details, just a simple outline, and they were informed that they could draw on the doll with markers provided and that they could take home the doll upon leaving the hospital. "Children were observed to consistently respond to the dolls with interest, more relaxed body posture, and increased positive affect" (p.217). Most children benefited from the activity, even the most ill of children according to the authors. The children were able to express their feelings about the hospital through the doll and also to be educated about procedures that would be performed by the doctors. The children gained a sense of control by having the opportunity to perform the procedures on the doll before they went through it themselves.

Art Therapy with Children in Hospitals

A medical environment can sometimes be a confusing and frightening place for a child. The children may undergo painful treatments or spend time away in the hospital away from their families. Due to the variety of physical, emotional and psychological

stressors, art therapy can provide an opportunity for the child to effectively deal with these new situations. Some of the specific stressors include an opportunity for expression as Wadeson describes. "Given the helplessness and confinement that many children experience in the hospital, art therapy can provide an important outlet for the ventilation of feelings, as well as offering one arena in which the child can take control" (2000, p.123). Making dolls could give the children a sense of accomplishment and a sense of mastery in a time when parts of their lives might feel out of their control. This gives the children a sense of pride, transforming them into an active participant in their recovery, instead of a victim of disease (Councill, 2003). Another way art therapy can help is to provide a distraction from the medical procedures or help to focus the child's attention in a chaotic situation. The children could reenact a scene they experienced, playing out a scene in which they become the doctor and the doll their patient. "Medical art therapy offers a modality that is at once comforting, challenging, and enjoyable, giving children hope and a voice in expressing their experience of serious life-threatening illness" (Councill, p.218). Children in hospital settings have sometimes experienced traumatic events from injury, invasive medical procedures or abuse. Third, art therapy offers a space for children to address their trauma. "Art is well suited as a modality for self-expression with children in trauma because it may be easier for them to use visual modes of communication before being able to talk about the trauma" according to Malchiodi (1999, p. 177). Children in hospitals might be sheltered from certain experiences because of frailty or disability. These children should be encouraged to safely explore a variety of materials and experiences in art therapy as a contrast to the limited encounters of the child outside of therapy (Kramer, 1998). The therapist provides a space for the children

where they are able to create without impediments. To fully help the child in therapy, the therapist must "provide experiences that may seem out of reach or must find materials that can be handled in spite of a child's handicaps, so that each child can reach whatever level of artistic production he may be capable of" (Kramer, 1998, p.223). This is conducive to an environment in which the child is able to grow, change and realize his/her full potential.

Process in Art Therapy

As an art therapist one's own artistic production can influence directly, or indirectly, the art that our clients create. Knowing what the client might potentially experience in the course of art-making helps better prepare the therapist for the issues that might arise during the therapy session. Alison Fox (2000) created a heuristic-based inquiry Master's research paper examining fiber arts, creating numerous pieces using a variety of methods such as stitching, beadwork, paper making, and weaving. She discussed at length her experience with the materials and also of the process and her insights about the art pieces afterwards. Fox created her artworks using all of her senses and gives a complete picture of the experience of the person sewing. She discussed metaphors associated with stitching. Fox compared the act of stitching to suturing in medicine. "Paradoxically, the needle worker damages the cloth in order to create with it, as in medical practice a wound may be wounded further with stitching in order to facilitate healing" (pp. 88-89). Fox examined the process of the art production from several viewpoints to give a more complete view of her experience. Fox suggests ways in which the fiber arts can be used with clientele in art therapy. She discusses the

potential reactions that clients could have to the textiles and stitchery. "Individuals' responses to sewing are likely to vary; while some may find it relaxing or soothing, other may find it frustrating or tedious" (p. 89). The level of frustration in sewing is especially relevant for children. Awareness of this frustration was important in presenting the sewing activity to the children.

Process, as in the art production, in art therapy is an important aspect of the current study. The experiences of the children as they make the dolls will be a central focus of the analysis of the material. Ward (1999) examined the creative process through her own art making, relating the movement and body language to the mental state of the artist/client. This is to say that a client who attacks the art materials is probably not in the same frame of mind as someone who timidly approaches the art. Ward aptly described the way in which we can learn through making art: "The actual physical struggle and contact between the medium and the body is so important because it is through the struggle that creative solutions are often found" (p.111). The children involved in this study might struggle with the new materials or techniques that I introduce to them. The children will also have individual reactions to the material and to the activity. It is important to respond to the needs of the child and their feelings about the activity of sewing. The child might feel frustrated or want to give up and the therapist needs to be sensitive to the requirements of the child. Helping the child through a difficult period or allowing for a break might facilitate the child to continue the project. Observing how the child reacts through verbal and non-verbal cues will indicate the frame of mind of the child as the doll is made, creating a better understanding of the process.

Research Methods

Case studies usually involve a single-case design, where the researcher will examine one person in depth. In a multiple-case design, the researcher is able to examine the similarities and differences in the cases being studied. Using a multiple case model provides a more stable foundation than with a single case study (Willig, 2001). Another benefit to studying multiple cases is giving the study a broader view of the topic and to show individual variations to the art making activity. No case study could investigate the whole individual and their complete history. The case study is a little like a snapshot, where a person is captured in a specific moment in time. The purpose of the subsequent case studies is to examine the technique of doll making with children in art therapy. Therefore the cases will consider more of what the children experienced while making the doll than the experience of the child in therapy as a whole. The snapshot will focus solely on the doll making of the children, showing the context in which they were made.

The researcher who includes biases and assumptions in the research allows for a more complete picture of how the research took place. Banister, Burman, Parker, Taylor & Tindall (1994) state "there is a need to realize that inevitably you as the researcher will have biases, interests, predilections, values, experiences, and characteristics that will affect your research and your interpretations of it" (p. 172). The researcher is then being transparent about the assumptions by including him/herself as part of the research analysis. Steier (1991) explained the necessity for reflexivity in research "by holding our own assumed research structures and logics as themselves researchable and not immutable, and by examining how we are a part of our data, our research becomes, not a self-centered product, but a reciprocal process" (p. 7). This is a more holistic approach to

research where all parts of the research can potentially be examined along with the traditional data analysis. This permits openness in the research process and demonstrates the humanity of the researchers. Reflexivity permits for the possibility that clients may not fit into our predetermined categories or assumptions. By using reflexivity the researchers become more aware of his or her own thoughts, which then allows for a more open dialogue with the participants about their experiences. I want to include my own experiences in this research because I feel they are relevant to how I will interpret the artwork of the children within the therapeutic context. As a researcher/therapist I cannot simply observe the behaviours of the children, I must participate in the activity thus influencing the outcome. With all the children, the dolls were a collaborative effort between the children and me. My responses or countertransference to the children is an essential component of the research. The children did not speak much while making the dolls so my interpretations are based on body language and how I felt in relation to what they were doing.

The doll is a mystical creature that takes on our hopes, fears, and our personality traits. We imbue them with parts of ourselves that are sometimes hidden. Dolls have always fascinated me. They possess so much that is beyond the fabric and stuffing from which they are made. The doll allows a distancing from oneself while remaining close to what is important to the person holding the doll. They have been used therapeutically with children in hospitals, in therapy sessions and in community settings. The dolls can teach children about their illness or make them feel more at ease with their bodies. Doll making has been around as long as humankind has been making art. They are made in

our own images, the image of our ancestors or something from our imagination. Stitching represents tradition and memory. It requires patience to complete, giving the person a sense of accomplishment by finishing it. A doll comes to life in the hand of the maker. When children play with their dolls, they immerse themselves into a fantasy world while showing what their own world is like. This play is an important part of the life of the child where they can learn about their environment and integrate new information. Play therapy allows children to be themselves and to work through issues by playing them out. The detachment playing permits gives the children more freedom in what they bring to the session. This research will examine four children and their process in art therapy as they create their own dolls. The multiple-case design allows for comparison to be made between the cases. The focus is mainly on the doll making activity, providing snapshots of the children in therapy during this period. Part of the process of this research is including my own perspective to the data collection. Working closely with the children to create the dolls, I could not present the material objectively. I made dolls of my own to experience fully what the children would go through during the course of this research. I learned to make dolls at an early age and this activity has remained with me to this day. They seem to come alive, to have stories of their own to tell. Dolls are comforting, familiar; providing companionship and teaching. They tell us about ourselves and about how we relate to others.

Methods

Personal Exploration.

As part of my preliminary research I made several dolls of my own before introducing the topic to the children. I experimented with a variety of techniques and approached the doll making from several perspectives. Part of the experimentation involved looking at the activity of doll making within the art therapy context. It is not a widely used technique. One of the goals of this study is to expand the types of materials that are used by art therapists in practice. The materials used in art therapy tend to rely on the basics of painting, drawing and sculpture. Contemporary art utilizes expansive materials to create art and the art therapy practice should be updated to incorporate new ways of making art. Fox (2000) astutely describes how fibre arts are perceived in art therapy and in general: "As art therapy is marginalized within the field of psychotherapy, so fibre arts are marginalized in art therapy and the art world" (p. 9).

I gave myself some challenges to experience as I made the various dolls. The goal was to prepare myself for the potential issues that could arise for the children as they made their dolls. One of the first dolls that I made was Lefty (Figure 1). I wanted to make a doll as close as possible to what I thought the children would make. She was made of felt with a simple body outline. I stitched the doll with my non-dominant hand, to simulate the dexterity and experience level of a child sewing. Sewing this way helped me design the project for children with the hopes that it would be easier for them. This doll took me much longer

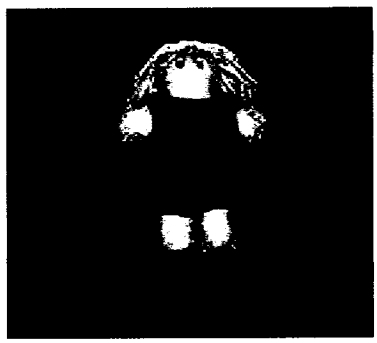

Figure 1. Lefty doll

than I had anticipated and also my level of frustration with the project was higher than when I normally sew. A pair of dolls that I made during this process gave me insight into what to expect from the children. I made Dismemberment Dan and Acupuncture/ Voodoo doll with a darker side of dolls in mind. I knew that the dolls made by the children might not be happy and might reflect some of the fears of the children. Dismemberment Dan is a cocky doll that is careless and fears nothing. I saw him as a kind of extreme athlete who is willing to risk life and limb for a thrill. His arms and legs are attached with Velcro so the user can detach the limbs as they so choose. I also set out to make a self-portrait doll. Initially this doll would have been to scale of my body, but this proved too difficult. I modified a pattern for a doll and made her out of muslin. I used a sewing machine to stitch this doll because this doll was about 3 times larger than the previous dolls while all the others were sewn by hand. It was not until the doll was completed did I think that it resembled me in some way. Her face was drawn by hand and her hair was hand stitched on. The clothes were created from my personal belongings, her undergarments were made from pajama remnants and her dress was made from a piece of hand dyed silk. She is a self-portrait as the Princess and the Pea (Figure 2). I had been

Figure 2. Princess doll (self-portrait)

working for several months on my own artwork within the context of this fairy tale. I identified with the sensitivity of the princess. In my own personal exploration I saw my emotional sensitivity or empathy as an asset and not a liability. I found myself being very protective of this doll, much more than the others. The time spent making this doll was also much longer than the other dolls I made. Most of the other dolls were made in about 5 to 10 hours while the princess took about 25 hours to complete. It was interesting to me that I invested more in a doll that was meant to represent myself and that I felt maternal towards this doll. It was as if I was taking care of that part of my personality in caring for the doll. Sewing on a sewing machine is quite a different experience than stitching by hand. With the machine there is less control over the materials yet it shortens the time. Hand stitching is painstaking work that requires sharpness of the needle, fine motor skills and attention. My final project in the exploration of the media involved presenting the doll making to my classmates in art therapy. As part of a class presentation, I gave the instructor and the 12 people in the class a kit to make a doll. People worked on their dolls as I presented the research. The kit contained a doll outline cut from muslin, polyester filling, a needle and thread. These doll kits were a close approximation to what the children would make. The reactions to the exercise ranged from animated, to loathing, to indifference. Some worked carefully while others were more carefree with the stitching. One classmate even made accessories for her doll and it became the mascot of her sports team. This was a good sampling of the reactions to the doll making activity. I knew some would enjoy it less but I did not expect such a diverse range in interest in this project. This would prove to be similar to the reactions of the children to the doll making.

Introduction of the Doll Making to the Clients.

For the study, each of the children was presented with the doll making materials in the therapy sessions. I did not want to be intrusive with the doll making, but simply offered it as an option to those who were interested. I kept the materials separate from the regular art supplies to reiterate the separateness of the doll making. When the children spotted the felt squares, thread, polyester fill, and plastic beans I would explain what they could do with the materials. I explained that they could make a doll, or a stuffed animal with the fabric. Some children then decided to make dolls while others continued with the other art materials and play things.

I struggled with the idea of directing the children towards a specific activity in therapy when I had been non-directive with them up until that point. I gave the children choices throughout the doll making process so they could retain a sense of control during the sessions as before. Coming from an art education background I also struggled with how much teaching of technique should go on during the therapy sessions. Teaching can sometimes divert the clients from their personal graphic style, adopting the style of the therapist. I gave a basic demonstration of sewing to each of the children before starting and reminded them that they could ask for assistance from me if needed. Felt was chosen instead of cotton fabric because it frayed less around the cut edge and was easy to stitch with a blunt tapestry needle for safety reasons. I anticipated that the doll making activity would be frustrating at times for the children so I would take steps to try and reduce this during the sessions. The obstacle with the felt was that its thickness was irregular and sometimes proved impossible to stitch through. The children required more help than I

originally anticipated, but I quickly adapted to this by offering more assistance when asked for or when the child struggled and I kept a close eye on the work the children did.

Participants.

What follows is four case studies examining the process of making the dolls with each of the four children who chose to participate. In the analysis of the activity after the case studies a discussion of the children who chose not to make dolls will be included. Two boys and two girls participated in this study. Each had their unique issues to work through during the course of therapy. James[1], age 10, was an inpatient on the psychiatry ward for Oppositional-Defiant Disorder. He also had a rare genetic disorder that manifests itself as minor physical abnormalities. The second child was Alex, the youngest at age 6, who was seen on an outpatient basis. He was in therapy for depressive symptoms as a result of his life long hemolytic anemia. He too had minor physical abnormalities as a result of complications during his birth. Emily, age 7, was the third child and was seen as an outpatient for her aggressive behaviour at school. Emily had a multitude of problems, including epilepsy and had been sexually abused at a very early age. Last, Isabel, the oldest child in the study was 11 going on 12 years old. Art therapy was recommended for her, on an outpatient basis, because her brother had recently been diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) and the psychiatrist felt that Isabel could also benefit from therapy.

[1] Names have been changed to protect confidentiality.

Chapter 2: Emily Case Study

At the time of the therapy Emily was 7 years old. She lived with her mother and older sister, 11 years of age. Emily's mother had just recently finished her nursing degree and had been working as a nurse for a few months. Emily and her older sister Rachel have different fathers. The family has no contact with either father. Emily and her sister and mother lived with her maternal grandparents until her mother was able to find a job and support herself and her children and get a place of their own.

Case Description

Emily displayed some problems from an early age. At four years old Emily was seen by a speech therapist and an occupational therapist. Emily showed a speech delay and her words were quite slurred. She had gross motor coordination problems where she was unable to hold anything in her hands or to walk without assistance. According to the file, the mother refused further treatment in both these areas.

Emily was in grade one at the time we began working together. Emily had suffered from epilepsy since she was 10 months old. During an assessment for Emily's aggressive behaviour at school, her older sister implied that there was something that the family was not disclosing. Rachel, the older sister said "mommy don't tell them what auntie did to us". Rachel was taken aside and she revealed that a young aunt had sexually abused her and Emily. The aunt was Rachel's paternal aunt but not related to Emily. The authorities were alerted and the family went through the legal steps necessary to press charges. By law, the children must testify before they receive therapy so the therapist does not taint their view of what happened. This occurred approximately six months before I started working with Emily. The abuse took place at the church the

family attended. Emily and her family members were active in their church. According to the social worker, the abuse had taken place for about 3 or 4 years for Emily and possibly longer for her sister Rachel. Rachel felt guilty that she did not report the abuse and that her sister was also abused and she felt somehow responsible. The aunt would allegedly offer treats to the girls for compliance and to keep the abuse a secret. According to Rachel, Emily received the promised rewards from the aunt but that she did not receive any rewards. There was some jealously over this between the girls. At the beginning of her school year Emily displayed some inappropriate behaviour, by exposing her vagina to her classmates for which her schoolmates continued to tease her. The sexual abuse report in the medical file did not contain any details of the abuse.

Emily has a serious form of epilepsy, which has caused her to be admitted to hospital on numerous occasions. According to the psychiatrist, seizure disorders of this type can lead to permanent diminished cognitive functioning. It is impossible to determine if this is the case with Emily as she has had epilepsy her entire life. In school she was average or slightly below the class performance level.

Emily is a charming girl of normal height and weight for her age. She looks well cared for except for her hair that always looks like it needs brushing. Usually when I met her in the waiting room she was eating some sort of chips or other snack food. Her speech was difficult to understand at some points even when she repeated her statement. Emily was seen weekly in art therapy as an outpatient for 7 months. The sessions were initially 45 minutes, but I had to watch Emily in the waiting room until her mother came out from her own therapy. Consequently I adjusted the time to one-hour sessions.

Emily was referred to art therapy by the social worker on the outpatient team at the hospital where I was an intern. The social worker initiated treatment for Emily, her mother, and Emily's older sister. The therapy could only start after the legal aspects had been looked after. The family and their individual therapies were discussed during weekly team meetings at the hospital. A social work intern worked with Emily's sister using a directive approach for her to be able to work through the abuse. The social worker saw the mother at the same time as the children. According to the social worker Emily's mother felt extremely guilty for what had happened to her daughters.

Early on in the sessions, Emily was quite bossy with me, insisting that I follow exactly what she drew or what she told me to draw. Her drawings were somewhat rigid, both in content and style. For the first three sessions the subject matter was vegetables. Food was a reoccurring theme both in her art and play. Emily used the puppets and dolls in play mainly as characters to feed. Emily also wanted to be the one feeding me. I wondered if this was her desire to be fed or to give back to me the attention I fed to her.

Midway through the sessions with Emily she began making messes. She would mix all of the liquid paints together making non-descript muddled paintings (Figure 3). Emily was constantly getting paint on herself, on me, on the floors during this phase of the therapy. Additionally, in her play she would construct precarious towers out of wooden block that toppled over easily. Emily's messy painting phase prior to making the doll is

Figure 3. Rainbow

the earlier form of play that Irwin (1983) describes as sensory-motor play. This type of play involves experiencing the materials through all the senses and is typically seen in pre-school aged children. Emily did this by pushing the paints around and discovering what colours she created. In making the doll Emily engaged the doll in the more age appropriate pretend play. This type of symbolic representation as seen in pretend play is only possible at a certain level of cognitive and emotional maturity that develops between the ages of two and six years, according to Irwin (1983).

Description of Sessions

First session doll making.

Emily initially did not take to the materials that I presented. Emily chose to make a doll three weeks after I introduced the materials. Emily picked the green felt and thread and wanted to start right away. I had to slow her down and explain the steps to her. She told me she wanted to do a person so I helped her to draw the outline of the figure. We pinned the paper to the fabric and Emily cut out the figure along the pattern. She did quite well with the cutting, better than I had expected because she had been so shaky the week before. In the previous session she repeatedly dropped the paintbrush she was using, she knocked over the water cup and her speech was more slurred than usual. I worried about her because of her diminished coordination so it was good to see her doing so well with the doll. She finished cutting out the figure and I asked her if she had ever sewn before. She said no. I gave her a little demonstration of how to sew by starting to sew her doll. I repeated the steps both in words and in demonstrating as I go. "Down through the top, and pull the string through". I found that saying a little something would help the children to remember what to do and eventually they would say the phrases on

their own. I handed the doll to Emily and she started sewing. I held the doll as she used the needle and thread. I had to gently remind Emily numerous times that she was too close to the edge. I would simply say "too close" and she would move the needle in. About half around the doll I again said "too close" and Emily said, "No I think it's just right". I agreed with her and resisted commenting again. Emily let me know quite clearly that she wanted some space to make mistakes and do it on her own. Axline (1947) states "acceptance of the child and a firm belief that the child is capable of self determination" is an important component of non-directive methods of play therapy (p.19). Emily would accidentally loop the thread on itself, making a knot in the stitch. Most of the time Emily was unaware of the knots, but she noticed when sewing in between the legs of the dolls. After twice commenting that it did not look right, I asked her if she wanted to fix it. She said no and decided to continue sewing. I noted that the part of the body that did not look right to her was in the genital region but did not mention this to her. I am unsure if this related to her abuse or just coincidence since Emily never spoke of the abuse during the entire time I saw her in therapy.

Figure 4. Emily's doll outline

Emily was excited about her doll and worked quickly (Figure 4). She commented "arts and crafts stay with you but sewing, I get to take it home". I empathized with Emily, saying I knew she wanted to take it home but the doll would have to stay with me. I told her I would keep it safe for her. I told Emily that she did a great job on the doll,

especially since she had never sewn before. She was so excited about the doll and wanted to show her mom. I reassured her that she would have a chance to show her mom the doll after the session was over. Emily worked quickly and she was able to finish sewing the outline of the doll. We only had a few minutes left so there was no time to stuff the doll. Emily wanted to make a dress for the doll. I let her know that she would be able to make the dress, and stuff the doll in the following session. Emily regularly had difficulties ending the session, but finally came with me when I told her that I would keep her doll safe, after showing it to her mother. I asked her if the doll had a name. She told me some unusual name, which I promptly forgot. Emily would often make up names that I would forget soon after. As we waited for her mother in the waiting room, I took off the safety pin that was left on the doll. Emily wanted to take the pin home. I refused her request but reminded her that she would see her doll the following week. It took quite a bit of convincing for her to give me the safety pin. I was struck by her insistence on taking something home since she did not usually make such a request. I felt she had a difficulty ending the session since she was so proud of what she had done and did not want to let go of that feeling. When her mother arrived she praised her for her doll and seemed quite impressed by her work.

Second session.

The second doll making session took place two weeks after the first session because her mother was unable to bring her to the session. The first step was to stuff the doll. Emily chose to stuff the head with cotton batting and the rest of the body with the plastic beans. She was able to stuff the head by herself but needed a lot of help to stuff

the body. When the doll was stuffed I held the doll closed while Emily finished stitching it up. She allowed me to help her more as she worked on the doll. I helped Emily finish the doll by securing some knots at the end. Next Emily wanted to make the face for the doll. She picked her colours and wanted to start immediately. I showed her how to make one eye so that she could do the other one herself. She had trouble with her eye and she wanted me to do it. I tried to encourage her to do it herself, but she insisted that I do it for her. She did not seem frustrated but she was insistent that I help her. After the eyes Emily wanted me to do the lips as well. I asked her to mark where she wanted the lips and I would check in with her after every couple of stitches. This was such a change from when I first started working with Emily. Earlier she would insist that I copy exactly what she made and would become easily frustrated if I was unable to replicate her work. When I was permitted to draw something on my own, she would choose the colours for me and decide the subject matter for me to draw. Working on the doll was the first time Emily willingly allowed me to help her with her art. I did not have to make a parallel doll as she worked; she was able to focus on her own work instead of what I was doing. When I finished the bottom lip Emily wanted me to do a top lip. I thought the mouth looked fine as is, but in keeping with Axline's non-directive approach, I responded to her request. Emily again drew on the doll as a guideline for me. I was showing Emily a new technique yet she needed to be in control of the situation by making guidelines on the doll for me. Emily sat quite close to me as I stitched; I turned the doll so she could see as I stitched. Repeatedly Emily exclaimed how nice the doll was and I would reaffirm that yes, she was doing a great job. I had shown Emily how to tie knots in the thread at the end of the last session. She asked me if she could tie the knots and I agreed. I felt like

this was Emily taking care of me because I tied the knots for her several times in the previous session. She wanted to reciprocate the care I had given her in therapy by helping me out. Then Emily wanted to make hair for the doll. She selected the colour for the hair and then asked me how to make hair. I showed Emily how to make the hair. I bunched the threads together, by looping the thread on itself repeatedly and then tied an extra string around the bunch to secure it. Emily looked perplexed, not knowing how this would become hair. I showed Emily how to fasten the bunch to the doll, first demonstrating and then passing the doll to her to complete. When finished she tied the knot. By cutting the loops in the thread, it became like strands of hair. I cut one side and Emily cut the other side. She exclaimed "Oh it really looks like hair now!"

I asked Emily the name of the doll, hoping she would repeat the name she gave it the previous session. Emily did not remember the name she had given it so she came up with a new name. She called the doll Cottonbeans because it had plastic beans in the belly and cotton stuffed in the head (Figure 5). Emily then wanted to play for awhile so she went to the box containing the play material. She played with the blocks, building a precarious tower as she had done numerous times before. After about 5 minutes, Emily went back to the table. Regressing to an earlier stage is easier for her and allows her to take a break from what she is less familiar with (Rubin, 1978). Emily stated that she wanted to make a dress for Cottonbeans. I reminded her that we only had about ten minutes left in the

Figure 5. Cottonbeans

session. She went through the fabric and picked an orange piece for the dress. She then picked the matching orange thread to sew the dress. I showed Emily how to trace the outline of the doll to make a pattern for the dress. I helped her pin the fabric together and then she cut the dress out. It took her a few minutes to cut out the dress as she had a bit of trouble using the scissors. She wanted to start stitching the dress so I reminded her we only had a few minutes remaining. She started stitching and ran out of thread quickly (Figure 6). I let her know we had to end the session because our time was up. Again Emily had a difficult time ending the session. Emily wanted to take the doll home and bring her back the following week. I reassured her that I would keep her doll safe for her. She was holding a scrap piece of fabric in her hand. I suggested that she could take the piece of fabric home with her, remembering her desire to take something home in the previous session. Reluctantly she came with me to the waiting room to meet her mom. I consulted the psychiatrist in my supervision about Emily's desire to take something home. She suggested that Emily wants to take me and the good feelings she gets from therapy home with her. The psychiatrist suggested that I allow her to take a little scrap of fabric home as a kind of security blanket

Figure 6. Dress for Cottonbeans

Third session.

Again Emily missed a session before I saw her again the next week. Her mother seemed resistant to bringing her daughter to the therapy sessions. Each week there was another excuse why they were unable to make it. Emily was excited by her doll when she

spotted it on the table. She requested to start right away. I helped her stitch the top part of the dress, where the shoulders were. I had to remind Emily which parts of the dress were not to be stitched up for the head, arms and torso. It seemed like she was unable to conceptualize how the dress was going to go on the doll. I worried that the dress would be difficult to put on the doll if it was fully sewn (it was a little on the small side) so I suggested a technique that I had discovered while making one of my own dolls, Art Therapist Barbie. I had wanted Barbie's sweater to look flattering yet stylish and this definition did not include a giant patch of Velcro on the back of the sweater. My solution was to sew one side of the sweater then stitch it on to the body of the doll. So Emily and I employed this technique with Cottonbeans. It was snug but I knew the felt would stretch out a bit. Emily needed quite a bit of help again with the stitching. She needed constant reassurances that she was doing a good job and that she was capable of stitching on her own. When the dress was finished, Emily declared that the doll needed pants. I wondered out loud why the doll needed pants if the doll was wearing a dress. Emily stated that this was a shirt and not a dress and that she, the doll, needed pants. Emily went over to the fabric pile and selected the colours for the pants and the thread. She was able to create a pattern using the method I had shown her for the dress and traced the pattern directly onto the fabric. I pinned the sides together for her and she cut out the fabric. The pants were ample enough that she was able to stitch the pants before putting it on the doll. With a little help Emily was able to tie the knots in the thread as she stopped and started each section of the pants. I cut the string for her and I helped her put the pants on the doll. The pants were snug but fit. As I put the pants on the doll I was reminded of the numerous times when I took care of Emily in such a way. Each session I would help her

with her jacket, boots or roll up her sleeves if needed. I tucked the pants under the dress, as it would not fit the other way, and I commented that sometimes Emily came to therapy with her school tunic and pants on. Emily was surprised that I remembered this and commented "that's right, she's dressed just like me". Cottonbeans (Figure 7) appeared to be a self representation of Emily, and she confirmed this indirectly through her comment. According to Rubin (1978) "a child represents himself and his problems in more or less disguised ways, which offer symbolic protection for the expression and communication of unacceptable thoughts" (p. 73). Emily often spoke of herself indirectly through her doll play.

Figure 7. Cottonbeans completed

She expressed her desire to make a hat and boots for the doll but we were almost at the end of the session. Emily did not make a fuss this time and went easily to the waiting room. This was also the first time that she did not insist on showing her accomplishment to her mother.

The following sessions were again cancelled by Emily's mother. Several weeks went by. My internship was coming to an end and I worried that I would be able to have a proper termination with Emily. I called her mother and explained how important the

last session is. The mother agreed to bring Emily. The session was cancelled and I again called the mother. She made excuses and I suggested an alternate time for my session with Emily. She again questioned the usefulness of art therapy for her daughter. I let her know that I promised Emily that she would be able to take home all her artwork at the end of our time together, and I would like a chance to say goodbye to Emily. Her mother agreed and I was able to give Emily her artwork back. She was most excited about being able to finally take her doll home.

Discussion of Emily

Repetition in the play and art shows something of significance for the child. A child will repeat activities in the play for several reasons. The child will use the repetition as a way of mastering something, repeating something that might have been traumatic for them, or to show the significance of a concept to the therapist by getting the therapist to examine the play with more depth (West, 1992). Emily's repetitions seemed to represent all the reasons for reworking something in the play as stated above. She often repeated scenes in play or images in her artwork prior to making the doll. She seemed stuck with certain ideas, repeating them over and over. Stitching is a repetitive activity that perhaps allowed her to focus on a single activity for several sessions. The stitching satisfied her need for repetition.

Throughout my time with Emily she repeatedly asked me to draw vegetables or used them in play. Her doll that she created reminded me of these vegetable drawings. The colours on the doll reminded me of vegetables, with the greens, the orange and

purple. Also, Cottonbeans reminded me of a scarecrow, whose purpose it is to protect a garden or field from damage.

During the play she was always feeding me, but at the same time restricting what kind of food I could ask for. I was never allowed to ask for anything other than vegetables. When asked about the symbolic meaning of the vegetables for Emily she stated that "vegetables help you grow big and strong". According to this statement, Emily was captivated by vegetables because they were something with special symbolism that she thought could help her conquer her illness.

Children who have been abused are often desperate for nurturance. This can manifest itself with the food or with the art making, using up excessive amounts of materials to create art. "They may also want to take quantities of materials with them at the end of the session [...] to fulfill an internal need to replace or replenish something perceived as lost" (Malchiodi, 1997, p. 24). Emily exhibited this when she expressed her desire to take the doll home, that it was separate somehow from our regular art making. This desire for nurturing can also manifest itself in the child being dependent on the therapist. They may ask for help repeatedly or need close physical contact. This dependency should be discouraged but "positive, appropriate touch for the needy child can be extremely beneficial for development of self-esteem and self-worth" (Malchiodi, 1997, p.24). Emily was often very close to me as she stitched, almost sitting on my lap, even though the sewing required close proximity.

Early-onset epilepsy generally carries with it a poor prognosis in every part of the growth of the child, mentally, physically, emotionally, and cognitively (Taylor, 1989). In general, children with chronic illnesses have certain disadvantages in term of their growth

and well being. The child may identify with the illness and it would then become part of the self-concept of the child (Taylor, 1989). Emily showed this in her play where two dolls fell over "Oh they're having seizures". For her, the epilepsy is a normal occurrence. Children with epilepsy would see themselves as "epileptics" where the illness becomes the central focus of the identity. Epilepsy can cause impairments in judgment, impulse control, apathy and indifference, and temper tantrums (Taylor, 1989). Children with epilepsy sometimes display difficulties in the perception of personal space "which create social difficulties for children with epilepsy whose cerebral dysfunction seems to render them blind to their intrusiveness" (Taylor, p. 130). This obliviousness to the space of others is apparent in Emily. She showed this lack of awareness in space with me during the sessions. She would sit extremely close to me, lean into my space and expect inappropriate behaviours from me for example leaning in to get me to blow her nose for her instead of doing it herself. This could also come from her being abused (Malchiodi, 1997). However, as mentioned earlier, this was not the focus of our therapy sessions so it is difficult to conclude. Through the course of the doll making Emily showed improvements in the areas of motor skills and also in her ability to collaborate with me in the making of Cottonbeans. The week prior to starting the doll her co-ordination was seriously impaired. She could barely hold a paintbrush and she had noticeable tremors and an unsteady gait. By the end of making the doll, her motor skills were greatly improved and she was competent in stitching on her own.

The one time during the course of her sessions Emily drew a full person and not just a head, she drew it on the blackboard, and the figure looked quite disjointed and distorted. Malchiodi (1989) stated "this particular type of disorganization in drawings

may occur in those children whose abuse has been chronic since early childhood" and that "long term trauma could dramatically alter thought processes" (p. 146). The doll that Emily made was much more coherent although this was partially due to me helping her with the initial outline of the doll. There were two areas of the doll that caused me some concern. The first was the crotch area and the second was the mouth. When Emily stitched in between the legs of the doll she fussed that it did not look right. It is conceivable that this related to her experience of sexual abuse but our time together was not spent on this issue.

Bach (1990) worked with numerous children in art therapy and discussed the symbolism of the colours children used it their art. Red is often associated with trauma or injury, or "a burning problem" (p. 45). Emily made red pants for the doll. Again this could be interpreted as a sign of trauma to this part of her body. Second, the mouth on the doll was also a concern for me. Initially the mouth was turned up in a smile, but Emily insisted that I stitch a top lip as well, turning the smile into a scowl. The mouth was disproportionately large which may relate to the need to be fed as mentioned earlier.

Emily derived a great deal from making the doll. Her excitement and pride in making the doll was contagious. She did not need reassurances about her ability; she was able to see what she had accomplished on her own. The doll making augmented her self-esteem from learning a new skill and allowing her to see what she was capable of doing. The doll making permitted an increase in manual dexterity, working like occupational therapy for Emily. Most importantly Emily was able to cooperate with me in the making of the doll. Her bossiness that I had seen throughout my sessions with her seemed to reflect what Emily goes through on a daily basis. Most of the adults in her life and her

sister tell her what to do. In therapy Emily mirrored this by telling me what to do. Through the course of making Cottonbeans, Emily learned to listen to me, and to listen to herself as well allowing for more of an advanced cooperative play (Schaefer, 1983). By telling me when she was doing fine on her own, she was able to take care of herself. When Emily asked to tie the knots for me, she showed me that she wanted to care for me, like I had cared for her.

Emily was able to leave her regressed paintings for the more structured activity of doll making. Her prior attempt at drawing a human figure was quite disorganized. Her doll was a much more complete representation of the body. I saw that perhaps they were both symbolic of Emily. The disjointed figure was how she viewed herself and the doll being her ideal self, whole and happy. Rubin (1978) states "it is important to keep in mind that self-representations may reflect the way things realistically are, or may be projections of the child's fantasies" (p. 73). Emily worked on Cottonbeans for three sessions, exceeding my expectations of her abilities. She showed me that she was capable of accepting help when she needed it and also that she could work on her own. She stitched both the doll and the clothing for the doll. This was the final project that Emily worked on in our 7 months together in therapy. In making the doll Emily was much more coherent and focused than I had seen in our previous sessions.

Chapter 3- Isabel

Isabel was almost 12 years old at the time I saw her in art therapy. Art therapy was recommended as a way for Isabel to be able to talk about her problems and issues away from the attention of her brother who had recently been diagnosed with ADHD. He is older than Isabel and he tormented her more than the typical sibling rivalry. Isabel was seen in art therapy for 12 sessions. Each session lasted 45 minutes and she never missed a session.

Case description

I was unable to find out a great deal of information about her developmental history because the intake interview was focused on her brother and there was nothing in her hospital chart to indicate anything other than a normal development with Isabel. Isabel also had another brother, 19, who had moved out of the parental home and was living quite a distance away. Her 14 year old brother was seen in art therapy with another art therapist concurrently.

Isabel was a thin girl who appeared very shy in the first session. By the middle of my time with Isabel, she showed me more of a mischievous and outgoing side of her personality. She would concoct elaborate dance routines for me to follow and insisted we play hide-and-go-seek in a small room with nowhere to hide. She seemed more like an adolescent in some respects than a girl of 11 yet at the same time had a large capacity to play. She was interested in boys and did drawings of her name, or graffiti, which is a stereotypical form of drawings in the adolescent age group (Linesch, 1988).

Description of sessions

First session doll making.

In our second session together I laid out the felt and sewing materials in addition to the regular art materials. She sat in front of the art materials and just looked at them. She did not seem interested in creating anything. Isabel asked me to give her a project to do. At first I suggested nothing, remaining nondirective, and let her struggle through her feelings about making art. She doodled with the markers drawing her name over and over. She asked me what she could do with the fabric. To keep consistency with what I told the other children I suggested she could make a doll or animal or anything she wanted. I switched to a more directive approach with Isabel to help reduce her anxiety regarding art making. "It is the art therapist's job to know when to offer what kind of materials, when to make suggestions or give active help, when to refrain from interfering" (Kramer, 1998, p.139). She chose a light skin coloured piece of fabric and said she would make a doll. She frowned and hesitated before starting. I knew she was not happy with her artistic ability so perhaps her hesitation related to her self-esteem and not my directives. She needed help with steps just as the younger children did. I suggested that she do a drawing of what she wanted before starting on the fabric. I did this with all the children to break the task into smaller steps and so they could work towards a specific idea and to foster greater self-esteem. She drew a face that was cartoon-like and then wanted to start on the fabric. She repeated the image on the felt, although it was more difficult to draw on the felt with markers. She was then ready to start. She cut the outline of the face on the fabric and then chose a colour for the thread. She chose pink and stated that she hated the colour pink. She giggled after saying that as

she looked over at my pink sweater I was wearing. I felt it was a way of her stating her separateness from me, which was appropriate for her age. Despite her age, she seemed to require as much help as the younger children. I showed her a few stitches and then asked her if she would like to continue. Isabel wanted me to continue stitching for a bit longer. After stitching about an inch or two I handed the doll to Isabel to continue. I held the doll as she stitched, consistent with my approach with the other children. She told me she didn't like sewing because she hated getting pricked by the needle. I reassured her that the needle she was using was safe and she would not get hurt. She was using the bluntest needle available. Isabel stitched slowly, but carefully around the face. She chose to stuff the head with the plastic beans. This gave the head the feeling of a bean bag. I wondered if the head would have a body. She said "no it's just a weird head". She commented that it looked a bit like her brother, but that it was not him. I found that she had trouble expressing her anger about and towards her brother. Isabel drew a face on the head and wanted to stitch it on but the session was almost over. She agreed that we could complete the doll the following week. She got up and started tossing the head up into the air. Isabel recruited me in a game of catch with the stuffed head for the remainder of the session. Later in therapy playing catch was a common theme in the sessions with Isabel.

Second session.

I was unsure if Isabel would want to finish her doll head. She seemed like she made the doll partially to please me, as if this was expected of her. I tried to remain neutral when presenting the activity to the children not wanting them to feel obliged to make a doll. I laid out the sewing material in addition to the regular art materials, giving

Isabel the choice. She picked up the head and started to pick the colours for the eyes and the lips. As she did this she spoke of her week. Isabel usually started her discussions talking about how she disliked her brother and then would move onto other topics. Isabel hesitated; she was unsure how to stitch the features onto the head. I demonstrated on one eye how to fill it in and then passed the doll back to her. I moved between a non-directive approach and a directive approach as the situation called. By giving some teaching here, I helped her gain some skill and proficiency with this medium, thus, helping develop her self esteem. Levine (1999) states how the therapist's interventions in play can help to "loosen up the play as much as possible" if the child has become restricted in play (p. 260). She struggled a bit with her stitching but she was determined to do it on her own without asking for help. Isabel finished the eye and asked how she could stitch the mouth. She did not want to use the same method as the eyes so I showed her another technique for making lines. I did three stitches and then passed the head back to Isabel. She tentatively made one stitch to see if she was doing it right. I reassured her that she was doing fine. I felt she was capable of using the more complex stitch. I did not introduce this technique to the other children as I felt it would confuse them. Isabel continued talking as she stitched. She completed the mouth and announced she was done (Figure 8). I asked if she wanted

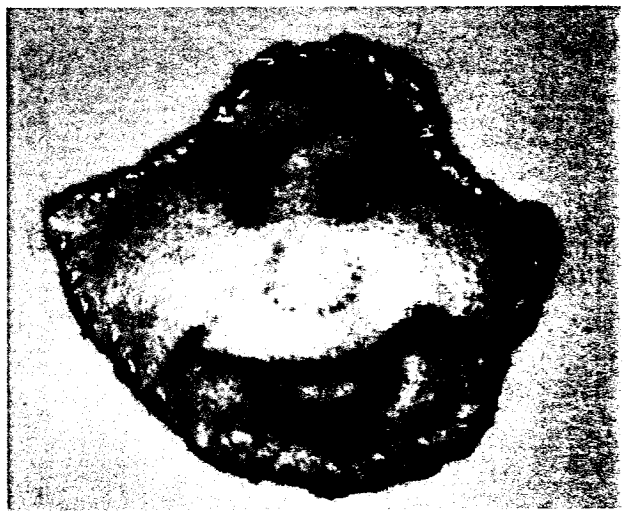

Figure 8. Doll head

to outline the nose. She shook her head, no. She paused, quietly for a moment then asked me if it was alright if she drew. Isabel took the markers and drew her name elaborately like in the two previous weeks. Drawing seemed to be an activity where she felt comfortable with her ability. Isabel did not make any more dolls during our time together, but later that session she asked if she could make a bracelet with the embroidery thread. I agreed and asked her if she knew how to make the bracelet. She said she did. She chose the colours for her bracelet. I also selected my own colours to make my own bracelet to demonstrate a technique if needed. I thought that it would also make Isabel feel more comfortable if I focused on my own work instead of watching her. Previously she had made a couple of comments about me watching her as she drew. She seemed uncomfortable having me watch her as she worked. Often clients will shy away from creating art in front of the therapist (Case & Dalley, 1992). Isabel asked if I did this with all of my clients. This is common occurrence at the beginning of art therapy. Having experienced this myself, it can be an unusual feeling drawing as someone sits by your side watching silently. Most clients lose their self-consciousness after a few sessions. Isabel often needed help making the bracelet but was reluctant to ask for it. It became a kind of joke between us. Instead of asking for help, she would stare at the threads and ask "where am I?" My response would then be "You're in the hospital". I worried this comment would pathologize her but she came to expect the comment from me and would protest if I forgot to say it. Isabel did not finish her bracelet, but at the end of therapy she gave it to me as a gift, and in return I gave her the bracelet I had completed.

In a later session Isabel would play with the doll head again stating that it was like her brother or on occasion she would call it by her brother's name. She seemed to

display guilt about her anger towards her brother. She would throw the doll head against the wall, or poke it with a pencil then on occasion apologize for doing so. Again Isabel initiated a game where we tossed the bean bag head back and forth.

Discussion of Isabel

Isabel was a girl on the verge of adolescence. She displayed the typical struggle of wanting to separate from her parents but also needing their support and attention. She expressed her desire to be close to her mother, yet their relationship seemed strained. Isabel felt that her parents favoured her brother because of his recent diagnosis of ADHD. Isabel expressed that she felt picked on by her brother but that her parents thought that she was the instigator of the mistreatment from her brother. The doll that Isabel made reflected the anger that she felt towards her brother. After making it, Isabel was able to release some of her pent up resentment by attacking the doll.

Sibling relationships can be complex especially in adolescence. Howe, Fiorentino and Gariépy (2003) described the sibling relationship as "an integral part of most children's social worlds affording opportunities for companionship, play, emotional support as well as conflict" (p. 184). In the case of Isabel, her relationship with her brother was one of mostly conflict. According to Isabel her brother received special attention from her parents because of his recent diagnosis. Her parents seemed to be at loss as to what to do about the fighting between the two children. Dunn (2002) described the risks of this type of behaviour in that the sibling generalizes the aggressive behavior in other settings and leaves the victim feeling inadequate. Isabel expressed her sense of incompetence and helplessness in her conflicts with her brother. She had few friends, and none that she could confide in about the situation. This gave Isabel little opportunity

to vent her feelings. Therapy gave Isabel a space to release her aggression in a safe and productive manner.

The artwork that Isabel created was stereotypical of children her age. She drew graffiti doodles and repeatedly wrote her name. "Children during this period focus on those things that are of paramount interest within their peer group and project them into their drawings" (Levick, 1983, p.93). Her peers were a strong influence on the types of images she created at first. There is a strong desire to fit in at her age (Rubin, 1999).

Rubin (1978) discusses that most artwork is directly or indirectly a representation of the artist. I felt that although the doll was meant to be like her brother, it was also symbolic of Isabel. She would express her hatred of her brother and then display guilt about this. When she attacked the doll head, it appeared to me that she was also punishing herself for her unacceptable feelings.

I found that Isabel viewed me as a "good sibling". One brother tormented her and the other was unavailable to her. She often expressed a wish to have an older sister during our sessions together. I interpreted this as her wish that I was her older sister. Her level of comfort with me allowed her to open up to me and express her feelings about her brother.

Isabel was only seen for 3 months in art therapy but our brief time together was beneficial to her. Her doll making and subsequent play allowed her to vent some of the feelings she had towards her brother, her parents and her friends. Her doll head that she created, along with the bracelets we made together were the only items that Isabel chose to take home at the end of our sessions together.

Chapter 4- Alex

Case description

Alex was a six year old boy who was seen weekly in art therapy as an outpatient for six months. Prior to the family assessment his mother complained that Alex wanted to be thrown out, or put in the garbage. When upset, Alex would tie himself to a chair and say that he wished he were dead. Alex suffers from hemolytic anemia and requires frequent transfusions. The psychiatrist decided not to hold a family assessment because the older brother (who has Pervasive Developmental Disorder) gets very upset when Alex's illness is mentioned. Alex also has an older sister who is being seen by a school counsellor for OCD type behaviours. Alex's family is intact. Both parents are engineers but his mother left her job to take care of the children full time.

In addition to the anemia, Alex was born with a broken clavicle. His mother suspected something was wrong with him because he would always cry when placed on a certain side. Medical professionals found out much later that he had broken his clavicle, probably during birth. This has lead to a shoulder that is slightly sloped, but he has complete use of his hand and arm on that side.

From my first meeting with him, he appeared to be much older than six. Physically he appeared as a regular six-year-old but his language seemed much more mature than that of a six-year-old. For example, he was very sarcastic during the sessions and he was not shy about letting me know if he did not like something. Graphically he painted like a typical six-year-old but the subject matter did not match his chronological age. One painting in particular was of a scene of Alex reclining on the beach with a lemonade drink. My supervisor, the psychiatrist, noted that it looked like an old man

enjoying retirement. During the sessions he was able to express anger, sadness and a sense that he was different from other children. With time, in therapy he was able to play and act like a six-year-old. When he discussed his anemia he was matter of fact about it. It was just something he had to go through. He explained that when he felt tired he needed new blood. Blood transfusions occurred about every two weeks. He said he did not mind the needles for the transfusions and constant blood tests but a recurring theme in his play was that he wanted to attack me by poking me. One activity that he did repetitively during the sessions was to clean the blackboard with a wet paintbrush. He did this during every session for several months. For a long time this behaviour was perplexing until Alex made a comment that he liked 'painting' the blackboard because he could make a mess without getting in trouble.

Description of sessions

First session doll making.

I introduced the sewing materials in the same way as I did with the other children. I placed the materials in plain view and waited for the children to approach the materials before describing what they could be used for. He noticed the doll materials the first week I introduced the materials and asked me what they could be used for. This was the ninth session that I had with Alex. I explained that he could make a doll or a stuffed animal with it. He seemed interested in the idea and asked me how he would go about making an animal. He said he wanted to make an elephant. He chose grey fabric and white thread. I suggested that he make a drawing of an elephant first. Alex told me he wasn't sure how to draw an elephant. He asked me to help him so I drew an outline of an elephant on the blackboard. He rejected my first model of the elephant so I erased it and

drew a second with his guidance. I did this to give Alex a sense of control as we collaborated on the design so it was his elephant and not mine (Rubin, 1978). He used the drawing as a model and made his own outline of the elephant. I showed him how to make a pattern to cut out the outline in the felt. Alex started cutting the fabric right away but I stopped him to show him how to pin the paper outline to the fabric to make it easier to cut. He responded by saying "oh well that makes more sense, why didn't you show me that before" he said, as he laughed. When he finished cutting out the shape he asked, "okay so now what do we do?" I had a few different needle sizes and I picked one for him that I thought would be the easiest to use because the felt sometimes resisted the needles. He tried it out and insisted that he try all the needles to see which one he like the best. He chose the largest needle and said he felt it was easier to use than the one I suggested. I asked him if he had sewn before and he said yes. He said "but I don't remember what to do". I demonstrated by doing a couple of stitches and let him continue from there. It was easier for him to sew when I held the fabric. He was quite focused on what he was doing and stayed with the activity for the duration of the session (Figure 9). This was the first time he was able to do a single activity during the session. Usually his attention would last 10-15 minutes on an activity and then he would move on to something else. Alex was slightly disappointed that he did

Figure 9. Elephant first session

not get to finish his animal during the session, but he was pleased with what he had accomplished up until that point.

Second and third sessions.

The next session the following week, I left out all the art materials in addition to the sewing materials so he would have a choice about what he wanted to do. Alex picked up the elephant and worked on it for about 5 minutes. He stopped and complained that it took so long to do. He played on the blackboard for the remainder of the session. Alex did not have the attention required that day to work on the doll, so he regressed to the water play on the blackboard, giving himself a rest (Rubin, 1978).

The following session, there was a video camera in the room as I was taping for part of my supervision. Initially he ignored the camera, although he had been forewarned that it would be there, and he picked up the elephant and started stitching. He stitched for about 2 minutes then stated that he wanted to start another doll. He wanted to make a parrot doll. I suggested that he draw the parrot first. He carefully drew the parrot without any help from me. He painted the parrot, adding numerous colours to the page. After finishing the painting he got up and went to the camera. He played with the camera and asked who was inside the camera and why they were watching him. The remainder of the session was spent with Alex playing and acting up for the camera.

Fourth session.

Alex went straight to the doll the following week. He was able to work on the elephant doll for the entire session. He worked carefully throughout the session. He pricked his finger as he was stitching. He said it hurt a little bit but it did not bleed. Soon

after this he poked me with the needle on my leg. When asked why he did this he said it was only fair since he got hurt that I should hurt too. I hypothesized that he thought since the making of the doll was a shared experience that I too should feel his pain. It was an interesting idea to me and I did not reject his idea of pricking me with the needle. I knew that his anemia required frequent transfusions and almost weekly blood tests so I was aware of the numerous needles he had to endure. The sewing needle was a symbol for the real life needles that Alex experienced (Lillitos, 1990). I told him that his suggestion was fair; however, I made guidelines to keep it safe for both of us. I decided that he could touch the top of my hand with the needlepoint but only when he hurt himself with the needle first. I also stated that he was not able to poke himself with the needle just to be able to do the same to me. He stayed within the guidelines and only poked my hand about 5 times during the two final sessions making of the doll. This seemed to be a unique experience for Alex when he could share what he was feeling physically with someone else.

Alex was anxious to stuff the elephant. After almost every stitch he wanted to know if we had done enough to stuff it yet. He stitched the trunk, and two front legs of the elephant (Figure 10). I was concerned that Alex would stitch too much of the doll to be able to stuff it so I switched to a more directive stance. I stopped Alex from continuing

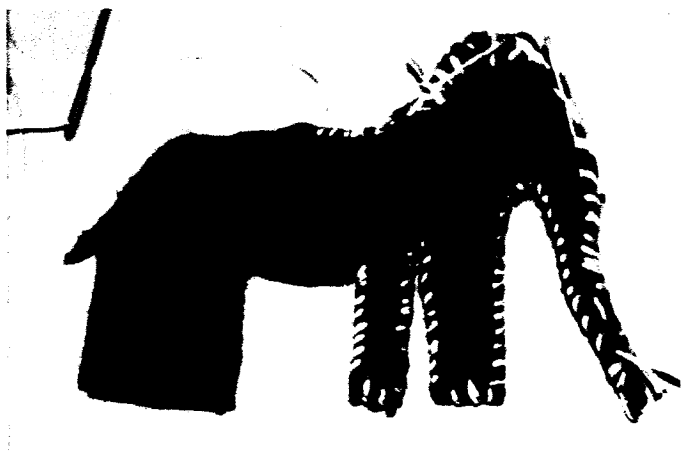

Figure 10. Elephant half stuffed

the back legs so he could stuff the doll through the belly. I finished off the stitching for him. Alex surprised me[2] by threading the needle with new thread. I suggested that we start on the back of the elephant, so that we could stuff the front part of the doll. Alex spoke of his day at school as he stitched. He got to the half way point on the back of the elephant and wanted to stuff the doll before the session ended. He chose the cotton batting to stuff the elephant. I showed Alex how to get the stuffing into the narrow parts of the doll by using the end of paint brush. He was enthusiastic about the stuffing and poked through the felt a few times, but he did not seem to mind. He stuffed half of the elephant and then the session ended.

Fifth session.

Alex was eager to finish the elephant. He commented that he had not expected that it would take this long to make. He seemed to be proud of himself for sticking with the project for so long. Alex stitched around the remainder of the elephant. When he got to the tail of the elephant he noticed that the tail he cut was much too thin to stitch. Part of the tail broke off in his hand, because the felt was delicate. He shrugged and said "oh well". I suggested that we could stitch on a thread tail when we were finished. Alex wanted to stitch the entire doll but I reminded him that we needed an open space to stuff the doll. He rolled his eyes and said "oh, I know that!" not wanting to admit his oversight. After he stitched the back legs he stuffed the body and then I helped him stuff the more difficult legs. Alex thought it was funny that we were stuffing the elephant through the belly. He made up some story about being stuffed in the belly. "Imagine someone was poking you in the belly like that?" he said as he stuffed the elephant and

[2] Threading the needle was difficult and I did not think he was capable of doing so.

made noises as if Alex was being stuffed "oof" "ah! No! stop!". I empathized that it must really hurt getting poked in the belly like that. He nodded as he continued to stuff the

Figure 11. Elephant completed

doll. When Alex finished stuffing the elephant he again threaded the needle to finish it. When the doll was finished I asked Alex if the elephant had a name (Figure 11). He shrugged and said "No it's just elephant". He wanted to take the elephant home but I reminded him that he could take all his artwork home when we ended together.

Post doll making.

When Alex did get to take his elephant home, he noticed that we forgot to put eyes on the elephant. His mother suggested that they could put eyes on the elephant at home. Alex said that they could draw on some eyes with a marker. In looking at the photographs of the elephant I also noticed that we did not make ears for the elephant as we had originally planned.

Discussion of Alex

Alex had an acute awareness that he was different than other children because of his illness. He described his illness in detail and the procedures he experienced. Malchiodi (1999) states, "children with serious illnesses [...] may understand more about their bodies than children who do not have serious health problems. [...] these children may have been sensitized to learning about aspects of their bodies relating to their conditions." (p.180). Alex appeared much older than his age. His maturity was probably the result of his experience with illness and treatment which was much different than most children his age.

Alex displayed anger and guilt about his illness prior to starting therapy. He punished himself by tying himself up, or would send himself to his room if he had done something wrong. He also had anger towards his mother but was unable to express this. "When a child is ill, words often fail, either because the child's vocabulary does not match experience or because the ill child feels he must protect the adults around him from his feelings" (Councill, 2003, p.212). What compounded this was that his illness could not be spoken of in front of his brother. His brother was overwhelmed and anxious if Alex's illness was mentioned. Perhaps Alex sees himself as bad because his illness upsets his brother so much.

Most children who are ill feel that somehow their parents are responsible for making them sick (Councill, 2003; Malchiodi, 1999). He projected his anger onto me by attacking me in his play and later attacking the doll. Early on in one of our sessions together Alex created imaginary sword fights with me where he would pretend to slice off my limbs until I 'fell' to the floor. In the sewing we came up with the controlled

version of that where he would tap my hand with the needle if he had accidentally pricked his finger. It seemed quite important to him that he be able to share his experience of pain with someone. Golden (1983) states that injections are one of the most common themes in play therapy for children who are hospitalized. The children often enact scenes where they are giving shots to puppets, or the therapist, insisting that the therapist must pretend to cry with the pain of the shot being given by the child. Although Alex told me that having transfusions were "no big deal" it appeared that it was still of some concern to him. Role reversal of the injections, allowed him to re-experience the stressful situation from another perspective, thus fostering a sense of autonomy and control (Cattanach, 1994).

The elephant did not have ears and eyes so it was quite shut out from the outside world. It was also quite flat which reflected for me the flat affect that Alex showed during our sessions together. He would rarely get excited about anything, and even when he spoke of being sad he was quite matter-of-fact. By choosing the cotton batting, Alex made the elephant rigid and slightly overstuffed. The grey colour on the elephant was flat but true to life for the animal. When asked what Alex thought of elephants he said "they are big and strong, and they can pick up things with their trunk". My interpretation of this is that Alex has the desire to be healthy and a useful member of his family.

Alex created an elephant doll over the course of 5 sessions. When he grew tired of stitching he would fill the therapy time with other activities. Alex seemed to self-regulate and work on the doll when he wanted to. In making the doll Alex demonstrated patience, and also was able to express his anger about his illness. He was able to work collaboratively with me in making the doll and capable of asserting his independence

when he felt the need. The elephant seemed very much a self-portrait of Alex. It had its legs planted firmly on the ground, and it was solid and unadorned.

Chapter 5- James Case Study

Case description

James was nine years old at the time I saw him in therapy. James lives with his mother and father and a sister who was almost twelve. James was diagnosed with Oppositional-Defiant disorder and with low self-esteem. There was a suspicion of Noonan syndrome, which was confirmed through genetic testing. It is a syndrome that causes physical abnormalities such as short stature, wide set eyes, sunken chest, heart abnormalities and mental retardation in about one quarter of those affected. James' IQ scores were in the lower limits of the normal range. James loves painting and was quite capable of expressing himself creatively both in art with me, and music according to the music therapist. The intake interview noted that James interacted little with either parent or his sister during the length of the assessment. James was seen on the psychiatry ward of the hospital for 8 months.

Description of sessions

Session prior to doll making.

Due to some scheduling problems, there was a period of one month where James and I could not work together. When we reconnected, he commented that it was a long time since we had seen each other. James showed me his new Beanie Baby as we went downstairs to the therapy room. He said the dog was Sidekick. We entered the room and James looked around for a bit since he had never been in that particular room before. James spotted a plastic barn on top of one of the shelves and he asked me to get it down for him. I did and he placed Sidekick in one of the windows. James told me that he wanted to draw Sidekick. He took the pencil crayons and started to draw. He was fairly

quiet as he drew the stuffed dog. When he was done James said he would add Luke as well. Luke was another Beanie Baby that James had previously introduced me to. James drew a good likeness of the dog from memory this time. He drew headphones on the two dogs. They were on a secret mission he said. They were working for the CIA. James drew a helicopter above the heads of the two dogs. He drew weapons in the hands of the dogs. He said the bad guys were in the helicopter and the house was their secret headquarters. James made gun-firing noises and said that the dogs were shooting at the helicopter. I asked what kind of mission they were on but all he said was that it was a secret I commented that it seemed like a very dangerous mission. James agreed but then said "They can handle it though, they're trained experts" and continued to draw. At the end of the session I asked James if he would like to make his own Beanie Baby. James was thrilled by the idea. I let him know that he could start the following week. Unlike the other children, I suggested the doll making activity directly with James because it seemed appropriate to the subject matter of this session. He would start making the doll in our 14th session together.

First session doll making.

James was anxious to start working on his doll. I tried to break down the steps for him but he could barely listen to me. He just wanted to start sewing. James brought the felt to the table and wanted to start cutting right away. I explained that perhaps he should draw a picture of the animal that he wanted to make before we moved to the fabric. I wanted to slow him down knowing that he tended to get over excited and messy when he did work quickly. Breaking down the steps for him helped him to assimilate the new information (Malchiodi, Kim & Choi, 2003). James quickly drew a teddy bear. I

showed James how to make a pattern to cut out the shape in the fabric. James was quite excited about the project and he predicted that it would take no time at all. Once the doll was cut out I showed James how to sew. He informed me that he had sewn before. James went back and forth between rushing to finish the doll and being able to slow down, to close gaps between the stitches.

Figure 12. Bear outline

A few times James commented "we're doing this together it's not mine" as I had helped him with some of the steps. I found it interesting that James thought of it as a collaborative effort. Cattanach (1999) discussed the role of the therapist in a play therapy setting stating the therapist and child play together in their special space. The therapist assists children in playing out their imaginary or actual worlds, in whichever way the children see fit. In making sculptures during our time together James would recruit my assistance. However, if he worked on a drawing or painting he would work by himself. He showed the capacity for flexibility in art where he was normally quite rigid in school according to his teachers on the ward. James completed about one third of the sewing in the first session (Figure 12).

Second session.

During the second session James went right to the bear and started sewing. He hurried and wanted to finish the bear quickly. I let him know that it was okay to be excited about the project but that he could take as much time as he needed to finish it.

James commented that it did not look like a real Beanie Baby. I reflected his concern that his doll did not look professionally made and I reassured him that it was good because he had made it himself. James seemed pleased by my comment. The bear, James informed me, would be part of an army. James said he would make hundreds of dolls. I asked James what he thought of bears. He said, "They are strong, but kind of dumb too". I had the impression that this is what he thought of himself as well. He mentioned that he wanted to give the bear to his sister and then quickly changed his mind. It was the first time he had ever mentioned his sister. From time to time, James would ask for help with the sewing, referring to it as our doll again. The fabric was irregular and there were spots that resisted the needle going through. He was quite animated as he worked and he stitched the doll quickly. We were ready to stuff the doll and James chose the plastic beads, like tiny beans, as the filling. He accidentally tipped the bag over and spilled beads everywhere on the floor. He laughed at the mess. He sat and watched as I struggled to pick up the beads all over the room. There was no broom in the therapy room so I used a pair of dirty mittens that I found in the corner. We were both laughing at how ridiculous the situation was. We filled the bear half way but we ran out of time. James was mildly disappointed that we could not finish the bear.

Third session.

At the beginning of the third session James commented on how long it took him to finish the doll "Two whole weeks!" he said. We worked quickly so he would not have to wait another week to finish it. He stitched the bottom half of the bear and looked for holes where the beads came out. I helped him repair the holes. James wanted to make a face for the doll. I showed him how to do the eye on one side and he did the other eye

himself. I did the left eye and he did the right eye. I did this to demonstrate a new stitching technique that facilitated making the features on the face. He wanted to add a nose but as he stitched he said it looked funny so he wanted to make it into a mouth. Before adding the mouth James had been playing with the doll, making a dent in the face as a mouth, giving it a grumpy look. The nose turned into a slightly down-turned mouth and the doll was finished (Figure 13). James giggled and wanted to show everyone on the ward. I let him take the doll with him because he was so proud of it. The children on the ward have very little from home and I felt the joy and comfort that the bear would give James was more valuable to him then keeping it from him. We agreed that he would bring it back the following week so I could photograph it. As James left with the bear he waved the bear's hand and so I shook the bear's hand and said goodbye. James then held out his hand for me to shake, so I shook his hand too. He seemed to have really enjoyed making the bear and it appeared he had a hard time letting go. As we exited the therapy room, he proudly showed the bear to one of the nurses on the ward. She was impressed with the bear and asked James if he had made it all by himself. James told her that we worked on it

Figure 13. Chocolate bear

together. She asked the name of the bear but James had not come up with a name yet. She named it chocolate bear and James liked the name and repeated "Yeah! Chocolate bear".

Fourth session.

James forgot to bring the bear to be photographed and he seemed distracted. He spotted a broken tricycle in the room and tried to make it into a robot but quickly gave up. He barely responded to me during the session. He was really in his own world. He seemed quite angry and withdrawn and when I asked him about his weekend, he did not respond. James played with the clay but not in his usual creative and animated manner. He disliked everything he tried to create and kept destroying what he made. James continued to make messes with the clay and water until the end of the session.

Fifth and sixth sessions.

James brought the bear back so I could photograph it. James seemed to enjoy the photo session. James chose several poses for Chocolate bear to take including one where the bear was 'mooning' the camera. James had the bear interacting with some of the plastic animals from the room, such as a baboon, two camels and a leopard. James also placed the bear in a truck that moved on its own, so it appeared that the bear was driving the truck (Figure 14). I had explained my research to James and had asked permission to

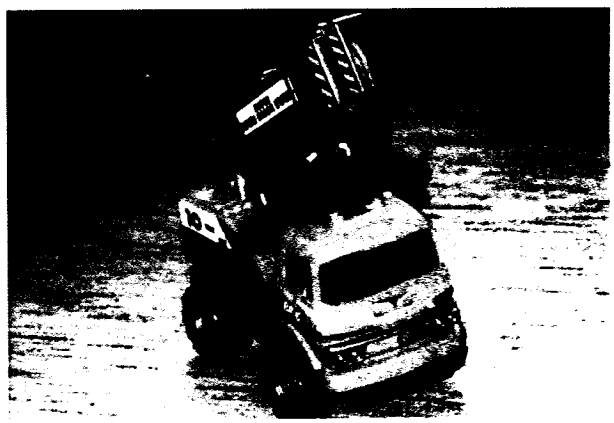

Figure 14. Chocolate bear driving

include his dolls. James told me he was disappointed that he could not have his real name included in the research. I asked him what he would like to be called, so he chose James, James Bond. He then went to the materials and said he wanted to make another bear. He chose the light blue felt and quickly drew an outline to cut out. He struggled a bit with the cutting (child-proof scissors) then asked me to cut out the shape as he played with the other bear. He started stitching the bear and struggled with the stitching until I held the bear for him. James was then able to go much faster and he noted his speed. He was able to stitch the whole bear and stuff it during a single session. He wanted to give the bear blue eyes, which I said he could do the following session. James named the blue bear Beary (Berry). He said it was a wife for chocolate bear and that he wanted to make little bears so they could be a family.

The following session was a short one. All the boys were playing on the ward when I arrived. James was in the middle of the action. Surprisingly he came easily to the session. He stitched the eyes and mouth on the doll (Figure 15). Afterwards I noted that he made pink eyes instead of the blue he wanted originally. After this was done, he begged me

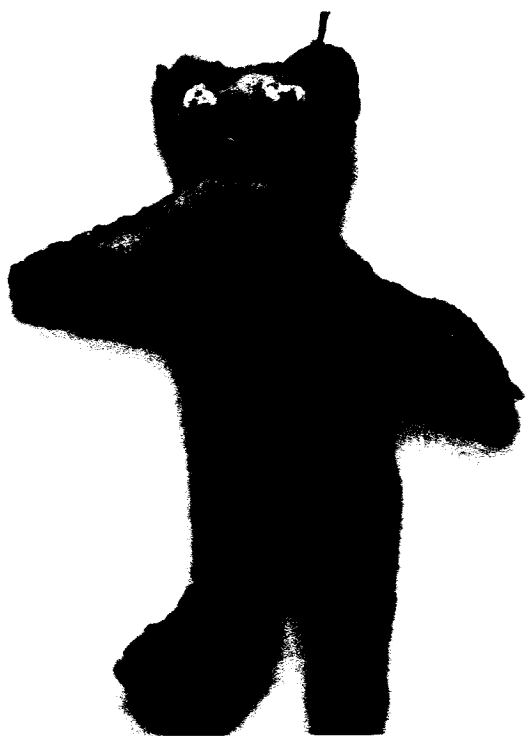

Figure 15. Beary (Berry)

to leave so he could continue playing. I agreed, and he got up from his chair put his arm around my shoulder and lightly kissed me on the cheek. The session ended after 10 minutes. James and I had 4 more sessions together, though he did not make any more dolls during that time.

Post doll making.

When James got to take home Beary he told me of the plans for Beary. She was to marry Chocolate bear and then they would go on a honeymoon together in Hawaii.

Discussion of James

In all of my sessions with James he was an animated story teller. He was the child who played most with his dolls. Initially James wanted to create an army for Chocolate bear. Building armies was a common theme in my work with James. Our initial meeting together James introduced me to his imaginary army contained in the sketchbook he brought with him. Later he recruited my help to create Plasticine armies for the "King" to destroy. This theme could be seen as James wanting to protect himself from both disappointments and emotional conflicts. James had few or no friends when he was in a regular school and the army was a source of companionship for him.

In researching the meaning of bears I found the following passage in Milne (1926). It spoke to me of the therapeutic alliance between James and myself, his sense of exploration of the art materials and also his issues of self-esteem. It reminded me of how James described bears, and in turn himself. James saw himself as a dumb bear and early on in therapy he needed constant reassurances that his artwork was good.

> Christopher Robin came slowly down from the tree.
> "Silly old Bear," he said, "what were you doing?

First you went round the spinney [tree] twice by yourself,
and then Piglet ran after you and you went
round again together, and then you were just
going round a fourth time..."
"Wait a moment," said Winnie-the-Pooh,
holding up his paw. He sat down and thought,
in the most thoughtful way he could think. Then
he fitted his paw into one of the tracks...
and then he scratched his nose twice, and stood up.
"Yes," said Winnie-the-Pooh.
"I see now," said Winnie-the-Pooh.
"I have been foolish and deluded," said he, "and
I am a Bear of No Brain at All."
"You're the Best Bear in All the World," said
Christopher Robin soothingly.
"Am I?" said Pooh hopefully. And then
he brightened up suddenly.
- Milne (pp. 42-43).

In matters of school, James would get easily frustrated with his school work. He had struggled for several years before entering the program at the hospital. In art James was capable, thoughtful and very creative. He needed to be reassured that he was good at something. From attending staff meetings on the ward I learned that James had difficulties meeting the expectations of his mother, who was unable to accept his limitations. Like Winnie-the-Pooh, James was always getting into trouble of some kind. It was not that he was a trouble maker rather; he was naïve and did not think ahead, just like Pooh.

I discovered much later that the two bears he created were almost identical in their outlines, even though he did not have Chocolate Bear with him when he started Beary. The bears were self-portraits of James. Both had the same characteristics that were apparent in James due to the Noonan syndrome. The ears on the bears were tiny and were placed low on the head and the necks of the bears were thick like James'. Instead of building an army, Beary became a mate for the Chocolate bear. He was able to transcend

his typical boy art and make something softer and more emotionally sensitive (McNiff, 1982). James told me a story of how the two bears were going to get married and go on their honeymoon in Hawaii. This was at the same time that James was leaving the ward after almost a year to go to a new school. It was if, the ward was a secluded paradise for him and he did not want to leave.

Noah-Cooper and Richards (1983) wrote of a boy with serious behaviour problems in the classroom which resembled those of James. They made the sessions as open as possible to permit free expression. James would often give me directions during the sessions, which I followed. I am quite sure James does not get this sense of control at home. James knew he could do what he wanted to during the therapy; I almost never had to refuse a request from James, unlike some other clients who were always testing limits. James felt at ease during our sessions together because art was familiar to him. He seemed to flourish during the course of the sessions, and the music therapist noted the same thing occurring in her sessions with him as well.

Conclusion

Play is an essential component of therapy with children. It is natural for them to play and they are capable of learning and growing through play. According to Cattanach (1999) the role of the therapist is to provide a safe space for the play, and to encourage exploration. It is in this playful exploration where the child can learn about him or herself.

Doll making is way in which children can make three-dimensional characters that are soft and flexible. Children project part of themselves easily onto the dolls they create as was shown by two art therapists Munro-Smith (1996) and Vollman (1997). The doll allows for a safe distance, providing more freedom of expression. Issues surrounding the body are common for children who must go to the hospital and dolls can be used as a therapeutic tool to demonstrate or discuss procedures or discomforts the child might feel.

Making my own dolls was very helpful to me as I later worked with the children. I knew of the potential frustrations and tried to minimize this for the children. I was surprised by the work that was done by the children, exceeding what I had anticipated they were capable of doing.

Comparisons of the children in the study

Of the children that I presented the doll-making activity to, there were two children who chose not to create a doll. One child who was six years old played with a piece of the felt and wanted to take it home because of its bright pink colour. When she asked what the fabric was for, I told her she could make a doll or an animal like I had said to the other children. She made a disgusted face and went back to what she had been painting. Another child who was eleven took the fabric and glued it to a paper and made

a collage with the sewing materials. She expressed the desire to make bracelets like what Isabel had made but in the end made a bracelet out of pipe cleaners instead. There were a few children that I did not introduce the doll-making to. One in particular had severe behaviour problems and I did not feel that it would safe for her to be using the sewing materials.

Three of the children in this study came from intact families while Emily's parents were not together. All of the children who chose to make dolls were the youngest siblings in their families. The boys made animals while the girls made dolls, or a head of a doll. Three of the children, Alex, Emily and Isabel spent 16% of their sessions working on the dolls, while James spent 24% of his sessions working on his two dolls. James was seen on an inpatient basis while the other children were seen in the outpatient clinic.

Each of the children in the study gained something different from the doll making activity. For Emily, the doll gave her a chance to develop a new skill, to enhance her self-esteem and to bring order to her often chaotic life. She was able to organize her thoughts and create an artwork that was unified and age appropriate. Emily suffered from epilepsy from a very young age and this condition affected her motor skills. In making the doll, Emily was more focused and coordinated than I had seen her previously in our sessions together.

For Isabel, the doll making was a way to safely vent her anger about her brother and for her to feel comfortable in the therapy sessions by introducing the element of play. This made Isabel more at ease during the therapy, allowing her to relax and get the most out of our brief time together.

For Alex, the process of making the doll was more important than the finished product. The doll making permitted Alex to safely explore his feelings about the numerous transfusions he received for his hemolytic anemia. Wanting his pain to be a shared experience, he created a scenario while making the doll that if he got hurt he felt that I should too. He took the longest to make his doll, but he persevered and had the patience to finish his elephant doll.

For James he was able to distance himself from his armies and from his highly skilled drawings of cars and make something that showed his sensitivity and fondness for the therapist. He used the most imaginative play with the dolls, acting out little scenes and creating stories about the dolls. During the photo session with Chocolate bear, James played with the doll quite a bit. The doll appeared worn-in when he brought the doll in again after completing it two weeks prior. I assumed that the doll had been played with during that time because of its condition.

Themes that emerged from the doll making

Two of the children were able to express their feelings of anger through the dolls. Alex and Isabel were able to find an outlet to express their angry feelings that they felt they could not express with their families.

Another theme arose from learning a new technique in art making. The children expressed pride, boosting their self-esteems at their capabilities in terms of sewing and doll making. By being more directive with the techniques, the children were able to accomplish more than if I had not given any instructions. Teaching them a new technique diminished their anxiety about their work, and reduced the level of frustration as they worked on the dolls.

Suggestions for further research

I would have liked to see the children play more with the dolls they created to get a sense of the attributes of the dolls according to the children. Sourkes (1995) created an interesting narrative of the life of a teddy bear that could lend itself easily to the work with the children. I am curious about how the doll making activity would have unfolded had I not made any instructional interventions with the children. This study was a beginning. More art therapists may wish to incorporate non-traditional materials into the sessions, opening up the potentials for the clients. Everyone could have something to gain from the process of doll making. The parents could gain a new appreciation for their child's emotional expressiveness, the child could gain self-esteem from having learned a new skill, and the therapist could gain invaluable insight into the private life of the child.

References

AIDSquilt.org (1987-2004). *AIDS memorial quilt.* Retrieved Jan 12, 2004 from http://www.aidsquilt.org/history.htm

Axline, V.M. (1969). *Play therapy.* New York: Ballantine Books.

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A Research guide.* Buckingham and Philadelphia: Open University Press.

Bettelheim, B. (1987). The importance of play. *The Atlantic Monthly.* March, pp. 35-46.

Billig, T, & Weaver, K. (1996). Individualized doll therapy with children experiencing limb loss. *Orthopaedic Nursing*, 15(6), 50-55.

Case, C., & Dalley, T. (1992). The handbook of art therapy. London and New York: Routledge.

Cattanach, A. (1994). Play therapy: Where the sky meets the underworld. London: Jessica Kingsley Publishers, Inc.

Cattanach, A. (1999). Co-construction in play therapy. In Cattanach, A. (Ed.), *Process in the arts therapies* (pp.78-102). London: Jessica Kingsley Publishers, Inc.

Councill, T. (2003). Medical art therapy with children. In Malchiodi, C. A. (Ed.), *Handbook of art therapy* (pp. 207-219). New York: Guilford Press.

Dunn, J. (2002). Sibling relationships. In Smith, P.K., Hart. C.H. (Eds.) *Blackwell handbook of childhood social development.* (pp. 223-237). Oxford, England: Blackwell Publishers Ltd.

Drucker, K.L. (2001). Why can't she control herself? A case study. In Murphy, J. (Ed). *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 101-125).

London: Brunner-Routledge.

Fox, A. (2000). *Fibre arts as art therapy media: An integrated art-based inquiry.* Unpublished masters research paper, Concordia University, Montreal.

Gaynard, L., Goldberger, J., & Laidley, L.N. (1991). The use of stuffed, body outline dolls with hospitalized children and adolescents. *Children's Health Care*, 20 (4), 216-224.

Gerity, L. A. (1999). *Creativity and the dissociative patient.* London: Jessica Kingsley Publishers, Inc.

Golden, D. B. (1983). Play therapy for hospitalized children. In Schaffer C.E. & O'Connor, K.J. (Eds.)*Handbook of play therapy*. New York: John Wiley & Sons, Inc.

Howe, N, Fiorentino, L.M., & Gariépy, N. (2003). Sibling conflict in middle childhood: Influence of maternal context and mother-sibling interaction over four years. *Merrill-Palmer Quarterly*, 49 (2), 183-208.

Irwin, E.C. (1983). The diagnostic and therapeutic use of pretend play. In Schaffer C.E. & O'Connor, K.J. (Eds.)*Handbook of play therapy*. New York: John Wiley & Sons, Inc.

Junge, M.B. (1999). Mourning, memory and life itself: the AIDS quilt and the Vietnam Veterans' Memorial Wall. *The Arts in Psychotherapy*, 26 (3), 195-203.

Kramer, E. (1971). *Art as therapy with children.* New York: Schocken Books Inc.

Levick, M.F. (1983). *They could not talk so they drew: Children's styles of coping and thinking.* Springfield, IL: Charles C. Thomas Publisher.

Levine, E.G. (1999). On the play ground: Child psychotherapy and expressive arts

therapy (pp. 257-273). In Levine, S.K., & Levine E.G. (Eds), *Foundations of expressive arts therapy*. London: Jessica Kingsley Publishers, Inc.

Lillitos, A. (1990). Control order and chaos: working with children with intestinal motility problems. In Case, C., and Dalley T. (Eds), *Working with children in art therapy*. London and New York: Tavistock/Routledge.

Linesch, D.G. (1988). *Adolescent art therapy*. New York: Brunner/Mazel.

Malchiodi, C.A. (1997). *Breaking the silence: Art therapy with children from violent homes.* New York: Brunner-Mazel Publishers Inc.

Malchiodi, C.A. (1999). Understanding somatic and spiritual aspects of children's art expressions. In Malchiodi, C.A. (Ed.), *Medical art therapy with children* (pp. 173-196). London: Jessica Kingsley Publishers, Inc.

Malchiodi, C.A, Kim, D-Y, & Choi, W. S. (2003). Developmental art therapy. In Malchiodi, C. A. (Ed.), *Handbook of art therapy* (pp. 93-105). New York: Guilford Press.

McNiff, K. (1982). Sex differences in children's art. *Journal of Education*, 164(2), 271-289.

Munro-Smith, E. (1996). Doll making as an art therapy activity. *Pratt Institute Creative Arts Therapy Review*, 17, 28-35.

Reynolds, F. (2000). Managing depression through needlecraft creative activities: A qualitative study. *The Arts in Psychotherapy*, 27(2), 107-114.

Reynolds, F. (2002). Symbolic aspects of coping with chronic illness through textile arts. *The Arts in Psychotherapy*, 29, 99-106.

Robbins, A., & Sibley-Seaver, L. (1976). *Creative art therapy.* New York: Pratt

Institute.

Rubin, J. A. (1978). *Child art therapy* (2nd ed.) New York: Van Nostrand Reinhold Company.

Rubin, J.A. (1999). Art therapy: An introduction. Philadelphia, PA: Brunner/Mazel.

Sinason, V. (1998). Doll and bears: From symbolic equation to symbol the significance of different play materials for sexually abused children and others. *British Journal of Psychotherapy*, 4(4), 349-363.

Steier, F. (1991). Research as self-reflexivity, self-reflexivity as social process. In Steier, F. (Ed.). *Research and reflexivity*. London: Sage Publications Ltd.

Sourkes, B. M. (1995). Armfuls of time: The psychological experience of the child with a life-threatening illness. Pittsburgh, PA: University of Pittsburgh Press.

Taylor, D.C. (1989). Psychosocial components of childhood epilepsy. In Hermann, B. & Seidenberg, M. (Eds.). *Childhood epilepsies: Neuropsychological, psychosocial and intervention aspects* (pp. 119-142). New York: John Wiley & Sons Ltd.

Vollmann, S. (1997). Doll making and play: A therapeutic modality for an adolescent boy with gender identity disorder. *Pratt Institute Creative Arts Therapy Review*, Vol. 18, (pp. 76-86).

Von Boehn, M, (1972). *Dolls* (Nicoll, J, Trans).New York: Dover Publications, Inc. (Original work published 1929).

Wadeson, H. (2000). *Art therapy practice: Innovative approaches with diverse populations*. New York: John Wiley & Sons, Inc.

Ward, C. (1999). Shaping connections: Hands-on art therapy. In Cattanach, A. (Ed.),

Process in the arts therapies (pp.103-131). London: Jessica Kingsley Publishers, Inc.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham and Philadelphia: Open University Press.

West, J. (1992). *Child-centered play therapy*. London: Edward Arnold.

Appendix A

Consent Information

Art Therapy Student: Jennifer Topp
Art Therapy Intern
Creative Arts Therapies
Concordia University
1455 de Maisonneuve Blvd. West
Montreal, Quebec

Supervisor: Suzanne Lister

Background Information:

One of the ways art therapy students learn how to be art therapists is to write a research paper that includes case material and art work by clients they have worked with during their practicum. The purpose of doing this is to help the student, as well as other students and art therapists who read the research paper, to increase their knowledge and skill in giving art therapy services to a variety of persons with different kinds of problems.

Procedure:

The research would comprise a series of 4 to 6 weekly art therapy sessions in which your child would make and later possibly play with a fabric doll. Your child will be given a variety of art materials and will be given instructions on the different ways in which a doll can be made. The purpose of the research is to explore doll making in an art therapy context.

Permission:

As a student in the Master's in Creative Arts Therapies Program at Concordia University I am asking you for permission to photograph the art work of your child and include selected images in my research paper. I am also asking you for permission to consult the medical file of your child for a period of one year, until I have completed my research paper. A copy of the research paper will be bound and kept in the Concordia University Library, and another in the Program's Resource Room. This paper may also be presented in educational settings in the future.

Confidentiality:

Because this information is of personal nature, it is understood that your child's confidentiality will be respected in every way possible. Neither the name of your child, the name of neither the hospital, nor any other identifying information will appear in the paper. The artwork will be completely anonymous and your child's identity will not be revealed. The final research paper will include narrative accounts of the sessions, describing aspects of the child's experiences using pseudonyms in keeping with the respect for confidentiality as described above.

Advantages and Disadvantages to Your Consent:

To my knowledge, this permission will not cause you or your child any personal inconvenience. Certain children may have feelings that are uncomfortable because of the personal nature of the exploration. The researcher/art therapy intern will be open to discuss these concerns with the child. There is a slight risk of physical injury because sewing needles will be included in the art materials. I will provide only blunt needles to minimize the risk of injury and instruction on how to properly use the needles will be provided.

Whether or not you give your consent will have no effect on the involvement of your child in art therapy or any other aspect of his/her treatment. You may to consent to all or just some of the requests on the accompanying consent form. As well, you may withdraw your consent at any time before the research paper is completed with no consequences, and without giving any explanation.

Consent Form

I, _____, undersigned, give permission to Jennifer Topp, Art Therapy Intern, to include my child_____ in her research paper about doll making in art therapy.

I understand that a copy of the student's research paper will be bound and kept in the Concordia University Library.

I understand that both my child's identity and the setting where the art therapy sessions took place with be kept confidential and that no identifying information will be given.

I understand that agreement to this request is voluntary and that I can refuse to allow my child's art to be photographed with no affect on the quality of therapy received.

I also understand that I may withdraw my consent at any time before the research paper is completed, without any explanation by contacting Jennifer Topp. This decision will in no way effect the quality of treatment my child receives in art therapy.

I authorize Jennifer Topp to take any:	YES	NO
Photographs of the art work	_____	_____
Case material	_____	_____
Audiotapes of the sessions	_____	_____

However, I make the following restriction(s):

_____

_____

_____

I have read and understood the contents of this form and the consent information form and I give my consent as described above.

_____ _____

Signature of parent Date

_____ _____

Witness to signature Date

_____ _____

Signature of child Date