REFLECTIONS OF SELF

The use of Drawings in Evaluating and Treating Physically Ill Children

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Introduction

What use can we make of the drawings of children suffering from physical illness? How can we consider treatment issues in light of this rich form of communication, without relying either on our own (often fallible) intuition or the child’s (often limited) verbal capacity to explain his or her experience? Let us consider two examples, where a child’s drawing revealed an understanding of his or her inner psychic and physical experience, and life history, to the benefit of those working with the child.

Stephen, a ten year old boy referred to an out-patient clinic for school problems— including extreme fatigue, muscle weakness, and lack of ability to concentrate— was asked to draw a tree by his psychotherapist. His carefully constructed tree was rather bleak, it had branches but no leaves, and had a large knot-hole about a third of the way up the trunk. Asked about the tree, Stephen stated that it was “about ten or twelve years old” and it “got the knot-hole when a branch was sawed off when the tree was just four years old.” The therapist was aware that 90% of children draw live trees, with leaves and often fruit, and that this child’s depiction was unusual (DiLeo, 1983). She was also aware that Stephen’s father died when he was four, and that knot-holes in trees are often thought to represent “loss,” so she was not surprised to hear the boy’s story of his tree. What made the drawing most meaningful was the fact that the child was completely unaware of the parallel in his own life, and had no conscious intent to portray the traumatic impact of that aspect of his history and his experience.

Elizabeth, a twelve year old girl under medical investigation for severe, recurrent headaches, repeatedly drew a picture of a female face as a way of distracting herself from her physical distress. In each picture she added a bright red mark, in the hair, on one side of the head. Asked about it, she said: “It’s my hair clip.” This was the only use of bright colour in the drawing, and a careful
observer might notice that despite this sincere explanation, Elizabeth never wore anything in her short hair. During testing in hospital, physicians administered a CAT scan, and found a brain tumor growing in the spot where the “red hair clip” had been drawn in each of the child’s self-portraits.

These clinical vignettes touch on some of the most important aspects of drawings when used in clinical settings. There is a developmental order to drawings which can serve as an aid in considering points of trauma or conflict in the child’s experience. The observer can learn from a drawing without the child having to be conscious of the communication being made. Equally true, an observer can never “know” exactly what a child is representing or depicting in a drawing, in any absolutely objective sense. Drawings evoke the observer’s projections, as surely as they reflect the artist’s experience or intention. Drawings communicate both conscious and unconscious experience of self and the environment (which includes significant people in relationships with the artist)—sometimes with graphic accuracy, sometimes in symbolic form.

Useful texts are available addressing the general topic of the drawings of individuals who have chronic or terminal illness. Adding to that literature, this chapter will primarily consider children’s depictions of the human figure and trees, as they contain especially rich reflections of an individual’s conscious and unconscious experience of illness. Two important areas will be mentioned only briefly, because they are well described elsewhere: ill children’s use of colour in drawings, and the interpretation of spontaneous drawings done by children with chronic or terminal illness (Bach, 1969; Furth, 1988).

As a framework for the chapter, relevant aspects of child development theory will be considered, along with recent research describing multiple, differentiated human memory functions. Each constitutes an important parameter of an individual’s potential capacity for expression of experience—both conscious and unconscious—through drawings. Meaning given to experiences of illness and medical interventions will be reflected in an individual’s body memories, psychological defenses and coping strategies, all of which are consciously and/or unconsciously expressed in the projective quality of drawings (Burgess & Hartman, 1993). While the dynamics of self experience and the projective aspects of drawings are equally valid for adults and children alike, children’s drawings will be given special attention here.
A combined focus on drawings of the tree and the human figure may seem an unlikely one, but in fact, since the original publication of the House-Tree-Person test in 1948 (Buck), it has been recognized that drawings of persons and trees share many projective aspects of the self, (Hammer 1955, 1958, 1980; Mortensen, 1991). In addition, studies have shown drawings of trees and the human figure to be reliably robust and stable in presentation and re-testing (Bolander, 1977; DiLeo, 1983; Vane & Kessler, 1964), and to reflect powerful aspects of personality organization which are particularly relevant in a study of the drawings of those suffering from chronic or acute illness (Furth, 1988).

As examples, I have selected particular drawings of a person or a tree, done by children who have a history of illness or medical interventions of a serious or chronic nature. Some examples will be from clinical case material, some will be based on empirical studies analyzing and comparing a larger number of drawings to determine “group norms”. When empirical studies are done, the drawings were collected in a standardised manner, scored on standardised scales, and rated by individuals who were unaware of the purpose of the study. I find that both clinical reports and statistical analysis provide important knowledge about the use of drawings in any setting, and I believe both have real value in our work with patients who have physical illness.

**Developmental Issues**

Given access to paper and drawing materials, once children have the hand-eye coordination and fine motor control needed to draw, they progress through an ordered sequence of developmental stages in drawing: from scribbles of various types which children begin around the age of two to two and one-half, to more representational drawings, which we adults can generally recognize, around the age of four or five (Gardner, 1980; Goodnow, 1977; Levick, 1983). These universal stages provide a firm basis for the use of drawings in studies which seek to understand children’s growth and development (Mortensen, 1991). Drawings continue to reflect increasing capacity to depict detail and perspective until and beyond adolescence. Specific, identifiable developmental stages in the drawing of the human figure are evident in all children’s artwork, regardless of the child’s country or culture of birth (Kellogg, 1969). This is so, because drawing capacity is a direct reflection of brain
development, with cognitive capacity, experience of affect and motor control mediating the resulting production on paper (Hammer, 1980).

Due to the universal nature of the development of human figure drawing capacity in children, the drawing of a person has been used for many years as a measure of non-verbal cognitive or conceptual maturity. Goodenough developed a reliable method of scoring a human figure drawing, using a standardised scale to give credit for specific details and proportional aspects of the figure, which results in a “developmental age” being derived for the human figure drawing (Vane & Kessler, 1964). In 1963, Harris revised Goodenough’s scale (published originally in 1926), developing what has become the best known and most widely utilized scale for evaluating human figure drawings: the Goodenough-Harris Draw-A-Person-Test (Harris, 1963). Recognising the rate of development was different for boys and girls, and that drawings of women differ in the amount of detail typically depicted, Goodenough and Harris derived separate scales for drawings of men and women, by boys and girls. Other developmental scales used to assess children’s human figure drawings have been devised following the general conceptual model of Goodenough-Harris, (Koppitz, 1968, 1983; Naglieri, 1988), each validating the universal aspects of the stages of development in the drawing of the human figure (reviews in Mortensen, 1991).

Traditionally, the Goodenough-Harris scales have been used to calculate a “nonverbal IQ score” by comparing a child’s chronological age to the developmental age achieved on his or her drawing of a human figure. A drawing with a developmental score equal to the chronological age of the child will produce a ratio equal to 1, equivalent to a nonverbal IQ of 100, the average IQ expected for a child of that age. While this use of the child’s human figure drawing as a measure of intellectual and cognitive capacity was the primary focus in the early phase of drawing research, it has been apparent to many clinicians that personality factors were also elicited by the projective task (Hammer, 1980). Goodenough herself felt that a child draws what he or she knows, not simply what is seen. What has been experienced is projected onto the drawn human figure, house or tree (Burgess & Hartman, 1993).

Koppitz, in 1968, added another scale to the assessment tools available for use with children’s human figure drawings. Her work took into account the child’s age and sex, building on the Goodenough-Harris findings, but she added a clinical dimension, by determining thirty aspects or
features in children’s drawings which may indicate an unusual level of emotional distress. These items comprise the Emotional Indicators Scale (Koppitz, 1966, 1968), and have been shown to be reliable in test-retest standardizations since that time (Koppitz, 1983; Moore, 1981; Ogdon, 1978).

In recent years, I have found the developmental age of a child’s drawing also to be a possible indicator of a period in the child’s life when there was traumatic stress which may have disrupted normal developmental patterns in some way (Moore, 1990). This has been shown to be a useful assessment tool in cases where a child has encountered emotional distress and/or trauma due to the experience of a medical diagnosis and/or treatment, or any type of abuse. The case accompanying the figure below illustrates one way in which a drawing’s developmental age score can inform case workers about traumatic events that are still psychologically unresolved for a child. [Insert figure one about here]

Mark was five years old when he drew this “person,” as part of an evaluation for aggressive and tantrum behaviour in school. His human figure has no nose, and was drawn without a chest (or body). The giant “mouth” is filled with numerous vertical lines, and its boundaries coincide with the outline of the face in such a way that it covers the entire lower half of the face—giving the impression that it is not a mouth at all, but rather something which is solid and covers the area where a mouth would be. These features suggested the experiences of many asthmatic children—terribly constricted chest, mouth and nose covered or unable to get air.
Taking a history from Mark’s mother, the psychotherapist learned that Mark had had physical and emotional difficulties from birth. In addition, his medical history included a diagnosis of asthma at one year, and he had had several acute attacks leading to emergency hospitalizations. The physical experience of asthma—including traumatic hospitalizations—was thus communicated in the specific features and omissions of normal body parts that would be expected in a human figure drawing of a boy his age (see Koppitz, 1968 “Expected Items”).

Mark’s psychotherapist also realized that the developmental level of Mark’s tiny human figure drawing would be approximately that of a two and one-half to three year old child. Keeping this in mind, at the end of the interview, the therapist asked whether there were any particular events that might have been especially traumatic for him or the family, when Mark was two or three years old. At that point, Mark’s mother became very tearful, saying she had placed him in day-care when he was two, while she went back to work. He was there every weekday for several months before she found out from another parent that he (and other children) were being gagged as punishment for screaming, and at times shut in a closet. Once this information came to light, Mark’s mother joined the other parents in bringing legal action which resulted in the closure of the day-care center. Nonetheless, she had been unable to resolve the intense guilt she felt for having placed him in such an abusive environment. She had not discussed her feelings with him, having been told by other parents that the children were “really too young to remember, and if they weren’t reminded, they would get over it a lot sooner.” [I will return to Mark’s case when discussing drawings which reflect multiple traumas, especially chronic illness and abuse experiences, later in the chapter.]

**Memory: conscious and unconscious / declarative and nondeclarative**

Drawings of the human figure, and symbolic self-representations such as trees, reflect both conscious self perception and/or self-knowledge, and an unconscious, historical record of the actual experiences one has had—especially those of a traumatic nature, the memory of which may be totally out of awareness (Hammer, 1955, 1980; Klepsch & Logie, 1982; Levick, 1983; Ogdon, 1978). An illustration of this aspect of drawings was produced by a young diabetic boy who—when asked to draw a person—drew a male human figure looking very distressed, with six heavily drawn “pockets” on the otherwise only outlined clothing. A tiny dot or circle was drawn in each pocket.
Looking at the drawing, it was striking that these pockets corresponded exactly to the areas on his body where he received repeated insulin injections. Realizing that both actual experience and constructed meaning (including defences and coping strategies) are potentially being expressed in a drawing allows the psychotherapist to vary interpretive content appropriately, recognizing that non-symbolic representations may reflect memories which cannot be verbalized at present.

As the observer of a drawing, it is never possible to identify definitively which aspects in a drawn human figure are conscious and reflectively created, and which are a representation of actual experience. Our role as subjective observer keeps the interpretation of drawings a joint communicative process involving both the viewer and the artist, not an objective science. However, we are increasingly understanding the potential levels of representation in a drawing, with the aid of our patients and some very important new knowledge available to us from the areas of cognitive and neuropsychological science (Cohen & Squire, 1980; Grigsby, 1991; Nadel, 1992; Schacter, 1992).

These authors, and others, have articulated the idea that we hold memories in separate and not always verbally accessible parts of our mind (Johnson, 1985).

Recent neurocognitive research has introduced the idea of a multi-modular memory system in the brain (Grigsby et al., 1991). A modular memory system allows certain aspects of experience to be recorded in interactive patterns as “procedural” knowledge or memory. “Procedural” memory is one type of nondeclarative memory, which records habit forming and skill learning experiences, but is generally not accessible to verbal recall. By contrast, declarative memory or knowledge can be verbalized (Cohen & Squire, 1980; Grigsby, 1991; Squire, 1992). In some instances, procedural and declarative memory are linked (for example, knowing that you know how to play checkers, being able to tell someone else how to play—including how you move each piece on the board & strategies for winning—versus playing a game, intent on winning), but various circumstances can result in a complete dissociation of the two memory capacities.

In a review of the literature on declarative and nondeclarative memory systems, Squire (1992) offers the following definitions: *Declarative* (or explicit) memory refers to memory for words, scenes, faces and stories. It is assessed by conventional tests of recall and recognition. It is a memory for facts and events. (p. 232) “*It can be brought to mind and content can be declared.*” (Cohen & Squire, 1980).
By contrast, Nondeclarative (including procedural, and implicit) memory is utilized in “nonconscious” abilities. This type of knowledge is grouped under several subsystems in the brain—the subgroups only having in common the fact that the memories cannot be consciously accessed and verbalized. Examples of the types of learning which might be considered “nondeclarative” are 1) the knowledge acquired during skill learning: motor skills, perceptual and cognitive skills, 2) habit formation, 3) emotional learning or classical conditioning. In other words, this knowledge is expressed through performance, rather than recollection. (Squire, 1992, p. 233)

This has obvious relevance for human personality organization, conscious and unconscious self-perception, and projectively, for the levels of self-knowledge reflected in drawings. Traumatic experience that is held in declarative memory can be consciously recalled, verbalized and represented in a drawing—whether related to illness, abuse, or other events (Goodwin, 1982; Kelley, 1985; Naitove, 1982; Terr, 1988; Udwin, 1993). In some cases, knowledge of what occurred may be repressed or dissociated—not retrievable from declarative memory—due to its traumatic impact. The interactive process or body memories of traumatic experience will be held in nondeclarative memory—in procedural form—whether there is a declarative memory that is available or not. These nondeclarative, procedural memories cannot be articulated verbally but will influence behaviour in specific ways, such as in habit formation.

A key feature of the various non-conscious mental processes is that “nondeclarative memory can support long-lasting changes in performance following a single encounter.” (Squire, 1992) A single near-death experience such as almost drowning, or the experience of a serious auto accident can alter our sense of self and behaviour for years—whether accessible to declarative memory or not. In most cases the experience of the event will be part of one’s procedural, nondeclarative memory for a lifetime (Terr, 1990).

Recent studies have shown that procedural memory is fully functional even in early infancy (Hartman & Burgess, 1993; Nadel, 1992). A child of four or five years, without conscious memory of a traumatic or life-threatening experience in the first year of his or her life, can accurately recreate the dynamic situation in play materials, when allowed the unstructured time to do so (Gaensbauer, 1993). A tendency to enact (Terr, 1988) or portray in drawings (Burgess & Hartman, 1993) “unremembered” as well as remembered early traumatic experiences is well documented in research
studying the behaviour and physiological sequelae of child survivors of traumatic events (Eth & Pynoos, 1985; review of literature in Udwin, 1993). A child’s drawing process, as well as the drawing itself, may reflect specific procedural memories of early childhood trauma, as illustrated below.

[ Insert Figure 2 about here] 

Maria’s human figure was drawn beginning with an initial “U” shape for the head, rather than the expected circle. After adding facial details and curved lines along the sides of the head for hair, she drew a curling spring-like line connecting the top points of the “U”. She placed a heart in one hand. Maria’s unusual drawing process and choice of added features in her drawing took on communicative value later when the psychotherapist took a history from Maria’s mother. She learned that Maria had been born with an “open skull” which seriously endangered her life. Concerned physicians believed that surgery to repair the skull was necessary to save her life, but Maria’s mother felt she would rather take her daughter to a “faith healer” whom she trusted. Maria was in an extremely vulnerable state for many months, with the family in a state of high anxiety, but her mother reported with pride to the psychotherapist that Maria’s skull did eventually grow closed.

**Self experience: Simple and Complex**

In a different vein, but with equal applicability to the study of drawings and illness, Bollas (1992) has described two separate but complementary self experiences we regularly encounter in dreams.
One is the experiential “simple self”, capable of deep experience but unable to view it other than unconsciously from within the (subjective) dream actor’s position. The other is the “complex self”, capable of observing the actions of the simple self, reflecting upon that experience and interpreting events to give a logic and meaning to the experience. In Bollas’ (1992, p. 3) words, “dream life mirrors an important feature of self experience, particularly that essential split between two subjective locations: the place of the initiating subject who reflects upon the self, and the position of that subject who is the reflected upon, turned in a brief moment into an object of thought. [my emphasis]”

The key to this “dynamic reflexivity” is that as “observed object” the experiencing self exists in an unconscious mode of being, fully unaware of any observed aspect of self. This loss of consciousness, allows what Bollas refers to as the “simple self” to be present, and as such—without the consciousness of reflective process about the self—this self experience is capable of certain self experiences that are meaningful, but escape full knowing. “When we are ‘in’ the dream, although as a simple self we do perceive dream objects, it is more to the point to say that we endure deep experiences there. [my emphasis] “Recollection and interpretation of the dream’s meaning do not necessarily address the essence of self experience gained by the simple self’s movement through the events of the dream.” (Bollas, 1992, p.7) Full knowing is provided by the activity of the reflective or “complex self” where an observing function is activated. Bollas believes we oscillate between these two psychic positions.

Some qualities of dreams are extremely similar to aspects of drawings, and undoubtedly utilize some of the same cognitive and affective memory systems in the brain (Moore, 1991). We might, in this context, substitute the word drawing for dream in the above paragraphs, and reach an important understanding of the rich texture of a human figure drawing. There will be reflections of a “simple self experience”, experiences which involved intense affect and proprioceptive knowledge of our body state (procedural) which may not be accessible to our “complex, observing” self process—the declarative process by which we seek to verbalize and represent our experiences.

In the drawing of a human figure, the process of projection allows for both types of self experience to be reflected and both conscious and nonconscious memories to be accessed in the creation of the drawing. While these two aspects of self are reflected in the drawing, we should hold in mind that
the simple self experience may not be symbolic in nature. Body and simple self experiences held in nondeclarative memory may be depicted graphically, placed physically on the body where the physical experience is held “procedurally”. Aspects of the drawing held in declarative memory will represent the reflective self, an interpretive, symbolic expression of the meaning we have given to nonconscious, simple self and body experiences. Thus, a rich tapestry of self experience is interwoven in the final product, however sketchily it may be manifested.

Two examples of this dynamic interweaving of complex and simple self experience are shown in the drawings below. Carl’s birth was difficult, and there was a brief period of asphyxia during which time he was reported to have “turned blue.” At the time he was assessed for cognitive delays and/or mental retardation at the age of seven and one-half, he evidenced severe gross motor control problems, and pronounced speech and language difficulties. His drawing of a human figure was “loosely” drawn, however his facial expression reflect intense concentration during the task. Without words he produced this eloquent expression of the experience of living with major physical and language handicaps, feeling within himself kind of double existence—a deeper self inside a physical self which is not coordinated or integrated with inner experience or intention. In the fist and punching arm, we might understand some of his anger that those on the outside respond to him and treat him as though that “outer armour” were all of him! [Insert Figure 3 about here]

A second example of simple and complex self-representation is a human figure drawing by an eight year old asthmatic boy uses a simple line across the chest as the only “clothing detail.” The added
detail to the face “complicates” the nose, while the line across the chest may represent the physical experience of tightening of the muscles, and constriction, a hallmark of an asthma attack. Here we may see representations of the experience of constricted breathing and loss of air in a frightening asthma attack, held as nondeclarative procedural memories. In addition, the line across the chest is reminiscent of the “crosswalk guard” who protects children as they cross the street. Perhaps there is a symbolic representation of the wish to protect his life when it is endangered by a severe asthma attack? [Insert Figure 4 about here]

I am suggesting that the communicative quality reflected in young children’s “enactments” and “re-creation of the events” in play materials is in part an expression of the procedural, nondeclarative memory of the child, and is equally represented in the projective drawings of the child. Simple and complex self experience are simultaneously reflected, as they might be in a dream. Life experience and self-perceptions are expressed on conscious and unconscious levels. This understanding of the complexity of communication in drawings allows many interpretations of specific features of the drawings of chronically or seriously ill children, as their physical, procedural memories will be represented—at times graphically, at times symbolically—along side the symbolic representations communicating a more complex intrapsychic and interpersonal experience.

It is extremely important to remember that, as outside observers, we have no accurate way to determine which features of a drawing represent various levels of communication, and cannot claim to be able to differentiate aspects which reflect simple self experience, procedural memories, or complex, declarative self-perceptions. We do know that some representations in a drawing will not be symbolic in nature, but will accurately reflect some body experience that is held without
reflection in nondeclarative, procedural memory. While we cannot know for sure which features are non-symbolic, we can hypothesize about the child’s experiences, and can do further non-intrusive investigations along the lines of our hypotheses.

**Trauma and Illness**

The impact of trauma on a child has been documented widely (Eth & Pynoos, 1985; Nir, 1985; Terr, 1990; Udwin, 1993), and both traumatic medical procedures and traumatic abuse experiences will be reflected in children’s drawings (Burgess & Hartman, 1993). There are similar representations in drawings of children who have a history of chronic medical difficulties and interventions, and those who have had a history of physical or sexual abuse (Burgess & Hartman, 1993; Goodwin, 1982; Kaufman & Wohl, 1991; Moore, 1990; Whol & Kaufman, 1985). It is important to note that while we see identifiable evidence of traumatisation in drawings, we cannot determine from a drawing alone whether the cause was a medical intervention or procedure, or other abuse experiences of one type or another. Simply recognizing that the child has been traumatized will be of help in treatment planning in either case, while we obtain more information regarding the exact details of the child’s experience(s).

One of the experiences that will vary among children and, as a result, will be shown in various ways in their drawings, is the degree to which the child is traumatized by specific medical procedures. The number and type of “anxiety indicators” on a drawing serve as one measure of the child’s level of distress. Chronic heightened anxiety is commonly seen in children and adults who have traumatic histories (Eth & Pynoos, 1985; Udwin, 1993). Many sources confirm the finding that anxiety is commonly reflected by one or more of the following features: excessive shading, small figures, rigidity in the drawing process, over-worked or heavily drawn lines in drawings (Burgess & Hartman, 1993; Furth, 1988; Hammer, 1980; Klepsch & Logie, 1982; Koppitz, 1968). As anxiety is reduced, the process of drawing becomes more spontaneous, excess shading is reduced and over-working of lines during the drawing process decreases.
The utility of drawings in evaluating and treating children in hospital has become more widely acknowledged in recent years. Nurses have found communication with children in oncology units to be enhanced by the use of drawings (Johnson & Berendts, 1986), and therapists can document shifts in a dying child’s self experience with sensitive interpretation of a child’s communication in drawings (Judd, 1989). Children’s experience of hospitalization is effectively reflected and communicated to care-givers through drawings (Allen, 1978; Broeder, 1985 cited in Wilson & Ratekin, 1990). Communication is enhanced when certain key qualities of a drawing can be discerned and utilized. One indicator that knowledge is held in declarative memory and can be verbalized is symbolic depiction in a drawing. Where experience is depicted graphically, verbal memories may not be available, and questioning or probing about traumatic experiences may be experienced by the child as intrusive and anxiety-provoking, if not re-traumatising. In such cases, interpretation of the child’s affect and longing for protection in a frightening environment, will be more appropriate as an initial focus. When the child initiates conversation about their experience—indicating that they are able to access declarative memory, either directly or by relating the story that accompanies a drawing—discussion of actual experience and more traditional psychoanalytic interpretation of events and the symbolic meanings given to experience, becomes the goal of therapeutic treatment.

Repeated medical treatments for an allergy of unknown origin were ineffective in curing Christina’s hives, which covered her limbs and trunk. Referred by her GP to a psychotherapist at age five, she stated that “she knew where her pain was, because she could see it in her skin.” A history revealed that the hives began when Christina was placed in nursery school at the age of four, a year after her father had died of congenital heart failure. He died in hospital very suddenly having gone in for what he and his family had considered a routine check-up. Christina was told that he “had not felt pain” and “he was sorry he did not come home again to see her, as he’d promised he would.” Christina’s mother experienced extreme but unconscious anger at her young husband for leaving her with three young children, and when Christina showed extreme distress whenever her mother left her, Mother felt intense guilt. Christina’s drawing, at intake, would have been appropriate for a child of about four, and revealed her bodily preoccupation, especially with marks on her skin, and a diffuse, non-differentiated, body image. [Insert Figure 5 about here]
Work began around her experience of fear and terror at separation from her mother, and her need to “know she will come back for me.” Christina vehemently denied any links made to her feelings about her father’s sudden death two years previous. Work with the mother took place in a traditional psychotherapy, where her complex feelings about her children and her unresolved mourning for her husband were explored. As mother’s unconscious rage and guilt became conscious, her ambivalence about her children’s post-traumatic heightened dependency needs was reduced, and she was able to comfort Christina at times of separation during the day and at night.

When Christina found she could ask for and receive comfort from her mother, the hives disappeared. She began to move in her own therapy to work on feelings of guilt and responsibility for her father’s death. This included confusion about his having died when he had “not felt pain.” She was able to ask how her father “got the hole in his heart.” She wondered very anxiously whether she herself “had shot him one time.” At this point, her human figure drawings changed dramatically, and showed age-appropriate body awareness and identity. [Insert Figure 6 about here]
Christina’s second human figure clearly indicates that she still experienced anxiety about her skin (heavily shaded arms and legs), and her defenses against feelings of abandonment raised fears about her aggressive impulses (“muscles” and “big arms”). We might speculate that the inclusion of flowers on her dress is a symbolic expression of her oedipal fears and wishes regarding her relationship with her father and mother prior to her father’s death (when she was three). These unconscious feelings may have been masked, initially, by more graphic, concrete (and age-appropriate for a four year old) concerns about illness and death, as her original undifferentiated human figure drawing masked the body and gender of the figure.

**Multiple traumas: Illness and Abuse**

In some cases, a child has a severe illness and has experienced some other type of trauma—perhaps physical or sexual abuse—which is also reflected in the characteristics of the drawing. Many aspects of a drawing may be multi-determined. One particular feature may represent both a graphic level of nondeclarative memory or experience, and symbolize complex meaning given to declarative knowledge. When we see something that appears to be symbolic to us, it may be more than that—it may be a graphic re-presentation of an unconscious procedural memory from early childhood and/or a repressed memory about something which the child is denying, in order to reduce the current state of anxiety.
Earlier I discussed the drawing of five year old Nick, shown in Figure 1. Using the two-and-a-half year old developmental level of the drawing as a clue, his psychotherapist helped his mother to discuss very traumatic abuse experiences he had had at the age represented in the drawing. Nick’s psychotherapist knew that his abuse history included having been gagged and locked in a closet, and she quickly saw that his drawing graphically reflected this experience—both procedurally and declaratively. It also was expressive of his experience of asthma since infancy.

It is crucial that we do not assume to “know” all that or “exactly what” a drawing “means” even when one hypothesis has been confirmed by other sources of information. What a loss it would have been for Mark and his mother, if his therapist, receiving this particular drawing, knowing his referral problem had been tantrums and aggressive behaviour, had simply interpreted the “large mouth” and “big teeth” as symbols of his aggressive impulses. (Which they may very well be, in addition to the other non-symbolic levels of expression we have discussed.) We do ourselves and our patients a disservice when we bring closure to our exploration of meanings in a drawing relying on theory rather than our sense of the multiple levels of communication in a drawing.

David’s case provides us with another poignant example of the complexity of cases where chronic illness and abuse are both part of the child’s history. I saw this child in a family therapy setting within a general hospital. David was the identified patient, brought in to the clinic because of aggressive acting out at school and at home, including uncontrolled fits of rage. He was nine years old, very small in stature. His impulsive, restless behaviour struck me as reflecting extreme anxiety. I asked him to make a drawing of a person, and he drew a tiny (under 2”), outline of a human shape, with eyes, but no mouth or nose. He put a hat on it. When I then asked him to draw a figure of the opposite sex, on a separate paper he drew an almost identical figure with eyes but no nose or mouth, however this one was twice the size of the first (about 3/5”), without a hat, but with eyelashes. He told me that “that was the best he could do”. [Insert Figure 7 about here]
Initial interviews with David’s mother revealed that he and his brother had a rare genetic disease that they had inherited from their mother—a progressive degenerative disease of the teeth and gums, which is carried by females but only manifested in males. The disease would cause all David’s teeth to decay, necessitating surgery and replacement with false teeth by the time he reached adolescence. He had already had several traumatic trips to the dentist, and was well aware of his illness and the painful aspects of his future tooth loss. Mother was aware of feeling extreme guilt for passing on the disease to her sons, as she had known she would do so if she had male children.

This in itself would be a rather straightforward explanation of David’s highly unusual depictions of human figures without mouths, however, it turned out to be only part of the story conveyed in this child’s drawings. On-going work with the family later revealed that David’s father, a high ranking member in a fundamentalist religious sect, habitually battered his wife and children, and had threatened each of them with terrible retribution if any one of them were ever to talk about the physical abuse they experienced. When this information came to light, it made clear a second powerful determinant of the highly unusual lack of a mouth on this child’s drawings. If he had no mouth (and mother had no mouth) neither could run the risk saying something which would bring destruction on the entire family.
Developmental Stages in Children’s Human Figure Drawings

While there are no validated scales that can be used to evaluate the developmental age of human figure drawings of children under the age of five, many authors have described the earliest stages in the development of drawings of the human figure in very similar terms. (Gardner, 1980; Goodnow, 1977; Kellogg, 1969; Levick, 1985; Moore, 1991; Mortensen, 1992; Thornburg, 1976). Between the ages of two-two and one half and five, all children progress through three or four more or less universal stages in the development of the drawing of a person. In part, the reason no more specific, standardized scale exists is that children’s development in those years is so varied, with lags and spurts in various skills and sensory modalities, with a great diversity in what is considered normal for boys and girls at any particular age. By the age of five, differences in rates of normal development have become stablized within narrower parameters—particularly in the areas of fine motor skills, language and cognition, and capacity to use and reproduce written symbols—making standardization of assessment scales more feasible. A general overview of the major shifts in capacity to draw a person, in children between the ages of two and five, follows.

Children’s earliest graphic expressions are scribbles; innate pleasure in movement is one motivation, although children are obviously pleased that their efforts leave a visible mark on the environment. Between the ages of two years - six months and three years - two months, scribbles become more skillful, and designs of whirls, zigzags and lines are produced. However, it is still pure play with little accommodation to reality and little control over what the pencil might produce.

Sometime after the age of three, children begin to label their scribbles. This transitional stage falls between scribbling and representation proper. Representation is verbal in character during this stage, until motor development catches up. Hilary, who, at age three years six months, responded to the request to draw a person with a scribble picture extending over the whole page, gives us an example of this “transitional” phase. She comments on her drawing: “It’s a person with a lot of hair—he is having a shampoo” (Thornburg, 1976, p.5).
Soon after the child begins naming his drawings, he establishes greater control over his pencil and begins to create simple but intentional representations of forms. The straight line and circle or ellipse start to appear, freed from the whirls and scribbles that surrounded them before. In the circle the child finds an effective tool to create figures and objects. The circle can be the sun, a face, eyes, mouth, bellybutton, etc. The child has moved to the discovery of similarities and develops his first representational concepts. Of course, still hampered by immature motor control, he cannot coordinate the medium with his intentions. These early phases of development are followed by sequential stages in the drawing of a human figure, which continue into childhood and early adolescence.

Children’s first and most frequent representation of a person is a large circle. During the next stage of development (usually at two years - six months to three years of age), two vertical lines sprout downward from the circle, creating the “Tadpole Human”. The child intends the two lines as an outline of the body as well as legs; the area between the lines is not perceived as empty space. Thus the bellybutton frequently found between these lines is not “floating” there but is appropriately placed in the center of the trunk from the child’s point of view. Some time after the appearance of legs, arms are drawn at right angles to the circle or torso/legs. [An example of a “tadpole person with arms is seen above —Nick]

An enclosed trunk appears on drawings of children who are approximately between four years - six months to five years - six months of age, creating the first “complete person.”. A horizontal line connecting the two verticals may show where the tummy ends. The square trunk arrived at by this method and the round trunk—where a second circle is placed under the head—are equally frequent.

Once the trunk is enclosed, the human figure becomes increasingly sophisticated as limbs are drawn with two lines (rather than as “sticks”), and clothing items, hair, feet, and eventually a neck are added. The arms drop closer to the body, hands and later fingers are added, along with pupils in the eyes, and nostrils in the nose. Details and proportions become refined and increasingly reality-oriented (Thornburg, 1976).

It is widely recognized that this ordered developmental sequence in the drawing of the human figure allows a child’s intellectual maturity to be estimated when his or her drawings are studied. Long, widespread use of the developmental scales evaluating children’s human figure drawings has
confirmed the reliability and validity of the HFD as a universal measure of cognitive abilities in children from five to twelve (Goodenough, 1926; Harris, 1963; Koppitz, 1968; Naglieri, 1988; Moore, 1978, 1981, 1990) or sixteen years of age (Koppitz, 1983).

**Trees and human figure drawings**

Due to the universality of the development of the capacity to draw the human figure, the study of person drawing’s in particular has been fruitful in understanding how our self perception is or may be projected onto paper. The traditional definition of a projective device is an ambiguous or unstructured stimulus or series of stimuli which necessitate the subject drawing on his or her own perceptions in order to give meaning to the stimuli. “Symbolically, potent concepts such as house, tree, and person are saturated with the emotional and ideational experiences associated with the personality’s development, and the drawing of these images compel projection on the part of the drawer.”(Hammer 1985)

With increasing maturity, the request to draw a person or draw the self is likely to evoke increasingly complex defenses, produced by self consciousness and increasing awareness of how the self is viewed by others. In adolescence and adulthood these defenses are very well established, and result in increased conscious “disguising” of the material being produced. For this reason, the drawing of a tree becomes more and more important as a second source of projected self image in older children, adolescents and adults. Few of us have well developed defences regarding the drawing of a tree!

Clinical experience suggests that it is easier for a person to attribute more conflicting or emotionally disturbing negative feelings to a drawn tree than to a drawn person, because the former feels less close to a self-portrait (Bolander, 1977; Hammer, 1955, 1985). While there have been no studies done showing “developmental stages” in children’s tree drawings, several authors refer to “commonly seen” characteristics in trees drawn by children of various ages. Koppitz (1968) refers to the “apple or fruit bearing tree” which is common among five-six year old children, and DiLeo (1983) interprets the drawing of an animal in a hole in a tree as a reflection of impulses which are within the conscious awareness of the child, but are being kept under control. Children draw a live tree 85-90% of the time, as opposed to dead DiLeo (1983). Hammer (1985) articulates the similarities and differences in communication of self perceptions in adult drawings of trees:
As to the tree and the person, both these concepts touch that core of the personality which theorists, notably Paul Schilder (1935) have labeled the body image and the self-concept. The drawing of the tree appears to reflect the subjects’ relatively deeper and more unconscious feelings about themselves whereas the drawn person becomes the vehicle for conveying the subjects’ closer-to-conscious views of themselves and their relationship with the environment. ... The tree, a more basic, natural entity has been found to be a more suitable symbol to project the deeper personal feelings, feelings about the self residing at a more primitive personality level than what is considered the norm. The subject’s methods of dealing with others and feelings toward them, are more apt to be projected onto the drawn person. (p. 138)

Trees provide us with a powerful “container” for our projections of self experience and defensive organization. Data from normal children’s drawings show that trees are drawn as live by a very large majority of children (over 90%), and are drawn with leaves and fruit, birds nests, animals living inside, etc. Children who have had experiences with rejecting or abusive parents or who have been in other abusive environments, may draw pine trees with sharp needles, or palm trees with their spiky branches and sharp, thickly armoured trunks (Wohl & Kaufman, 1985). Violet, a seven year old child from an abusive family, diagnosed with a dissociative disorder, drew a simple house and stick figure, next to a large tree with deep horizontal gashes across the trunk between the ground and the leafy top. She labelled the heavy marks on the tree trunk “scars.” She spontaneously added that she had “made the scars into places where she would put her feet” when she was climbing the tree, “to
get into the top, where I can hide for a long time, and no one can find me.”

This drawing illustrates Hammer’s statement (1985) describing the portrayal of emotional (and I would add physical, actual) trauma “by scarring the drawn tree’s trunk, and truncating its branches.” Hammer believes that such a depiction is much more likely than the “mutilation of the drawn person’s face and body and similar damaging of the drawn person’s arms.” (p.138) It is my belief that the child’s heavy shading of the person’s clothing—especially the heavy pencil pressure used in drawing lines across the shirt—may represent repressed memories of physical abuse, reflected without conscious awareness, from the child’s procedural memory.

Findings from studies of children with chronic illness also shed light on the use of the tree as a projective measure. Drawings of trees were collected from children in the diabetic ward, in a London teaching hospital. The trees drawn by these children had several surprising features in common, and differed from what one would expect of normal children: the trees consistently bore broken branches, showed leaves or branches falling, or were described by the child as “dead or dying”. [Insert Figure 9 about here]
The striking and highly unusual commonality of these children’s trees reflected what appeared to be a shared experience of the traumatic impact of receiving the diagnosis of diabetes, and beginning the anxiety provoking and painful insulin treatment process. One child told the evaluator, “This is a live tree, but it has just been told it has Dutch Elm disease and it will be cut down at the base tomorrow.” Perhaps the characteristics of the tree drawings reflect something of the “shortened life-span expectation” that has been documented in traumatized children (Eth & Pynoos, 1985; Terr, 1985, 1988; Udwin, 1993).

Cindy: A diabetic case study

In 1992, a child psychotherapist in Melbourne, Australia, contacted me to relate the following story of the use of drawings in the treatment of a ten year old diabetic girl. The child was already in psychotherapy when her therapist learned of the unusual characteristics seen in the London diabetic children’s tree drawings. Cindy was a ten year old diabetic girl referred to a large Australian Paediatric hospital, due to her endocrinologist’s concerns about her severe and prolonged grief reaction to the diagnosis of diabetes. Her symptoms were the most extreme he had seen.

A history revealed that Cindy was seven years old at the time of diagnosis, which came just a few months after the sudden and unexpected death of her maternal grandfather. Her mother’s family
were very close both emotionally and geographically, living a mile apart on the same farm property. From the family’s description, the maternal grandmother’s reaction to her husband’s death had also been severe. Maternal grandmother was still significantly depressed—in a state of “learned helplessness”—remaining very dependent on Cindy’s mother for emotional support and day-to-day care. During the three years post-diagnosis, Cindy had become more and more reluctant to go to school. She emphatically wailed that she was dumb and, in order to stay at home, claimed daily that she suffered numerous aches and pains. In the few months preceding referral, she had attended school on only two occasions.

Cindy presented as a solid, but immature ten year old girl. On reflection, she seemed much more like a seven year old (her age at diagnosis and family crisis) than a ten year old. She was friendly and talkative throughout the assessment with a clinical psychologist on the hospital staff, who continued to work with her in a combination of individual and family therapy. Due to the long distance the family needed to travel to the hospital, short-term, time-limited psychotherapy was planned.

Coinciding with Cindy’s time in psychotherapy, her psychotherapist attended a workshop on the use of drawings in assessment of children with physical illness. Although past the assessment phase, she wondered whether she could use the technique therapeutically as part of the psychotherapy. In the next individual therapy session, she suggested that Cindy draw a tree. Since a large majority of the diabetic children in the London sample had drawn dead or dying trees with broken branches, Cindy’s psychotherapist found herself “expecting” to see a dead tree drawn. Instead, Cindy drew what appeared to be a live tree.

When asked if there were a story about the tree, Cindy related the following: “It’s the tree in our front yard. It’s half broken. The big storm knocked half of it over. Now, Mum and Dad are fighting about what to do with it. Mum wants to cut it down, and Dad wants to let it live.” Cindy’s psychotherapist reflected: “I wonder if it’s a bit like the battle inside you. One part feels dead and the other part wants to be allowed to live and start growing again.” Cindy quietly nodded.

Following this session, Cindy seemed less internally conflicted and anxious and started going to school without difficulty. It was as if the intervention, while highlighting her dilemma, acted as a freeing device. In the following family session, all members were happier about Cindy, but they informed the psychotherapist that Cindy’s brother James had hurt his leg so he was at now home.
This information was used to help the family think about the need for one family member to stay at home to look after mother and grandmother. In response, to the psychotherapist commenting out loud on how worried the family seemed to be about Cindy’s mother, everyone began to cry. Another family session followed, focusing on how the mother could convince the family she was OK. Focus had shifted from Cindy to her mother. Follow-up three months later found Cindy settled back in school, her brother’s leg healed, and her mother starting part-time work.

Other symbolic representations: Sun

Along with trees and houses, drawings of the sun are apt to be clinically significant in children’s drawings. At age of five or six they are very normal: most children include a sun in one upper corner or the other of a house or person drawing. After that age, suns are not as common, and by the age of nine or ten, they are considered “uncommon” in children’s drawings. Clinically, drawings of the sun are thought to represent a protective figure—most often a parent—or an emotionally significant figure in the life of a child. At the age children start school, they may be leaving home for the first time and spending a substantial amount of time in the company of other non-parental authority figures. In this context, the drawing of a sun in the corner of a picture can reflect the child’s sense of being “watched over and protected” by the internal parental object, who replaces the actual object in the child’s experience away from home.

Later, in latency, a smaller, whole (round) sun is more common than the “part object.” sun drawn in the corner of the page. Due to this developmental progression in sun drawings, the larger a sun is drawn, or in the corner of the page (partial view) rather than a circle, the greater the likelihood that a tendency toward dependency on the parent—of the kind that would be considered normal in a five or six year old child—is being expressed. In some cases the drawing of an inappropriately large sun over a house, tree or person can be a reflection of an overprotective parent in the child’s life.

Obviously, a child who is ill from infancy, or who has a chronic or terminal illness, is likely to be more dependent on his or her parents for help managing the illness, or coping with medical procedures. Here we might expect to see a larger sun drawn, especially if the medical diagnosis occurred when the child was five or six years old. In other cases, parents whose child who is ill from infancy may have difficulty letting the child become less dependent as he or she matures, and an
enmeshed or overprotective parent-child relationship may result. I believe Richard’s drawing illustrates just such a case. [Insert Figure 10 about here]

Richard:

During assessment in a mental health clinic, Richard, a frail-looking boy of eight, drew a picture of a house, a person and a tree. He added a sun with rays that filled almost one half of the page. Scribbling heavy pencil lines on both sides of the tree trunk, he commented: “This green stuff is moss and algae.” He went on, spontaneously: “What happens is, it’s always raining around there but with that sun, that green stuff grows all over the tree.” The “person” in Richard’s drawing was only 1/2” tall, but a “flower” (slightly larger than the person), grew out of the algae-covered side of the tree. He placed a small “animal” in a large knot-hole on the tree. He commented that he didn’t know “what kind of animal it was, but it had a home there, and was protected from the rain.” I felt these were hopeful signs.

When I met Richard’s parents I learned that he had had many physical difficulties from the time of his premature birth. He had respiratory and eating difficulties as an infant, was colicky, allergic “to most foods” and slow to learn to speak. His mother stated immediately that she had inadvertently become pregnant at the point when the couple had finally decided to separate, after three years in a
very unhappy marriage. Each parent felt so guilty about his difficult birth and on-going physical difficulties that they felt obligated “for Richard’s sake” to stay together. When I met them eight years later, they had no remaining personal or intimate relationship as a couple, and were both massively depressed. Richard’s mother cried much of each day, and his father adopted a rigid “Let’s always look on the bright side!” attitude to cope with his own internal despair. Richard’s experience was of being simultaneously smothered and drowned and inappropriately restricted physically.

His tiny “person”—a conscious self portrayal—was a direct contrast to his unconscious self expression reflected in the large tree, almost center-stage on the paper. Here we see his procedural self-knowledge, as the object of constant physical and medical attention from each of his parents and many doctors. During psychotherapy sessions with Richard and his family I learned that he had “never smiled until his little sister was born”. Five years his junior, an active and affectionate child, she was his closest companion, and his “best friend.” We might wonder about that “flower” growing out of the algae on the tree!
Spontaneous drawings and the use of colour

The intent of this chapter is to add to the existing literature on the drawings of children with physical illness by focusing primarily on the multiple levels of representation of self experience in human figure and tree drawings. Formal cognitive and developmental scales require a standard administration procedure to ensure comparability of drawings obtained across time and in various settings. Drawings must be done in lead pencil in order to allow a high degree of detail in the child’s portrayal, as the scale scores are based on the number and quality of details included in the human figure drawing. Colored pencils or felt tipped pens--due to the flow of ink or the softness of the colored pencil leads--may obscure drawn elements or features which are essential scoring details. These requirements in administration are well documented in basic texts on the use of drawings (Harris, 1963; Koppitz, 1968, 1983; Naglieri, 1988; Ogdon, 1978).

However, children’s spontaneous drawings almost always use colour, and are potent communications of the child’s affective state, fears, joys, concerns about physical health, relationships with family members, and so forth. Unlike the drawings obtained for assessment purposes using standardized measures, spontaneous drawings are a powerful projective communication with an intended receiver in mind! In this way, the creation of spontaneous drawings in psychotherapy is very similar to the creation of dreams. Dreams inhabit the “intermediate area” (Winnicott, 1971) a third area--reflecting both experiential and reflective self states--that paradoxically allows a psychic sense of actual space and is composed of objects that have actuality but which also signify aspects of the subject’s inner world. (Bollas, 1992). I am suggesting that drawings co-habit this paradoxical area with dream material. And, as such, spontaneous drawings are intended as communications to another. Often they are a bid for affective engagement.

Thus, such drawings have a very different purpose from those produced in compliance with the request from a therapist or another person in their environment. As in a dream, unconscious expression utilizes very mental resource available to create meaning, and form, content, colour are intertwined and manipulated “ruthlessly” to use Winnicott’s term for the use of the transitional object (Winnicott, 1971). In the service of communicating self experience, ill children’s drawings
may include brightly colored blue or red trees, or flowers may become black, taller than houses and people, or embedded in other objects (Bach, 1969; Furth, 1988).

This material needs to be utilised by the child and psychotherapist, just as the communication of a dream might be—personally, intimately, searching for the unique meaning given a form or colour by the individual child. In this way, the somatic experience of the child is provided symbolic expression—something which may not have been possible previously. McDougall calls some somatic expressions “dreams which are not dreamt” (McDougall, 1989). Spontaneous drawings can projectively bridge the gap between the world of somatic experience and the psyche.

Two authors have produced substantial texts based on years of sensitive work with individuals who were chronically or terminally ill. Their thorough analyses of spontaneous drawings and use of colour by children with physical illness are extremely valuable resources (Bach, 1969; Furth, 1988). Others have written with fresh insight about various aspects of work with children with cancer, and issues around the experience of hospitalization (Allen, 1978; Broeder, 1985; Johnson & Berendts, 1986; Wilson & Ratekin, 1990). Psychotherapy with children who are ill would be enriched by the use of drawings as illuminated by these authors.

An example of a spontaneous drawing which was a powerful communication arising out of material in a psychotherapy session is shown below. The drawing was created using colour—felt tip pens—but is reproduced here in black and white. [Insert Figure 11 about here.]
Betty drew four people in a row, while talking to her therapist about her family. They are careful likenesses of her two sisters, her mother, and herself. She is the second from the left, and drew herself with a “heart shaped hole” on her chest, then added many “freckles” within which the dot for her nose became obscured. She has a “rip” in one leg of her trousers. At this point in her drawing, Betty’s mother entered the therapy room. Greeting her mother, Betty quickly added “ground” for the figures to stand on, and a rainbow which encloses the entire family. The rainbow ended underground in a circle of gold.

Betty’s history included severe croup and bronchial infection from infancy, with food allergies developing and expanding as she matured. At the time of therapy she was being treated for a mild school phobia which had developed when mother and father were divorced the previous year. Mother was agoraphobic, and severely depressed (with suicidal ideation) after the divorce. She commented that Betty had always been the child who took care of her, “made things better.”

Particularly striking to an observer, I think is the tightly enclosed space inside the rainbow. There is no room for growth or development. One wonders whether aspects of Betty’s panic attacks—possibly “air hunger”, inability to breathe, and a pounding heart—are portrayed in her figure with “covered nose” and a “heart shaped hole in the chest.”

**Procedure in collecting drawings**

If at all possible, it is best to be present when the child is doing the drawing. It is only in this way that one can be certain where on the human figure, house or tree, the child starts the drawing. Very frequently a child will start with a part of the body (or the symbolically equivalent part of a house or tree) which has psychic significance for him or her. It is possible to use this as a reliable guide to unconscious meaning in a child’s drawing, precisely because there is a universal standard not only for what is “typically” drawn by a child of a certain sex and age, but also for the process of creating a human figure drawing. Approximately 85% of the time human figure drawings are begun with the head and face, and completed from the head down. (Koppitz, 1968; 1983) If a child starts her drawing with the feet or the genital area, or with one hand, she is telling us something about the importance of that part of her body, and she is sharing something of her experience in relation to it.
When watching a child draw a person, the direction that lines are drawn is also significant. In one case, a young boy drew a figure with stick legs and both of the legs were drawn from the ground up into the figure. The figure was drawn “floating” above the ground, and then the legs were drawn, heavily and overworked, repeatedly upward, as though the act of drawing the “legs” up into the figure already on the page were a reenactment of something having been “stuck, or pushed” into the lower half of the boy’s body. This becomes significant because we know that most children (and adults) draw the details of the human figure from the head down and draw each limb starting from the body which has already been created, directing the lines of the limbs away from the body.

Of course, seeing this, we are not able to tell why the child has started with an unusual part of the body, or reversed the expected direction of the lines drawn. There can be many reasons one might do this. The fact that it happens so rarely in the children’s drawings, tells us that it is unusual—not that it’s pathological— and that it very likely does have some meaning for the child, perhaps totally unconscious. Very young children (four years and under), just beginning to draw or write, may alternate directions while learning the fine motor skills involved in the use of paper and pencil. It is the habitual and emphasised reversal of the “usual” direction in drawing that takes on significance for the evaluator.

In the case of the boy above, obtaining a history from the parents revealed the fact that he had had a chronic problem with constipation, and daily enemas had been prescribed by his pediatrician. This procedure, which the child resisted and which involved significant physical and emotional distress for the boy and his parents, had continued for many weeks. This information allows us to consider one possible meaning which can accompany the reversal of direction in lines drawn on a human figure: The child may be reflecting a “procedural” memory which involved physical penetration of the body. We can see the possible implications for other “unusual directionality” in lines drawn on the human figures of children who have experienced multiple medical interventions, as well as physical or sexual abuse.

1. When having a human figure drawn, encourage the child to do the “best” drawing he or she can, but if the child seems anxious about lack of drawing skill, reassure him or her that you’re interested in all drawings, not because they are “art” but because only that child can do his or her drawing...no one else could create it! Creating a drawing for another (in this case for the evaluator) is giving that person a gift on one else can give.

2. Do not give any “suggestions” for the drawing, even if the child asks for help. When they are drawing a person, just encourage them to “do the best drawing of a person they can.” Whichever task they are attempting—drawing a person, house, tree or their family (a Kinetic Family Drawing)—any way they choose to do it is fine.

3. Often children ask to draw a favorite picture they “like to draw”—such as a car, or spaceship, or gun, or an animal. If you are planning to use one of the scoring systems to evaluate their drawings, it is best to have them draw a person first—let them know that “after this” you’d like to have them do their “favorite drawing” for you.

4. When a child has drawn something, you can talk to him or her about it to learn what they might be communicating to you in the drawing—what’s the story that goes with the drawing:

**However, questions NOT to ask are “Why did you draw this thing?” or “What is this thing?” “Where are the (missing body parts)”? These questions sound like a judgment about the quality of the drawing, and frequently make children feel self-conscious. When this happens, they often stop communicating about the drawing, because they are afraid of not giving the “right” answer.

**Some questions you might ask are: “Can you tell me about your picture?” “I’m interested in this picture—can you tell me what is happening here?” You can also ask about specific people or things in the picture by asking how the figure might be thinking or feeling, how old the person (or tree, or animal) is, what might happen next in the picture, when the person (or animal) feels happiest, and/or saddest.
5. Never criticize children’s drawings or their answers to your questions. Statements like “shouldn’t this person have arms?” are shaming to the child. Remember they are telling you about their experience of themselves as well as the drawing!
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**Figure Captions**

Fig. 1 Human figure drawing by Mark, a 5 year old asthmatic boy.

Fig. 2 Human figure drawing by Maria, a 7 year old girl born with an open skull. (Unless otherwise noted, this and subsequent figures are shown at 50% of actual size).

Fig. 3 Human figure drawing by Carl, a 7 year old boy with severe motor coordination and language difficulties.

Fig. 4 Human figure drawing by a 7 year old asthmatic boy.

Fig. 5 Human figure drawing by Christina, 5 years, with hives.

Fig. 6 Human figure drawing by Christina, 5 1/2 years, hives have disappeared.

Fig. 7 Male & Female Human figure drawings by David, 8 1/2 years, gum disease. (This figure is shown at 100% size).

Fig. 8 House-Tree-Person drawing by Violet, 7 years, dissociative disorder.

Fig. 9 Tree drawing by a 13 year old diabetic boy.

Fig. 10 House-Tree-Person drawing with Sun, by Richard, an 8 year old boy born prematurely.

Fig. 11 Kinetic-Family-Drawing with Rainbow, by Betty, a 10 year old girl with panic attacks and multiple food allergies.