Dr Margaret Lowenfeld Trust

The Use Of The Lowenfeld Mosaic Test In Child Psychology

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The Lowenfeld Mosaic Test was first introduced over fifty yews ago; since then a great deal of research has been conducted into its possible uses. Besides its continued use at Dr Lowenfeld's Institute of Child Psychology, workers from all over the world have employed this test; anthropologists in cultural cross-cultural studies; psychologists in the study of normal children and adults as well as mental defect; psychiatrist for differential diagnosis and the study of mental disorder. This paper id confined to one use of the Lowenfeld mosaic test, namely in the diagnosis and psychotherapeutic treatment of children.

Administrative procedure:

The mosaic piece are laid out ready for us in box, grouped by shape and displaying all the colours in each shape. There are five shapes, all bearing mathematical relation to each other (Figure1). The basic shape in a square from which the isosceles, equilateral and scalene tringles are derived; the sides of the Dimond are the same length as the square (30mm.) Each shape is available in red, blue, yellow, black, green and white and arranged in the box in this order. This box is presented to the child alongside a tray (fitted with plain white paper) whose dimensions were chosen so that complete edged patterns could be made with certain shapes and the

tray could be entirely covered, though this is very difficult to achieve satisfactorily.

To administer the mosaic, the child is shown the box and the variety of pieces available and then asked to 'do something with these pieces, using as few or as many as you choose, on this tray. You can make anything you like.' In treatment, I usually allow a maximum of one hour for the child to complete a design or designs, the time being dictated by the conventional length of a consultation rather than any intrinsic factor arising from the mosaic material. In practice, most children finish in much less than the hour allowed.

When the child has finished, I usually discuss with him what he has made, ascertaining whether the design is meant to depict something (i.e. representation) or just a pattern (i.e. abstract) and whether the idea was in his mind before he started or came to him as he manipulated the pieces. Care has to be taken not to allow one's own preconceptions to be reflected in the questions. The main skill required at this point is in asking questions which elucidate the mosaic without circumscribing the possible answers. For instance, most people would say Figure II is a picture of the sky, a house and garden with a tree in it. Indeed, it is the sky but, on questioning the child who made it, the house turns out to be a railway station and the garden, a train puffing away.

The Lowenfeld Mosaic Test as used in psychotherapeutic treatment is not, however, a test but a tool: it is firstly a tool to enable the child (or adult for that matter) to explore and express non-verbalizable ideas, using the pieces as a personal vocabulary. For the therapist, it is a tool to assist in the diagnosis of the problem and for estimating the progress, if any, made in treatment. In terms of psychotherapy, it is not used as a test because its value lies not in a score but in the INDIVIDUALITY of the response. There can be no right or wrong about the mosaic because the question is not about right or wrong; it is a much more global question, one simply of 'what is the response?'. It is what is made, how it is assembled, which is going to give insight into the child's view and approach to the world.

It is how the child approaches the material (e.g. does he sit and stare at the tray or does he take out pieces and experiment with them freely); it is how the selection is

made as well as which piece is chosen (e.g. does he pick and distribute pieces at random whilst looking at me all the while or does he take out handfuls at a time and then consider how to use each of the pieces in his hand); it is therefore also the manner in which the pieces are disposed as well as their place in the tray: all these must be taken into account as it forms a global picture of the response. It is what Dr Lowenfeld called the Total Response, which is of paramount importance. It is attention given to this Total Response which will yield the maximum assistance to the therapist.

Unlike a verbal response, it does not rely on the size of one's vocabulary or one's ability to use language. The actual pieces are given: both their differences and relationships are clear. One is then free to pay full attention to how the subject exploits these differences and relationships. One can even observe how and what problems arise and see whether and how they are resolved. On the other hand, it is not just any response that is of interest, as might be elicited when one asks a child to draw or paint. What is important is to see the natural response to an external stimulus. Whilst, like drawing or painting, the response is infinitely variable, the Lowenfeld Mosaic Test has other advantages which allow the response to be more clearly defined: the manipulable material is limited, standardised, provides a neutral focus to work from and requires the minimum of skill. Thus, the Total Response demands in return total acceptance; it is a statement of his situation as perceived by the maker.

It is beyond question that there can be no universal meaning attached to either particular colours, shapes, patterns or pictures made. The meaning may have general, perhaps cultural, characteristics, but it is used idiosyncratically by the individual. So that it is not what red may mean generally but what it means to the mosaic maker that is of importance in therapy. It is not even necessary for the therapist to know what red means, merely to note whether or not it has been used, in what shapes and in what relationship with other colours and shapes. So, it is not necessary to have preconceptions about human responses to be able to use the mosaic material as a projective technique. It does, however, require the utmost attention to the global nature of the response.

Illustrative Cases:

I would now like to present three cases: one rather briefly and two in more detail. It must be admitted that there is great difficulty in knowing how to present them, principally because of the problem of reducing a multidimensional event — the Total Response — into a linear form.

The first case is a child who came to the notice of the School Medical Officer because he had outbursts of anger and temper tantrums when he was ten years old. These started around the time when it was first noticed that his left breast had begun to grow. When he was twelve years old, he was admitted to hospital for the removal of the breast, which the boy was keen to have done; but at the last minute, the operation was cancelled. The surgeon explained that he had decided it would leave an unacceptable scar. This produced a dramatic effect on the boy: not only did his violence increase in degree and frequency, he became weepy and withdrawn, he began truanting from school where he was making no progress and started stealing. He continued to have periodic check-ups when he would be told that the swelling would disappear in time. Because of his worsening behaviour and emotional state, he was referred to the Child Guidance Service and eventually came for psychotherapy.

It took three sessions and three mosaics before the boy, in total silence, made a mosaic design which was to be a decisive point in his treatment. As soon as it was completed to his satisfaction, he brushed the pieces aside and began reassembling what looked like the same design. He took an extra piece out of the box and muttered 'It's a bigger one' as he placed in on the tray. He then told me that it was a flower, that they were both flowers. He then disarranged the design and made a house, using the petal pieces (red equilaterals) to make the roof and discarding the other pieces, the house had no base. As the first two were destroyed before I could make a copy (by then he was familiar with the fact that I record his mosaic responses) I asked him to remake them both on the same piece of paper. He said he couldn't remember exactly but he would try (Figure IIIa) was the result. Note that the larger flower is on the left, and it was his left breast which had become enlarged. This led me to judge that he was ready to explore his worry about his breasts and indeed the next mosaic (Figure |IIb) showed there was conflict involved. It is also a flower in the shape of a cruciform

with a white centre. The cruciform is a classic pattern of conflict, but he was not just a person torn by conflict: the white centre on white paper, indicated that, at his core, he felt himself a non-person. It also expressed the relationship between the white square and the four red equilaterals: that the relationship is only minimal, that the triangles are being used to suppress the impact of the white centre, and thus, even if the conflict is resolved, work will have to be done on the white centre. At this juncture the remarkable consistency of expression in mosaic terms could also be noted: the white stem, the lack of a base to the house, the white centre and the minimal relationship between the shapes.

The next two mosaics are those of an adolescent in treatment: the first one he did, and another done a year later, both of them at my request. The first one was done as part of the usual procedure at his first visit. it was the three dimensional effect that he particularly wished to achieve and he was quite satisfied. In the next year the treatment consisted mainly of talking — he was not at all keen to use any of the non-verbal material available in the room. After a year of regular attendance, he said he felt that he had learnt a great deal about himself and that he was ready to terminate treatment. As it had been agreed that he could stop whenever he wished, I concurred and, as part of the termination procedure, asked him to do a mosaic. He completed (Figure IVa) and I was so struck by it that I produced his first mosaic (Figure IVb) for him to see for himself. The two mosaics were placed side by side as well as one over the other for comparison. He agreed that, apart from including all the colours instead of only some, his present mosaic was really an elaborated version of the first mosaic — the basic structure had not altered. Upon the evidence of this, he said of his own accord, ‘I think I had better continue’.

That was a case where the mosaic showed the maker the absence of any real change despite his saying that progress had been made. The next and last case is one where the mosaic strikingly confirmed that the outward improvement in a patient was accompanied by profound interior change.

This third set of mosaics was made by a teenage boy during nineteen months of treatment. He came regularly once a week. This boy was first referred, when he was nine years old, for obsessional and ritualistic behaviour and enuresis. He insisted

on being washed and dressed by his mother and had a lengthy and complicated dressing and undressing ritual which followed a definite pattern. If a step was missed, then the whole ritual had to begin again. This first referral was not taken up by the family. However, improvement was reported after a short stay in hospital instead. He was referred again to the Child Guidance Service three years later, this time for signs of school phobia as well as the return of his previous obsessional behaviour, now further complicated by eating rituals. These included only eating food which was prepared by his mother, to the extent that he would not eat his boiled egg unless his mother took the top off. The school phobia turned out to be more a difficulty in getting out of the house and he required an escort to do so.

His series of mosaics (Figures Va—Vg) was made always at my request. He always complied with grace and usually told me what it was he had done without being asked. They were made at fairly regular intervals, usually either around the beginning or end of the school term. Of course, one could pursue the motifs of the mosaic response in terms of colours and shapes used and find an internal consistency in them. I shall confine myself to describing what was happening in the boy's life at the time a mosaic was done.

The first mosaic in the series (Figure Va) was done at the initial interview and took him the entire session to do. At the end, he was still trying to fit pieces into the remaining spaces. This is a typical obsessional pattern. It must be emphasised, however, that, while this pattern is typically obsessional in general, the content and how it is made, are particular to the maker.

Figure Vb was taken after a term in treatment. He described the mosaic as the sun, a row of houses with a block of flats at the end and a tree, all this enclosed inside a frame of mosaics, i.e. the picture is double-framed. In his daily life, he had now started to come to the clinic on his own and his mother reported, with some relief, that he had begun to cut up his own food.

Two terms later he made two mosaics (Figures V0 and Vd) in one session. For the first time, I noticed that he was more animated in his response, less serious, almost mischievous. Vc was a cat. After making this, he asked immediately to do another. He

accepted that he would have to do the next mosaic on the paper without the tray, that is without a frame. Vd depicted a sun, a flower growing out of the grass, falling rain and a rainbow.

By now his mother was reporting that he was going to bed on his own and no longer insisted that she should stay upstairs whilst he undressed. He was eating a greater variety of food and not just boiled egg for tea. There was no further mention of his lengthy occupation of the toilet.

Six months later, I again asked him to do a mosaic and, again, he made two at one sitting, but this time with a difference. For the first time he made separate abstract designs on the tray (Figure Ve). He began with the hexagon in all the available colours. For only the third time had he started with an equilateral, and on both previous occasions he had used this shape as an edge piece. Not since his first mosaic had he made anything abstract. The next design was the star-shaped pattern using only diamonds and the third was a large square made up of isosceles, that is, still following the order of his first mosaic. The fourth item on the tray was a cross made only with squares. He had wanted to make the fifth design using the only remaining shape, the scalene, but nothing satisfactory emerged until he added the two squares. With this design he became very excited, as though he had made a fresh discovery and wanted to make something else, but there was no more space on the tray. When I offered him another piece of paper, he almost snatched it from me. Vf was the result, it was a wasp. He was concerned that he could not make the wasp‘s eye, and insisted that I write it in. He had great fun making the sting.

At home, comportment more appropriate to his age had begun to emerge. He had begun to take on more responsibility for his share of the domestic chores — for example, walking the family dog, cleaning out the fish tank and budgerigar cage — and these became his regular contribution to the work at home. He had also gone shopping for himself by himself, outside his local area. Obsessional symptoms seemed to have disappeared, at least they no longer figured in the Social Worker’s report.

At this point, I would like to give you a brief summary of the background to this case. This boy's life began as the result of an unexpected and unwanted pregnancy, born ten years after the previous child. The family already had three sons and the mother only became reconciled to the pregnancy by thinking she might have a girl this time.

The mother suffered from agoraphobia, which had started a few years before his conception, and many other complaints which required the family's attention, particularly the husband's. She had frequent attacks of migraine and also suffered from allergies, so that, from the beginning of his life, this boy had had to compete with his mother for his needs to be met. On the other hand, he also became a very good excuse for his mother to stay at home.

The next mosaic was his last, made as part of the termination procedure. He had begun spontaneously to talk to me about his future, about job prospects related to his current interests. He was eager to grow up but admitted that he was not ready to leave home. He talked more openly about friends and, although still timid, no longer complained about being bullied. He was by now fifteen years old.

This last mosaic (Figure Vg) was a picture of a hungry duckling upon a pond, the flower was its food, and the two birds in the distance were the duckling's parents. As he did for his first mosaic, he spent the whole session doing this mosaic. He took great care to produce the bent stern of the flower and the ruffled surface of the pond, to show that there was a strong breeze, and he spent half the time making the duckling look as realistic and as alive as possible. The open beak is meant to convey the duckling's hunger and the flower, its food was at the opposite edge to give the impression that it was out of the duckling's reach. The duckling's parents were far away and unaware of its plight. This mosaic is remarkable for the fluidity of outline that has been achieved with angular pieces, and, compared with his first mosaic, the achievement becomes wholly astonishing.

Moreover, this mosaic describes in a nutshell, the origin of his obsessional behaviour. Throughout the series, his mosaics showed a gradual loosening of the compulsive structure. He came to see that his obsessive manipulations were at the

level of an infant and, eventually, to recognise not only that this life-style was hindering his personal development but, and this is the crucial point, that it was established very early on in his life, by him, for a legitimate purpose, but which was no longer relevant.

Of course, a collection of mosaics does not always show such clarity of expression. This could have two possible explanations: one, that the maker is groping towards expression; two, that the observer has not yet found a way into making sense of the mosaic. However, it is one of the more remarkable features of the mosaic, used by the therapist with respect for the Total Response, that it enables the maker to discover himself in his own way, at his own pace. It eliminates the necessity of resistance and denial on the maker's part and the therapist's response is always anchored by the mosaic — starting where the child starts, and following where the child leads. As an aid to diagnosis and assessment in psychotherapy, the Lowenfeld Mosaic Test can be an indispensable tool.

SUMMARY: The paper describes the use of Lowenfeld Mosaic Test as a non-verbal communication tool in diagnosis and psychotherapeutic treatment with children and young people. Used with the sensitivity and skill, particularly with regard to the totally response of the subject, it can elicit information not available from interviews based entirely or mainly on verbal enhanced, It enables discussion of the content of the communication, i.e the mosaic, on terms clearly dictated by the subject rather than the interviewer. This paper outlines the procedure and style of presentation with three examples of case material

References

LOWENFELD, M. (1954) The Lowenfeld Mosaic Test. Newman Neame, London. Reprints and enquiries to T. Woodcock, Child and Family Psychiatric Service, Child Guidance Centre, Vale Drive, Barnet.

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