CHALLENGING CASE: FAMILY RELATIONSHIPS AND ISSUES

The Use of Family Drawings by Children in Pediatric Practice*

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Developmental surveillance, the process of monitoring behavior and development in the context of the child, family, and social environment over time, is a major focus of preventive pediatrics. The primary care pediatric setting is well suited for this task because it assumes responsibility for continuity of health care throughout childhood and adolescence. The challenge to achieve the goals of effective developmental surveillance can be seen in the wide variety of developmental and behavioral screening tests created for primary care settings. There is not, however, a single test used by most pediatricians, and the test reported as used most widely (the Denver Developmental Screening Test—II) is used primarily when pediatricians suspect a developmental delay.

The family drawing is an alternative method to survey development at a given moment in time as well as longitudinally in a primary care setting. A single drawing is a snapshot of a child’s point of view of her role in the family, her relationship to other family members, and her self-esteem. Sequential drawings monitor both ordinary and extraordinary events and stresses in a child’s life. In addition to providing a clue to individual behaviors and family relationships, these drawings reflect the maturation of visual, motor, and spatial skills. In this context, it can be used as part of a school readiness examination or during an assessment of neurological or learning problems. At the least, an individual figure can be used in a Draw-a-Person test and scored to generate a developmental age that correlates with visual-perceptual and visual-fine motor functions.

In the Kinetic Family Drawing (KFD) test, the child is asked to “draw a picture with everyone in your family, all doing something.” A clipboard in each examination room, along with a black felt pen, can be available to encourage the routine use of these drawings. In my office practice, children and youths are asked to complete a KFD at each health supervision visit. Other practitioners find it useful when they suspect a specific problem. Although the KFD is a projective test, in which a child reveals her inner feelings about herself and her family, and although it is used by psychologists with a standard set of evaluation criteria, its use in pediatrics can be more subjective. I found it remarkably helpful on many occasions as a way to open a dialogue with parents and children concerning important behavioral and family issues. Typically, the KFD reveals a behavioral issue that has not been brought to the clinician’s attention previously. It is not uncommon for a parent or adolescent to make a significant comment or interpretation about a drawing without any direction from the clinician. When used on a regular basis as a component of developmental surveillance, the KFD illustrates many inner strengths in children and in family relationships. Visual motor maturation, facial affect, the proximity of the child to parents and siblings, and the activities depicted in the drawing might give a clinician an opportunity to comment positively about these strengths. Cultural differences might also be highlighted in the drawings. Caution, however, must be taken in interpreting the drawings. A family drawing is similar to a urinalysis or electrocardiogram; it is only one piece of data at one point in time, and it must not be overinterpreted.

I selected several examples of KFDs from pediatric practice. They illustrate the applicability of the KFD in both primary care pediatrics and a consultation practice in behavior and development. The use of drawings can also be a stimulating source of insight about child behavior and development for medical students and residents. The KFDs stimulate discussion among clinicians about child development because they remind us of the extraordinary breadth and individuality of maturation through childhood and adolescence.

DANIEL

When Daniel’s mother made an appointment for his health supervision visit just before his seventh birthday, she talked about his recent behavior change. During the past 6 months, his teacher phoned his mother on several occasions with concerns about Daniel’s disruptive classroom behavior. He hit other children on two occasions, offered comments when not called on, and frequently wandered aimlessly around the class, talking to other students and upsetting their work. He often did not complete his assigned work, either in school or at home. This behavior pattern was in contrast to his former cooperative, interactive, and productive style of learning and social interactions. The pediatrician discovered that Daniel’s parents separated 6 months ago, after a conflictual marriage during the past 3 years. Verbal battles between the parents were common, and Daniel witnessed physical spousal abuse on two occasions. Daniel saw his father on weekends, but the parents’ lingering distrust and anger surrounded the visits with ambivalence and stress. Daniel did not talk to the pediatrician about the visits with his father. He was subdued and answered questions with a single word and limited eye contact. His physical examination was normal. When the pediatrician rec-


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ommended a brief period of counseling to help Daniel explore his feelings about the separation and his new living situation, his mother adamantly refused. She declared that “therapy would harm him more.” While Daniel was waiting for the doctor, he was asked to draw a picture of his family (Fig. 1). When the pediatrician showed the drawing to his mother, she cried immediately, and then said, “Of course, you’re right. Daniel needs counseling to help him.” Daniel drew himself as a very small person next to his mother and her new boyfriend. The visual image of a diminutive person with a poor self-esteem helped his mother to overcome her resistance to counseling by associating his behavior with a poor self-image. The drawing acted as a nonverbal trigger to seek help. After five sessions with a therapist, Daniel’s classroom behavior improved, and he was once again receptive to learning.

JOY

Joy was 11 years old when she drew this picture during a visit for a mild acute illness (Fig. 2). She had lived with her mother in a single-parent family since birth. She had no siblings. On the surface, her physical health, school work, and social development were satisfactory. There were clues, however, to restricted interpersonal and social development. Joy made friends slowly. She was unusually cautious about leaving her mother to go to a friend’s house. She preferred to have a friend come to her house and play in her mother’s presence. Her pediatrician was concerned that the close bond between Joy and her mother limited the emotional separation between mother and daughter. Separation and individuation, the gradual process from dependency to autonomy, were not completed. At several previous office visits, her pediatrician unsuccessfully looked for an opportunity to discuss this observation with Joy and her mother. This drawing was an opening. When her mother was asked, “What do you think about this picture?” she initially responded with pride in her daughter’s drawing skills. Then she said, “We are rather close, aren’t we?” The pediatrician encouraged the mother to explore that observation. After 10 minutes alone with the pediatrician, Joy’s mother was motivated to help her daughter (and herself) to discover ways to achieve psychological separation while maintaining their loving and close relationship.

RECURRENT ABDOMINAL PAIN

Recurrent abdominal pain in school-age children is a common somatic symptom that often has no clearly defined physical, social, or psychological etiology. As many as 15% of school-age children experience these pains at least 3 days a week for 3 months. Family drawings are often helpful in beginning a dialogue with these children and their parents. Frequently, the family drawing reveals parents and children of the same height, shape, and dress. A characteristic smile is on everyone’s face. The child’s artistic ability and visual-motor skills might be average or outstanding, but the affective theme is striking and consistent. These cookie-cutter family drawings (Fig. 3A), in which sameness and happiness pervade, are seen in children who experience either recent or chronic tensions. The stressors might be significant or, in a temperamentally susceptible child, they might be no more than normal events in the life of a child. It is as if there is “something bubbling up in their belly” that projects outward into a desire for control. The cookie-cutter drawings seem to reflect a need for a structured environment, i.e., an attempt to control a stressful situation. The frequency of this pattern of family drawings suggests that it should not be used, by itself, as a marker for excessive stress, anxiety, or a tendency toward overcontrol. Rather, it is another clinical tool to begin to explore life-event stressors or a more serious problem in young children with recurrent abdominal pain. Figure 3B illustrates a different pattern of family drawings in a child with recurrent abdominal pain.
The birth of a baby changes the family landscape for all of the members. Although psychological preparation of an older child before the birth is now fashionable, a newborn in a family is a major life-event change for older children. Pediatricians know that a child’s response to the new baby is highly variable depending on the child’s age, developmental maturation, temperament, and past experience with siblings or an extended family. I find it helpful to encourage older siblings, when possible, to come to the first or second health supervision visit with the new baby. When older children are engaged in a dialogue about the new family member, while they sit next to the baby on the examination table, their importance in the expanded family is supported. A family drawing might reveal the children’s core feelings about the new baby and their sense of self within the family. This 5.5-year-old boy, with well-developed fine motor and visual-perceptual skills, illustrated his high regard for himself and a healthy expression of self-esteem (Fig. 4). His body parts, compared with those of his parents, are expanded in this self-portrait. Gender identification is well established. As suggested by the drawing, this child accepted the newborn with ease and did not seem threatened or anxious.

ANDY

Family drawings are an expression of self that is independent of expressive verbal language. Andy was 13 years old when he drew this family portrait. I met him shortly after his third birthday, when he presented with a 2-year history of chronic draining ears, profound deafness, and no detectable expressive language. His receptive language capacity was minimal. He lived in an isolated rural community, and he had chronic otitis media with purulent draining ears most of his early life without appropriate medical therapy. His middle-ear bony ossicles were destroyed, and his oval window was affected. He had a combined severe conductive and neurosensory hearing loss. Speech therapy, hearing aids, and special education programs augmented his education. He was taught sign language and lip reading with limited success. When he drew this picture of his family, his speech was limited to unintelligible sounds. His affect was flat. When meeting Andy for the first time, many people assumed he was moderately retarded. I had not seen Andy for 2 years when this family drawing was done. He was living in a residential school for deaf children; I was amazed at

5.5 YEAR OLD WITH NEWBORN SIBLING

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the fine motor precision, expression of individuality, facial expressions, and printing of names illustrated in this single drawing. Andy clearly had an active intelligence and point of view about his world. The simple request for a drawing during an office visit gave me a new perspective on Andy as a person as well as his potential for additional maturation (Fig. 5).

OLIVIA’S OEDIPUS

Some predictable themes of childhood are seen frequently in family drawings. Their individual expression in a particular child provides an opening for a discussion concerning maturation and development. Olivia was a healthy child. At an earlier office visit, her mother brought up a concern that “she’s so sensitive, especially about small changes” in her life. At a 6-year health supervision visit, her mother reported that Olivia frequently awakened at night, had occasional difficulty falling asleep, and had increasing days of school refusal, often complaining that “my tummy hurt.” The child’s physical examination was normal. Olivia’s drawing (Fig. 6) was typical of many children between 4 and 6 years old, when a strong attachment to a parent (or other important adult) of the opposite sex often develops. It is a period when children consolidate their own gender identity before taking on more challenging social roles, often with peers of the same gender. This Oedipal stage of psychological maturation is the theme of Olivia’s family drawing. She is seen holding hands with her father, with whom she developed a close relationship during the past year. At the same time, she drew her mother and 3-year-old sister as larger figures attached together at the hands. The drawing provided the pediatrician with an opportunity to comment on Olivia’s healthy bond with her father, an experience that should help her through some of the feelings she might have toward her younger sister. The normative aspects of these attachments were emphasized. Her mother then talked about her own confusion concerning Olivia’s changing attraction to herself and her husband. She experienced Olivia moving away from her as she preferred to spend more time with her father. Olivia’s drawing informed her mother about the oedipal conflicts and gave her an opportunity to explore the issue with her pediatrician and her husband. At a subsequent visit, she reported that the insights from the drawing were invaluable for both parents.

PHYSICAL DISABILITY

Not surprisingly, children with a visible physical deformity might illustrate their perception of the deformity in a drawing. These drawings have two clinical benefits. They provide insight for parents and clinicians into the child’s view of a physical deformity or functional disability, and they are an

Fig 5. Andy is a 13-year-old deaf boy with significantly limited expressive language and a flat affect.

Fig 6. Olivia is a 6-year-old girl with mild behavioral and somatic symptoms. She drew herself holding hands with her father (top drawing). Her close attachment to her father is in contrast to her perception concerning the relationship between her younger sister and her mother (bottom of drawing).

Fig 7. Physical disability. This picture was drawn by a child with spastic left hemiparetic cerebral palsy.
opportunity to talk with the child openly about the problem. The picture is a neutral ground to discuss what is often an embarrassing or emotionally painful subject. A child with a congenital hemiparesis pattern of spastic cerebral palsy illustrates this particular use of drawings (Fig. 7). He recently completed a 2-year course of intensive physical therapy. Although it had only a modest effect on functional outcome measurements, his self-image, which was previously restricted because of an excessive concern about his weak left side, improved dramatically. His overall sense of accomplishment in some sports, social relationships, and self-confidence showed gains as he entered the 5th grade. The drawing was referred to with pride when he talked about himself, with encouragement from his pediatrician.

TONY’S TERRIFYING NIGHT

Tony’s behavior changed dramatically during the past 2 weeks. His temper flared easily. He fluctuated between uncharacteristic overactivity and periods of sullenness. He was awakening at night with scary dreams. On two occasions, he refused to go to school. Before this, Tony had not demonstrated any atypical behaviors. He was a good student in the 2nd grade, made friends easily, and lived in a stable home environment. When a behavior change is as abrupt as in this case, it is usually revealing to explore the events in the child’s life preceding the new behaviors. In Tony’s case, his parents associated the new behaviors with an unusually violent evening thunderstorm. The lightning and strong rain, pounding against the house, were a new experience. When his parents tried to reassure him, Tony withdrew emotionally and turned away. When his parents were interviewed, Tony composed an important drawing (Fig. 8). When asked to tell us about the drawing, he said “a giant visited my house.” He went on to say that the giant’s visit was accompanied by loud noise that was “real scary.” The drawing of Tony watching the giant from the rooftop was a visual entrance into his emotional life. Tony’s pediatrician encouraged him to talk more about the giant’s visit during the office visit and at home. He was also encouraged to make other drawings that told the story of the giant’s visit and show them to his parents. A follow-up phone call 2 weeks later revealed resolution of the tantrums, hyperactivity, and sullen affect. In this case, the family drawing was simultaneously diagnostic and therapeutic.

ADOLESCENT ISSUES

Adolescence is a developmental stage characterized by dramatic changes in physiology, physiognomy, and psychology. Physical changes in body size, body shape, and secondary sexual characteristics begin the process of redefining the adolescent’s sense of self. Alan had clearly entered puberty (Tanner Stage 3) when he came to the office for a 13-year health supervision visit (Fig. 9). He exercised daily and recently started to lift weights. His view of himself in relationship to other family members was apparent in his family drawing. Alan’s focus on body image (“buff me”) was an opening for his pediatrician to talk about physical (and psychological) changes experienced by youths. Alan’s concern with his body also offered an opportunity to discuss nutrition, adequate sleep, and reasonable exercise. He also explored Alan’s knowledge about the abuse po-

Fig 8. Tony’s drawing illustrates his “terrifying night.” Temper tantrums, nightmares, and school refusal followed a violent evening thunderstorm when “a giant visited my house.”

Fig 9. Alan, a 13 year old who is exercising daily and beginning to lift weights, illustrates preoccupation with body image and perceptions of other family members.
the potential of anabolic steroids. Alan was a reasonably healthy adolescent struggling with predictable developmental issues and functioning well in school, at home, and with peers. The drawing was a stimulus for additional dialogue between patient and clinician. This is in contrast to an interpretive use of the same drawing, e.g., the generalized omission of heads (the denial of facial/brain functions), the exaggerated view of self, and the excessive shading and crosshatching in Mom and Dad (an attempt to control anxiety through obsessive methods). Psychologists trained to interpret symbolic meaning from drawings might discover projections, repressions, and emotions that might be useful in psychotherapy.

A 17-year-old adolescent who was in good health and high achieving in academic and extracurricular activities and who denied any concerns drew a remarkable picture while waiting for his examination (Fig. 10). He explained the drawing by informing his pediatrician that his best friend died after an automobile accident 1 month ago. The drawing is a dramatic visual portrayal of real and symbolic feelings around the event. The request to “please psychoanalyze” exemplified the use of humor to help him through a difficult time. Although this patient was working through his grief effectively (with family, friends, and an informal group at school led by a school counselor), he said that it was helpful to talk about the tragedy at the office visit. The pediatrician completed the visit amazed that, without the drawing, this very significant event in the patient’s life would not have surfaced during the office visit. How often do patients complete a visit to a doctor without exploration of the patient’s most compelling concern or discussion about a major life event change?11

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REFERENCES

Fig 10. In the aftermath of a friend’s sudden death in an automobile accident, a 17 year old drew this picture while waiting for a health supervision visit.
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