Abstract: Crisis assessment is different from other assessments used in the field of mental health. It must be quick, accurate, and directly useable in the intervention process. Building on a three-dimensional model that involves children’s affective, cognitive, and behavioral reactions, the Triage Assessment Form: Crisis Intervention meets these criteria by providing structure to the assessment process. The instrument can also be used to monitor children’s needs throughout the intervention. A description of the instrument, basic information on its use, psychometric data, suggestions for training, and a case study are presented.

Recent violent events in schools, day care centers, and churches have drawn attention to the need for crisis intervention services; especially for children who are particularly vulnerable to stress due to age, immature defenses, and lack of life experiences (Farberow & Gordon, 1995; Webb, 1999). Government officials, school boards, and therapists have scrambled in an attempt to design programs to address problems associated with these random acts. One goal of these attempts is to develop crisis intervention plans to assist victims of assaults and children in schools who experience repercussions.

Professionals have recognized the importance of crisis intervention following a traumatic event to prevent invasive, long term mental health problems in children (Armsworth & Holaday, 1993; Jensen & Shaw, 1993; Putnam & Trickett, 1993). Expedient and accurate assessment must provide information regarding children’s reactions to the crisis event. Through this process, the meaning of the event for the child is determined and an intervention plan can be devised and strategies selected with the goal of helping children return to the level of functioning experienced prior to the crisis event (Hoff, 1995).

Evaluation of children who have experienced trauma is a growing field in crisis intervention (Lowenstein, 1995). Much of the literature focuses on diagnosing children by comparing their reactions to crisis with symptoms associated with Post Traumatic Stress Disorder (PTSD) (e.g., Aptekar & Boore, 1990; Miller & Veltkamp, 1995; Munson, 1995) and other diagnostic categories developed for adults (Terr, 1989). Others claim that rather than diagnosing children in this manner, crisis assessment should guide professionals to use techniques that will help children regain their pre-crisis level of functioning (James & Gilliland, 2001; Myer, 2001; Terr, 1989).

This paper describes an assessment process that enables clinicians working with children and adolescents to evaluate reactions to traumatic events. First, we differentiate assessment for crisis...
intervention from two other common assessment methods, to provide a framework for the assessment of children who have experienced crisis. Second, we describe the assessment model developed by Myer, Williams, Ottens, and Schmidt (1992a) and its application with children that assists professionals in the treatment of crisis victims. In this section we also discuss the “Triage Assessment Form: Crisis Intervention” (TAF) along with its psychometric properties (Myer, Williams, Ottens, & Schmidt (1992b). Third, we explain the training needed to use the TAF. And, finally, we describe a case in which the TAF was used and how this form helped to direct the intervention process.

**Methods of Assessment**

Within the field of mental health, several methods of assessment can be used to understand children. The two methods most closely related to crisis assessment are **diagnostic assessment** and **symptom assessment**. Diagnostic assessment is the practice of cataloging characteristics that can be explained through a label (Hohenshil, 1996). Symptom assessment is similar, but rather than assigning labels, one simply lists the characteristics (Spielberger et al., 1995). These assessment methods differ from crisis assessment in two ways: the goal of the assessment and the relationship to treatment (Myer, 2001). In diagnostic assessment, the goal is to provide a comprehensive understanding of a person through a label that carries an understood meaning (Hohenshil, 1996). For example, instead of listing all the characteristics associated with a diagnostic label such as major depression, only the label is needed to convey them. In symptom assessment, the goal is to screen for issues that may require further evaluation and this type of assessment generally is not considered comprehensive (Spielberger et al., 1995). Scores from self-report instruments are used to identify symptoms being experienced by clients. If a score falls within a range requiring attention or additional assessment, a referral is made.

Crisis assessment is similar to symptom assessment because it is not a comprehensive approach and different from diagnostic assessment in that labeling is avoided. However, unlike diagnostic and symptom assessment, the results of crisis assessment must be of immediate relevance in the treatment process (Hoff, 1995; James & Gilliland, 2001; Webb, 1999). Crisis assessment is also tied immediately to treatment (Aguilera, 1994; Webb, 1999). In contrast, diagnostic and symptom assessment methods inform the treatment process, but are not utilized immediately (Beutler & Harwood, 1995; Kellerman & Berry, 1997). Lastly, once diagnostic and symptom assessment methods are completed, a report is written. This report usually outlines a treatment approach with goals and objectives. However, in crisis assessment, the information must be organized in a manner that is easily translated for immediate use in the intervention process. The luxury of taking time to organize the information and write a report is not part of crisis assessment (James & Gilliland, 2001; Myer, 2001); therefore, a concise model for obtaining and organizing information is needed in (Hendricks & McKean, 1995; Hoff, 1995).

**Triage Assessment Form: Crisis Intervention**

The Triage Assessment Form: Crisis Intervention (TAF) (Myer et al., 1992b) was developed to guide the assessment process during crisis intervention. The instrument is applicable to any age group and can be used for all types of crises. The instrument is designed for use by anyone providing crisis intervention services, including mental health professionals, school counselors, school psychologists, teachers, volunteers, policemen, firemen, emergency medical technicians, nurses, and other medical personnel. Assessment takes place concurrently in each situation in discussion with the client, family members, or others who are knowledgeable of the client’s reactions to the crisis. The TAF is the operational format of a three-dimensional model for assessment developed by Myer et al. (1992a). The model theorizes that reactions to crisis events can be assessed using three dimensions: affective, cognitive, and behavioral. The range of reactions is further defined in each of the three dimensions by building on previous research. For the affective dimension, research on primary emotions is used. Primary emotions are feelings shared between people and other animals, that is, these emotions can be identified as occurring in animals other than humans (Plutchick, 1980). Recent literature also supports the concept
that a limited number of emotions can be considered as primary, and these were chosen for use in the TAF: anger/hostility, sadness/melancholy, and anxiety/fear (National Advisory Mental Health Council, 1995).

The range of reactions in the cognitive dimension is defined by Rapoport’s (1962, 1965) early writings on cognitive reactions to crisis events and more recent research in the area of stress (e.g., Lazarus, 1993; Lazarus & Folkman, 1984). These reactions are transgression, threat, and loss. Transgression is seen as a “demeaning offense against me and mine” (Lazarus, 1993, p. 26). The perception of the event is seen as happening primarily in the present. Threat, on the other hand, is viewed as something potentially happening or approaching in the future. The perception of loss is viewed as being in the past and perceived by clients as irrevocable. Myer (2001) emphasizes that clients’ perceptions, whether accurate or not, are to be used in the assessment of cognitive reactions.

The range of reactions in the behavioral dimension are defined by research conducted by Caplan (1964), Dixon (1979), Koopman, Classen, and Spiegel (1996), Lindemann (1944, 1956), and Parad and Caplan (1960). In the Myer et al. (1992a) model, clients’ behavioral reactions can be categorized as immobility, avoidance, and approach. Immobility is defined as being stuck, or unable to consistently sustain any attempt to resolve the crisis. Avoidance is defined as an active attempt to escape or bypass problems associated with the crisis. In contrast, approach reactions are those that are active attempts to resolve problems resulting from the crisis. Myer (2001) further differentiates behavioral reactions as either beneficial, that is, helpful in resolving the crisis or detrimental, that is, hindering the successful resolution of the crisis.

**Description of Instrument**

The TAF is a three-page instrument to be completed by the clinician either during or immediately following the session. The first page of the TAF asks for a description of the crisis event. This portion should be completed by including a summary of the crisis event as well as an account of what the crisis is from the point of view of the client, in this case, the child or adolescent. The remainder of page one is devoted to identifying the type and severity of affective reactions including anger/hostility, anxiety/fear, and sadness/melancholy. The interviewer is encouraged to record indicators gleaned from the interview that support the assessment. At the bottom of the page, the interviewer is asked to judge the severity of the reaction on a scale from 1 to 10, with 10 being the most severe. Behavioral descriptors are provided for each rating to help clinicians complete this part of the assessment.

The second page is devoted to assessing cognitive reactions to the crisis event. Four life domains are identified: physical, psychological, relationship, and moral/spiritual. In each domain that has been affected, clinicians are asked to identify cognitive reactions including transgression, threat, and loss. Note that only the life domains affected by the crisis are recorded and, the cognitive reaction for the life domains may differ. For example, a child may experience a loss of relationships while perceiving a threat to physical safety. This may be the case in the aftermath of violence in which there was loss of life, such as the incident at Columbine High School. The bottom of the second page includes a severity scale similar to that on the first page. The person completing the form is asked to rate the overall severity of the cognitive reaction, using behavioral descriptors provided to facilitate this process.

Behavioral reactions are assessed on the first part of the third page. Behavioral reactions are: immobility, avoidance, and approach. Similar to the previous pages, space is provided to record the reason for the assessment. Included in this description should be a judgment of whether or not the behavior is beneficial or detrimental to the resolution of the crisis. A severity scale also appears on this page. This scale is similar to previous scales and uses ratings from 1 to 10, with 10 being the most severe. Descriptors are provided to help in this part of the assessment. Below the behavioral severity scale is a summary section in which the ratings from the severity scales are totaled. This total is used to guide how direct the counselor should be in subsequent intervention.

In summary, the TAF distinguishes the type of reactions in each dimension, the severity of each reaction, and the overall magnitude of the reac-
The type of reaction provides information on what needs should be addressed in the intervention. The severity of each reaction indicates the starting point for the intervention. For example, if a child’s most severe reaction is in the affective dimension, the intervention should begin with strategies that target that area. If, on the other hand, the most severe reaction is in the behavioral dimension, strategies that facilitate resolution in that area should be utilized initially. Finally, the sum of the ratings suggests how direct the intervention should be. The more severe the reaction, the more direct the intervention.

**Psychometric Properties**

Reliability and validity of the TAF have been examined in a study conducted by Watters (1997). In this study, four groups of participants representing varying degrees of expertise in crisis assessment were taught to use the TAF. Participants included 22 beginning graduate and undergraduate students (lowest level of experience), 29 police academy recruits (second level of experience), 24 advanced graduate students in counseling (third level of experience), and 31 experienced crisis intervention personnel who attended the 18th Annual Convening of Crisis Intervention Personnel in Chicago, IL in April, 1994 (highest level of experience). A fifth group, comprised of Drs. Richard James and Burl Gilliland, authors of a textbook in crisis intervention, and Dr. Rick Myer, first author of this paper and principal author of the TAF, were chosen to represent advanced expertise in crisis intervention.

After completion of a 90-minute training session these groups were presented three videotaped vignettes depicting a client in crisis and a crisis worker. The vignettes were developed to represent varying degrees of severity, and were shown to the participants after they had been trained in using the TAF. The results of their assessment were compared with each other and with experts (Dr. James, Gilliland, & Meyer) in crisis intervention.

Using a methodology suggested by Pike (1994), Watters (1997) calculated reliability coefficients to determine inter-rater reliability using the components extracted from a reliability analysis of variance. The higher the coefficient, the higher the reliability within each group. Based on criteria suggested by Thorndike, Cunningham, Thorndike, & Hagen (1991), for groups of 25 a coefficient of .60 is considered quite reliable. Results of Watters’ (1997) analyses varied from a low of .53 to a high of .79 on the most severe vignette, from .63 to .86 for the vignette representing a moderate reaction to a crisis, and from .65 to .94 for the vignette that represented the least severe reaction. See Table 1 for a complete listing of these reliability coefficients. As can be seen, only one coefficient fell below .60; therefore, Watters concluded that the severity score of the TAF has adequate to excellent inter-rater reliability.

Content validity for the three domains (affective, cognitive, and behavioral) and four life dimensions (physical, psychological, social relationships, and moral/spiritual) of the TAF was built into the instrument using existing research that identified reactions experienced by people in crisis. Establishment of this type of validity is important for the TAF in order to ensure that clini-

<table>
<thead>
<tr>
<th>Group</th>
<th>Vignette 1 (severe)</th>
<th>Vignette 2 (moderate)</th>
<th>Vignette 3 (mild)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning Graduate and Undergraduate Students</td>
<td>.68</td>
<td>.71</td>
<td>.88</td>
</tr>
<tr>
<td>Police Academy Recruits</td>
<td>.53</td>
<td>.63</td>
<td>.65</td>
</tr>
<tr>
<td>Advanced Graduate Students</td>
<td>.79</td>
<td>.86</td>
<td>.94</td>
</tr>
<tr>
<td>Experienced Crisis Intervention Personnel</td>
<td>.71</td>
<td>.86</td>
<td>.87</td>
</tr>
</tbody>
</table>

Adapted from Watters, 1997.
cians assess all possible reactions. Research examining people’s behaviors following a crisis or traumatic event was thoroughly reviewed and used in the formation of the TAF. A brief discussion of this research is made earlier in this paper and a more complete discussion can be found in Myer (2001). The outcome of this review was incorporated into the TAF to denote the range of reactions people experience when in crisis.

Watters (1997) also attempted to establish criterion validity of the TAF’s severity rating scales. Arguing that criterion validity involves comparing raters’ scores with some criterion, this process could be accomplished by comparing the average raters’ scores with the average score of the three experts in crisis intervention. The threshold of agreement was arbitrarily set at 75% within the three individual ranges of severity of crisis (mild, moderate, and severe) represented in the vignettes. According to Watters, use of the ranges of severity is appropriate since a discrepancy of 3 to 5 points would not significantly alter treatment. See Table 2 for the results of these analyses. Analyses showed that the four groups agreed with the experts at the 75% level in 7 of 12 instances. Police academy recruits and graduate students failed to agree with the experts on Vignette 2, and experienced crisis intervention workers failed to agree with the experts on all three vignettes. Watters suggested several possibilities for this lack of agreement. One possible explanation is that experienced intervention personnel were less amenable to training in the use of the TAF because they already had experience using other methods. Another is that the instrument may be less appropriate for highly trained personnel. A third possibility is that the group of experienced crisis intervention personnel was too heterogeneous to be considered experienced. The selection of this group is problematic since they were comprised of individuals attending a conference on crisis intervention, but no further information was gathered on their experience. Although it can be assumed that the conference attendees had an interest in crisis intervention, there is no way to determine their actual levels of expertise. In fact, the wide variability in their scoring of the vignettes suggests, in fact, that this was a very mixed group.

Results of the Watters study provide mixed evidence for criterion validity of the TAF. While it appears to demonstrate adequate validity for less experienced users, and for mild and severe reactions to crisis, the lack of agreement between presumably experienced crisis workers and the experts suggests the need for further investigation of criterion validity. Such research should more carefully define levels of experience and expertise of users in order to determine validity for experienced users.

### Training

A wide range of people, including volunteer crisis workers, psychologists, social workers, police, clergy, public school teachers, school counselors, and school psychologists, have been trained to use the TAF. The amount and type of training needed varies depending on educational background and previous experience. We have found in our experiences that people with training in interviewing and listening skills quickly adapt their prior learning for use with the TAF. Those without training in these skills must first become familiar with, and proficient in, these areas in order to learn

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**Table 2**

<table>
<thead>
<tr>
<th>Group</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning Graduate and Undergraduate Students</td>
<td>77.3</td>
<td>77.4</td>
<td>77.3</td>
</tr>
<tr>
<td>Police Academy Recruits</td>
<td>96.6</td>
<td>37.9</td>
<td>96.6</td>
</tr>
<tr>
<td>Advanced Graduate Students</td>
<td>95.8</td>
<td>45.8</td>
<td>79.2</td>
</tr>
<tr>
<td>Experienced Crisis Intervention Personnel</td>
<td>46.7</td>
<td>70.0</td>
<td>63.3</td>
</tr>
</tbody>
</table>

*Adapted from Watters, 1997.*
to use the TAF. In addition, people with training in assessment readily absorb the information needed to use the TAF. Experience also plays a part in teaching people to use the TAF (Watters, 1997). Generally speaking, people with experience helping in crisis situations are able to understand the TAF more rapidly than those who have little to no experience.

For people inexperienced in crisis intervention, training should include an overview of crisis intervention and theory along with an introduction to interviewing and listening skills prior to learning to use the TAF. Once a knowledge base has been established, training can move to practical application with realistic exercises that should mirror actual crisis situations. Trainees can practice with videotape and role-playing sessions, receiving feedback from supervisors to refine interviewing and assessment skills, and to achieve inter-rater reliability. Training to use the TAF can usually be completed in 2.5 to 4.5 hours, depending on previous training and experience.

**Application**

The following case study is a composite of several situations and is representative of crises that arise in school settings. Specific information has been altered to protect the confidentiality and anonymity of the adolescents involved.

Ian is a 14 year-old 9th grader attending a large public high school. He has two older half brothers, Jeremy, a 17-year-old in the same school and Chuck, a 20-year-old currently in the military. Ian and Jeremy live at home with their mother and Ian’s father. Two weeks before Ian was referred to a counselor, Jeremy was placed in juvenile detention for physically threatening a teacher and several other students. Although Jeremy and Chuck had become identified as troublemakers, Ian had only been in trouble once since beginning high school, for engaging in a fight while helping to defend Jeremy. Ian’s homeroom teacher referred him to the counselors because the quality of his work had deteriorated from a B+ to a C, and because he had seemed distracted since Jeremy was placed in detention. She was concerned because she knew that Ian wanted to attend college. Ian stated that everything had gone wrong since his brother was placed in detention. His mother and father were fighting about how to handle the situation, and his father had begun putting pressure on Ian to distance himself from his brother. Ian says his mother talked incessantly about Jeremy, but was also pushing him to overcome the “curse” of the family. At school, Ian reported that other students had also been treating him differently. Some students stopped associating with him, while others were harassing him with name-calling and picking fights.

The counselor also discovered that Ian had mixed feelings about his brothers. Although he loved them and respected their toughness and independence, he wished they would stop causing problems. He said he found it difficult to overcome the reputation they had developed in high school. When questioned about his drop in school performance, Ian reported that he could not concentrate and had lost what few friends he had at school. He felt the added pressure at home was distracting and that no one understood his situation. At one point in the interview, Ian stated that he felt as if he was going to explode and run away.

Although the precipitating event was Jeremy’s threat and subsequent confinement in a detention center and Ian’s declining school performance, the crisis is the experience of being abandoned by those he cares for, including his brother, his parents, and classmates. The clinician came to this conclusion as a result of Ian’s discussion about his experience. He no longer had daily contact with his brother and his interactions with his parents had changed to the point that he was experiencing a lack of recognition. He believed his parents no longer appreciated him or respected him for who he was, and he expressed a sense of isolation and detachment from his friends.

Assessment in the affective domain indicated that Ian’s primary affect was anger/hostility, with a degree of impairment as 5 on the severity scale. The source of this affective reaction is Ian’s frustration at his brother for the precipitating event, aggravation at his parents for their reactions toward him, and irritation and bewilderment at his friends’ treatment of him since the event. In addition, Ian is angry because he feels he is being unfairly treated and judged “guilty by association.” The severity rating of 5 for the level of impairment was based on Ian’s increasingly longer periods of negative mood and increasing difficulty
in controlling his emotions.

Assessment within the cognitive domain revealed that Ian perceived the situation as a psychological threat, a loss of social relationships, and a transgression in the moral/spiritual dimension. Ian’s experience since the precipitating event has caused him to perceive a threat to his emotional well-being and to question his self-concept. Ian also appears to be unsettled with respect to his confidence in how others view him. These perceptions are based in the future, meaning Ian is experiencing a threat to his psychological well-being. Ian also is experiencing a loss of relationships, since he has described his perceptions as being in the past. Ian perceives that when, and if, these relationships are renewed, they will be different. The old relationships are now defunct. The assessment of transgression in the moral/spiritual dimension was based on Ian’s perception that others are not treating him fairly, but instead judging him as being just like his brother. According to Ian, his own parents seem to be waiting for him to follow in the footsteps of his brothers. Although his personal integrity and belief system are unblemished, in his mind he is being treated unjustly, and this is an affront to his personal value system. The experience is ongoing, meaning it is assessed as a transgression. Ian’s cognitive reaction was rated as 8 on the severity scale because of Ian’s inability to concentrate on anything but the crisis. In addition, he is beginning to experience self-doubt, limiting his ability to solve problems and make decisions.

In the behavioral domain, the clinician assessed the severity of Ian’s impairment as 4, because Ian is beginning to neglect tasks necessary for daily functioning, but overall has been able to maintain a normal daily routine. The primary behavior was assessed as immobility. Ian has not attempted to resolve the problem or actively avoid it, but rather he seems stuck, not knowing what to do.

This assessment led the clinician to use the following helping strategies. Since the combined total of the severity scales was 17, the clinician used a collaborative approach with Ian. In a collaborative approach, the clinician teams with the client, in this case Ian, forming a partnership to help resolve the crisis (James & Gilliland, 2001). The clinician helps in identifying the problem, may make suggestions, and provides guidance in developing a plan to resolve the crisis. The client fully participates in this process and is active in making decisions about the intervention. The clinician functions as a catalyst to help the client map out the steps needed to resolve the crisis. Since the most severe reaction was cognitive, the clinician began helping Ian in this area. Three general strategies that are applicable include ordering of thoughts, clarifying the meaning of the crisis, and delimiting the impact of the crisis (Myer, 2001). Once Ian begins to have a clearer perception of the crisis, the clinician can begin the intervention process in the other two domains, affective and behavioral.

Conclusion

The TAF is a promising tool for helping in the assessment of children in any type of crisis. The instrument provides structure for the assessment process that translates directly to the intervention process. Research indicates that inter-rater reliability is good and there is some evidence for criterion validity, especially with less experienced crisis intervention personnel. Additional research is needed to establish criterion validity with experienced crisis workers. The TAF may also be used to continually monitor reactions in order to adapt the intervention to the immediate needs of children. As children move toward resolution of a crisis, the severity of reactions also alters, and clinicians must adjust interventions accordingly. The TAF provides a method for accomplishing this process.

References


CRISIS EVENT:

Identify and describe briefly the crisis situation:

AFFECTIVE DOMAIN

Identify and describe briefly the affect that is present. (If more than one affect is experienced, rate with #1 being primary, #2 secondary, #3 tertiary.)

ANGER/HOSTILITY:

ANXIETY/FEAR:

SADNESS/MELANCHOLY:

Affective Severity Scale
Circle the number that most closely corresponds with client’s reaction to crisis.

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<th>5</th>
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<th>7</th>
<th>8</th>
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<th>10</th>
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<tbody>
<tr>
<td>No Impairment</td>
<td>Minimal Impairment</td>
<td>Low Impairment</td>
<td>Moderate Impairment</td>
<td>Marked Impairment</td>
<td>Severe Impairment</td>
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<td>Stable mood with normal variation of affect appropriate to daily functioning.</td>
<td>Affect appropriate to situation but increasingly longer periods during which negative mood is experienced slightly more intensely than situation warrants. Emotions are substantially under client control.</td>
<td>Affect may be incongruent with situation. Extended periods of intense negative moods. Mood is experienced noticeably more intensely than situation warrants. Liability of affect may be present. Effort required to control emotions.</td>
<td>Negative affect experienced at markedly higher level than situation warrants. Affects may be obviously incongruent with situation. Mood swings, if occurring, are pronounced. Onset of negative moods are perceived by client as not being under volitional control.</td>
<td>Decompen- sation or depersonal- ization evident.</td>
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**COGNITIVE DOMAIN**

Identify if a transgression, threat, or loss has occurred in the following areas and describe briefly. (If more than one cognitive response occurs, rate with #1 being primary, #2 secondary, #3 tertiary.)

**PHYSICAL (food, water, safety, shelter, etc.):**

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<thead>
<tr>
<th>TRANSGRESSION</th>
<th>THREAT</th>
<th>LOSS</th>
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**PSYCHOLOGICAL (self-concept, emotional well being, identity, etc.):**

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<tr>
<th>TRANSGRESSION</th>
<th>THREAT</th>
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**SOCIAL RELATIONSHIPS (family, friends, co-workers, etc.):**

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<tr>
<th>TRANSGRESSION</th>
<th>THREAT</th>
<th>LOSS</th>
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**MORAL/SPIRITUAL (personal integrity, values, belief system, etc.):**

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<th>TRANSGRESSION</th>
<th>THREAT</th>
<th>LOSS</th>
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**Cognitive Severity Scale**

Circle the number that most closely corresponds with client’s reaction to crisis.

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<td>Moderate Impairment</td>
<td>Marked Impairment</td>
<td>Severe Impairment</td>
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- **1** Concentration intact. Client displays normal problem-solving and decision-making abilities. Client’s perception and interpretation of crisis event match reality of situation.
- **2** Client’s thoughts may drift to crisis event but focus of thoughts is under volitional control. Problem-solving and decision-making abilities minimally affected. Client’s perception and interpretation of crisis event substantially match reality of situation.
- **3** Occasional disturbance of concentration. Client perceives diminished control over thoughts of crisis event. Client experiences recurrent difficulties with problem-solving and decision-making abilities. Client’s perception and interpretation of crisis event may differ in some respects with reality of situation.
- **4** Frequent disturbance of concentration. Intrusive thoughts of crisis event with limited control. Problem-solving and decision-making abilities adversely affected by obses-siveness, self-doubt, confusion. Client’s perception and interpretation of crisis event may differ noticeably with reality of situation.
- **5** Client plagued by intrusiveness of thoughts regarding crisis event. The appropriateness of client’s problem-solving and decision-making abilities likely adversely affected by obsessiveness, self-doubt, confusion. Client’s perception and interpretation of crisis event may differ substantially with reality of situation.
- **6** Gross inability to concentrate on anything except crisis event. Client so afflicted by obsessiveness, self-doubt, confusion that problem-solving and decision-making abilities have “shut down.” Client’s perception and interpretation of crisis event may differ so substantially from reality of situation as to constitute threat to client’s welfare.
BEHAVIORAL DOMAIN

Identify and describe briefly which behavior is currently being used. (If more than one behavior is utilized, rate with #1 being primary, #2 secondary, #3 tertiary.)

APPROACH:

AVOIDANCE:

IMMOBILITY:

Behavioral Severity Scale
Circle the number that most closely corresponds with client’s reaction to crisis.

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<th>1</th>
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<td>Marked Impairment</td>
<td>Severe Impairment</td>
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<tr>
<td>Coping behavior appropriate to crisis event. Client performs those tasks necessary for daily functioning.</td>
<td>Occasional utilization of ineffective coping behaviors. Client performs those tasks as necessary for daily functioning, but does so with noticeable effort.</td>
<td>Occasional utilization of ineffective coping behaviors. Client neglects some tasks necessary for daily functioning.</td>
<td>Client displays coping behaviors that are likely to exacerbate crisis situation. Ability to perform tasks necessary for daily functioning is noticeably compromised.</td>
<td>Client displays coping behaviors that are likely to exacerbate crisis situation. Ability to perform tasks necessary for daily functioning is markedly absent.</td>
<td>Behavior is erratic, unpredictable. Client’s behaviors are harmful to self and/or others.</td>
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**DOMAIN SEVERITY SCALE SUMMARY**

| Affective | ______ |
| Cognitive | ______ |
| Behavioral | ______ |
| Total | ______ |
Abstract: The objective of this paper is to examine the usefulness of Kinetic Family Drawings (KFD) to help identify diabetic children with family distress. Drawings were evaluated using the Peterson/Hardin screening tool, and the subjects included fifty-seven children with Type I diabetes, 8 to 14 years. The use of the Peterson/Hardin Screening of 57 children’s drawings revealed indications of possible family distress in 10% and 14% of the children using qualitative and quantitative criteria, respectively. For the children who had a physician’s assessment of family stress, (32 out of the sample of 57) the use of the screening tool and picture analysis alone identified an additional five children at risk. Younger children (8 to 10.5 years in this study) had the most indicators of family distress on the KFD. Factors such as gender or the presence of a diabetic family member did not affect findings. The art indicators for this population were similar to those identified in other studies of children with diabetes. The study concluded that the use of drawings in children with Diabetes Mellitus can provide additional evidence to therapists regarding children with possible family distress who might not otherwise be identified in routine medical care. The drawing may be most useful for screening younger children because they are more able to communicate through drawings than by interview. After the age of eleven, drawing is less sensitive for data retrieval, as older children are more self-conscious about drawing and they express well in words.

Introduction

Insulin-dependent diabetes mellitus (IDDM) is a chronic childhood illness, affecting between 1 and 2 children per 1,000. Management involves a complex regimen of daily insulin injections, blood glucose monitoring, exercise and diet. Careful management is required to prevent short-term complications such as ketoacidosis and long-term complications such as blindness, cardiovascular and renal disease with early mortality. Life threatening consequences strain parent-child relationships because the adult attempts to control the child and the child resists the parent's control (Johnson, Emery, Maruin, Clarke, Loringer, Martin, 1994).

Some studies have shown a small correlation between family interaction and metabolic control (Simmonds, Walker, Rawlings, 1981; Anderson, Auslander, Jung, Miller, Santiago, 1990; Marteau, Block, Gaum, 1987; Anderson, Miller, Auslander, Santiago, 1981). Other studies have shown a large correlation between specific aspects of parent-child interaction and poor medical adherence (Johnson, 1994; Hauser, Jacobsen, Lavori, Wolfsdorf, Herskovitz, Wertilief, et al., 1990). Specifically, children don’t adhere to treatment when they experience family conflict, a factor more compelling than parental warmth, discipline or structure (Johnson, 1994). Conflict and family stress affect the child's day to day diabetes management, leading to chronic elevations of glucose, a major risk factor for the...
development of serious complications. If the parents are hostile, depressed or paranoid, their dysfunction can intensify conflict and lead the child to later acquire an eating disorder (King, Hovey, Brand, Wilson, 1997; Maharaj, Rollin, Olmsted, Daneman, 1998).

Therefore, early detection of family distress is essential to good medical intervention over time. This can be difficult to ascertain within the prescribed time limits of modern care and the failure of either parent or child to reveal their difficulties. Parents are often embarrassed to admit conflict or ineptitude. Children fear disapproval or punishment if they divulge family secrets. Thus, alternative methods of communication are needed to identify distressed families.

In a recent study of nine hundred patients seen by family physicians, only 24% discussed their emotional well being with the physician (Tamkins, 1995). The physicians addressed specific psychological needs rather than family problems. As a result, patient questionnaires have been developed to help doctors identify patient emotional needs. The Family Apgar (Murphy, Kelleher, Pagano, Stulp, Nutting, Jellinek, et al., 1998) and the Pediatric Screening Inventory (Jellinek, 1998) have been used to identify children with chronic illness who experience family distress. These tools however, have some limitations. Results from the Pediatric Research in Office Settings (PROS) Child Behavior study including 9,626 children aged 4-15 years, indicates that the Family APGAR is not a sensitive or specific measure of child behavioral and emotional problems and does not replace direct inquiry into child behavior (Jellinek, 1998). The Pediatric Symptom Checklist (PSC) is specific to identifying children lacking social support (King, 1997). This is a good, albeit lengthy questionnaire to detect emotional distress in children. The parents fill out the form so their interpretation of child distress, rather than the child's direct expression of distress, is noted.

Efficacy of Child Drawings

Drawing is a way a child can express ideas and define her/his experience. The production of a picture is a way of exploring, explaining and mastering a situation. Nickerson suggests that children's art is "their effort at synthesizing and integrating their egos with the demands of society" (Nickerson, 1977).

When a child has to face the rigors of daily diabetes care, a drawing can be used to portray the home situation. It can further reflect a child's emotions during the stages of adapting to the disease. Producing a drawing may be a socially accepted way to express anger or frustration about insulin, injections, and blood monitoring. The art may show open protest against the parents, siblings, doctors, or significant others (Oppawsky, 1991). A child may draw her parents as overpowering and interfering or withdrawn and helpless in their attempts to monitor the child's medical regimen. Art is especially useful for latency-age (6-11 years) children, as younger children find it harder to verbally express frustration with their parents than older children do (11-18 years).

Specificity of Children's Art

A child's art differs from that of adults in that it is more spontaneous and less self-conscious. A child will draw what is direct and close to the truth as they see it. Children draw what has meaning by emphasizing or enlarging that part of the picture (Peterson, Hardin, 1997). For example, in a drawing done by a child in a refugee camp, the cook serving the food is much larger than the people standing in line (Volavkova, 1978). During the war in El Salvador, a wounded pregnant woman dominates in size and placement over soldiers and helicopters (Yornberger, 1986). In the modern hospital, a huge needle and syringe outsize the small person drawn in bed (personal communication, Henry Artman, September 15, 1992). A child with diabetes writes words on the picture to make sure the caretaker knows his feeling about the disease: "DIABETES STINKS! FIND A CURE!" (Peterson, 1997). For many adults, the most confusing aspect of child art is the spontaneous addition of symbols associated with happiness. A child may add a happy face, a flower, a heart or the sun which could deter the adult from taking the art seriously (Peterson, 1997). For this reason, use of an art screening tool based on qualitative and quantitative developmental research is helpful in deciphering what is and is not significant. Because children with diabetes must in effect traumatize themselves daily with shots and blood drawing, one might ask if they show art indicators like those of abused traumatized children (Peterson, Hardin, Nitsch, 2001).
Types of Art Analysis

Two types of drawing analysis have developed in the history of screening child art productions. One type of analysis is qualitative and is based on the viewer’s subjective projection. Using the qualitative approach, two art analysts might interpret the same picture differently. To one, the child is perceived to be “sad,” whereas the other viewer sees only a “gloomy day.” The differences in interpretations have lead some clinicians to discount the clinical usefulness of child art productions. The other type of art analysis, a quantitative appraisal, is based on the initial research of Goodenough (1928) and Koppitz (1967). Using the quantitative approach, the viewer scores the presence or absence of specific art indicators. These indicators have identified that emotionally distressed children make additions or deletions in a drawing that are rarely or never expressed by an emotionally adjusted child (Koppitz, 1967). Koppitz’s quantitative art indicators have been validated over thirty years by the ability to detect emotional distress in children at different developmental levels (Koppitz, 1967).

Research has traditionally focused on human figure drawings (HFDs), where a child is asked to draw a picture of a person. Burns and Kaufman broadened this approach through the analysis of a child’s kinetic family drawings (KFDs) where the child is asked to “draw a picture of your family doing something, including yourself” (Burns, Kaufman, 1970 and 1972). The HFD is generally considered the child’s representation of the self, whereas the KFD shows the child’s perception of relationships and support among family members.

Kinetic family drawings have been shown to discriminate homes characterized by abuse, divorce, and juvenile delinquency and have proven useful in obtaining information about school problems, self esteem, body image and affective states (Reynold, Kamphaus, 1990). A comprehensive review of 61 articles written between 1984-1993 about projective techniques, including drawing, described the differences in the kinetic family and human figure drawings of chronically ill, acutely ill, physically disabled and healthy children. (Bellack, Fleming, 1996). Well and ill children showed differences in structure and form and choice of color in their drawings. These investigators and others encourage professionals to collect child art over several visits and ask a child to tell a story about his picture in order to make the most valid assessment.

Findings of Aggression and Stress In Children with Diabetes

In one study of Kinetic Family Drawings, children with diabetes showed more art indicators including aggression (weapons and fighting), distortion of body parts, and isolation (enclosing themselves in compartments or turning away from family members) as compared with a non-diabetic control group, who had no known stress and no such findings in their drawings. (Sayed, Leaverton, 1974). In another study of 64 children with diabetes in which mental status exams rather than drawings were used, an increase in aggression was noted when compared to non-diabetic controls (Ahnsjo, Humble, Larsson, Settargren-Calsson, Sterky, 1981). In a later study of 80 chronically ill children, a child depression inventory, aggression questionnaire, and illness questionnaire were completed by the parents. Diabetic children were found to have more aggression than child asthmatics (Nelms, 1989). In a study of 41 diabetic patients and their non-diabetic siblings, parents reported that diabetic males in the 6-11 year old group showed higher levels of externalizing their aggression, hyperactivity and obsessive-compulsiveness than girls (Lavigne, Traisman, Marr, Chasnoff, 1982). Investigators using the “Draw a person test” with 23 diabetic children reported that diabetic children drew distorted figures of healthy persons, often making the healthy person smaller in size (Nuvoli, Maioli, Gerrari, Pala, Chiaretti, 1989).

Hypotheses of the study

Analysis of the KFD of diabetic children using the Peterson/Harden screening tool will:

a) not be affected by gender, years since diagnosis, or presence of family diabetes.
b) be most useful for younger rather than older children.
c) identify additional children with family stress not identified in routine medical care.
d) identify drawing indicators similar to those found in other studies of traumatized children.
Methods

Sample: Subjects were 57 children that had the diagnosis of diabetes mellitus and attended a week of diabetes summer camp at Lake Tahoe, Nevada. There were 27 boys and 29 girls and one of unknown gender who ranged in age from 8 to 14 years. Time since diagnosis of diabetes ranged from as little as a few months to 12 years (mean = 4.2±3.3 years). Twenty-three (40%) of the children indicated that they had another family member with diabetes, and fourteen of the twenty-three indicated that this other family member also used insulin shots. Thirty-two of the 57 children in this study were being followed by one of three University of Nevada pediatric endocrinologist collaborating on this study. Twenty-five of the children who participated in the drawing exercise had physicians who were not available to the investigators.

Procedures: The university’s institutional review board approved the study, and informed consent was obtained from the children’s parents to permit collection of family drawings for this study. Each child was assigned to one of eight cabins by gender and age. Drawings were collected from the children in each cabin separately, during quiet time in their cabins on day four of camp. All of the children in a cabin were given instructions and materials by the investigator who answered questions and stayed during the drawing process to ensure that children did not look at each other’s pictures. They were also asked to complete a short “questionnaire” to indicate how long ago they were diagnosed with diabetes, whether anyone else in their family had diabetes, and whether anyone else in their family was receiving insulin shots. Children were given as much time as they needed to complete their drawings, and questionnaires were collected by the investigator who then went on to the next cabin to repeat the process. Once the drawings were collected, a trained rater scored the children’s pictures using the Peterson/Hardin KFD screening instrument (see Appendix B).

One goal of this study was to determine whether the use of family drawings would identify previously unidentified children experiencing family distress. Therefore the university physicians were asked to rate family discord for the sample of 32 children in their care who also attended the diabetes camp. These physicians identified 11 of the 32 children as having family distress and the remaining 21 of the 32 as having no known signs or symptoms of distress. Assessment of family distress was not available from the physicians who cared for the additional 25 children in the sample of 57. (The entire group of 57 pictures was analyzed but only 32 pictures were correlated with physician pre-assessment of family distress.)

Measures: The Peterson/Hardin KFD screening inventory (see Appendix B) contains three sectors that are purely qualitative: quality of the overall drawing, child's perception of family members, and child's perception of the self. The approach to analyzing/describing these sectors is similar to that of the mental status exam. The rater/examiner evaluates the global picture before proceeding to the fine detail of symmetry, deviation from norm or unusual features. Once the overall qualitative appraisal is made at the top of the form, the rater proceeds to actually score the number of quantitative indicators in the three sectors on the bottom half of the form: styles, treatment of figures, and actions with negative aspects. This part of the form is analogous to the fine discrimination needed to do a physical exam to determine any deviations from normal.

On the screening form in the qualitative section (top half of the page) there is a designation of red, yellow, and green columns to help the clinician discriminate degrees of deviation from normal. These discriminators are analogous to the street-light. When a red indicator appears, one should stop, look and listen to what the child is attempting to communicate nonverbally. In this study, the total number of ‘red flag indicators’ present was tallied for each child, and children with 4 or more of these indicators were considered as being at risk for family stress. This is a departure from the original scoring of the KFD, as Peterson and Hardin gave no numerical score for the qualitative sectors.

On the screening form in the quantitative section, (bottom half of the page) the three sections (Styles, Treatment of Figures, Actions with Negative Aspects) have varying numbers of weighted components (in parentheses) which have been validated by previous testing of this scoring system. The sum of the individual weighted abnormal scores was used to derive a total quantitative score. If the total quantitative score was 0-2, the drawing was
considered normal, if the score was 3-5, it was considered undetermined, and if the score was 6 or greater, it was considered suspicious/refer. Samples of four drawings done by children in this study, their brief history, and a summary of the rater's scored findings are shown in Figures 1, 2, 3, and 4.

Statistical analysis of these data was performed using a commercially available software package (Statistical Package for the Social Sciences, version 7.0, SPSS, Inc, Chicago, Ill.)

Results:

Relationship of Gender to Findings in Drawings: There were no significant differences in the number of qualitative indicators detected between females (0.8 + 2.0) and males (1.0 + 2.3). Neither were gender differences noted in the mean quantitative scores (girls = 3.8 + 1.9; boys=3.7 + 1.9).

Years with Diabetes: Children who had diabetes 2 to 5.5 years tended to have more qualitative indicators (1.4 + 2.6) than children having diabetes less than 1.5 years (0.35 + 1.0) or more than 6 years (0.44 + 1.5). Children having diabetes the longest (> 6 years) had the lowest quantitative scores. Children with scores in the suspicious/refer category tended to be those who had diabetes for less time (3.1 + 3.2 years) than those in the undetermined category (4.7 + 3.1 years) or normal (4.0 + 3.8 years) category.

Presence of Family Member with Diabetes: Having a family member with diabetes was not related to the qualitative score. Of the six children with scores of 6+ in the quantitative sector, three had family members with diabetes, and three did not. Similarly, having a family member who also uses insulin did not affect the total score.

Relationship of Age to Findings on Drawings: Age was significantly correlated (p=.044; r = -.268) with the number of “red flag” qualitative indicators (the younger the child, the greater number of serious indicators; the older the child, the fewer serious indicators). Relatively more of the younger children had quantitative scores in the suspicious/refer category. (See Appendix A, Table 1.)

Kinetic Family Drawing findings: The type of “red flag” qualitative indicators identified in the drawings of children in this sample included: peculiarity, depressed mood, disorder, and disproportion in size and shape of family and self. Of the 57 children, 7 had four or more “red flags,” 2 showed mixed emotions, but none showed severe depression or angry mood. Four children (3 boys and 1 girl) drew disorganized pictures. Disproportion in size was seen in 8 drawings, disproportion in shape was seen in 6 drawings and distortion of family members was seen in 6 drawings. Analyses of the drawings of the child himself or herself within the family indicated disproportion in size by 7 children, disproportion of shape for 6, and distortion of the self drawn by 5 children. Eight of the 57 children (14% of the sample) had quantitative scores greater than 6, indicating the need for serious concern and possible referral to a mental health specialist for further evaluation. Only one child was identified by both qualitative and quantitative scores as being at risk for having family distress. (See Appendix A, Table 2.)

Distress Identified by Physicians versus that identified by Kinetic Family Drawing: The hypothesis that the Peterson/Hardin Screening tool might uncover previously unidentified children with distress was confirmed in the sample of 32 children seen by University physicians. Five additional children showed indicators in their pictures for family distress beyond those identified by their physicians. There was agreement between physician prediction of stress and pictures with stress indicators in five children. (See Appendix A, Table 3.)

Discussion

The Peterson/Hardin screening form detected quantitative indicators (aggression and isolation, withdrawal) as reported in other studies of drawings by children with diabetes using the KFD. These children did not show trauma indicators of physically or sexually abused children (Peterson, 2001). Isolation was evident in 17 pictures with encapsulation, 3 pictures with compartmentalization, and 17 pictures that included barriers. Seven children showed withdrawal by moving themselves to the periphery or by not including themselves in the picture. Three children (all male) drew aggressive pictures, whereas an additional 16 children drew extensions (associated with aggression). In this sample there were erasures in the drawings of 37 children, identified by previous investigators to be associated with the compulsive nature of diabetic children. Finally, 11 out of 57 children revealed distorted features which have been a notable characteristic in the art of children with diabetes.
Although other screening instruments exist to assess the presence or absence of family distress and child emotional and behavioral problems (the Family Apgar and the Pediatric Symptom Checklist), they do not screen the child’s perception because they are completed by the parents. The findings in this study would support the idea that children themselves may reveal distress that would not necessarily be forthcoming from their parents. This might also account for the additional children identified for distress that were not previously identified by their physician. What if the parent is detached, ill, involved in a custody fight or not bonded to this particular child? All of these and other factors could affect adult responses. Furthermore, a child with a sensitive or reactive temperament could show distress, even in a family that has relatively little internal stress. This might account for those children showing qualitative indicators (mood, peculiarity, disproportion or distortion) that do not show quantitative emotional indicators.

Given that it is easy and quick to acquire a child’s drawing while interviewing the parent, a practitioner could pick up a subset of children experiencing family distress that might be missed entirely. By asking a child to draw a picture, the physician may enhance the child’s sense of self worth or allow the child to express aggressive feelings that could never be safely expressed in words. Certainly this drawing activity can enhance physician-child communication and can be augmented by additional questions to engage the child. (See Appendix A, Table 4.)

Clinically, the scoring of a child’s drawing may appear tedious to the busy clinician. What may be more important is simply “eyeballing” pictures to look for ways in which children express family issues. Unusual placement or size of figures, interaction or isolation, aggression in the form of weapons or words, encapsulation or omission of the self altogether from a picture may provide clues to distress. Learning to score the Peterson/Hardin qualitative and quantitative system of scoring does require some training, such as a two-hour workshop or the reading of Children in Distress (Peterson, 1997). Such training is analogous to the training one might take to learn to use the Denver Developmental Screening Tool (Frankenburg, 1990).

If the therapist decides to learn the scoring method it is important to keep in mind that drawing indicators are rare, just like an asymmetry or unusual finding in the physical exam. An anomaly in the physical body or the child’s picture could, however, reflect an underlying pathology. Conversely it is important not to over-interpret a child’s situation from one picture. Interviewing a child and collecting a series of pictures aids validity. These data lend themselves to single subject interpretation rather than global statistical analysis. One would not expect a large number of indicators over the entire sample of children. This is precisely why procuring a picture is clinically relevant for triage and clinical intervention. An overall statistical mean score for a group of children is less significant than a 6+ quantitative score for a select number of children that need specific intervention.

It is notable that 10-14% of this sample showed art indicators of a significant number. The fact that five children were detected for family distress not previously known to their physicians, demonstrates that the use of the KFD could be useful in a clinical practice with chronically ill or diabetic children who will be seen over time. The amount of family distress found in the pictures may or may not have been influenced by the relatively relaxed atmosphere of summer camp away from the family milieu. It is conceivable that more children would show emotional indicators in family drawings retrieved in the physician’s office setting.

Once the problem list for family distress is developed from the parent and child interviews and from the drawing, interventions can be initiated. The physician may be able to do this in the office, or by referral to a counselor with expertise in family systems. Some families may benefit from self-help books and sources on the internet such as an on-line ‘community for kids, families, and adults with diabetes(http://www.childrenwithdiabetes.com, accessed February 6, 2002). Periodic re-evaluation and collection of drawings over time may show progress or uncover new problems.

Conclusions

Results of this study indicate that the use of the Peterson/Hardin KFD screening for children with diabetes mellitus can provide additional evidence to the therapist regarding children with potential family distress who might not otherwise be identified in routine medical care. Therefore, the Peterson Hardin KFD screening tool validates and extends identification of
children experiencing family distress.

The data in this study suggests that use of KFD is most helpful in identifying stress in younger, latency-aged children (in this study, eight to nine and a half years) who have been recently diagnosed for diabetes. The KFD seems a less sensitive indicator of stress for older children, either because they can manage their diabetes with greater independence or because they are self-conscious doing expressive drawing and they can discuss concerns verbally.

The stress indicators historically found in drawings by diabetic children: aggression, withdrawal and isolation were seen in this sample of children. There were no trauma indicators. Neither gender nor presence of another family member with diabetes were significant predictors of findings of family distress in the children’s drawings.

ACKNOWLEDGMENTS

The authors wish to acknowledge the contributions of, Barbara Jones, MD (a 4th year medical student at the time this study was conducted), Kathryn Eckert, M.D., and David L. Donaldson, M.D., pediatric endocrinologist, who provided clinical assessments of family stress in their patients who participated in this study.

REFERENCES


APPENDIX A
Tables

Table 1. Number and Percent of Children In Each Age Group Quantitative Scores Indicating Need for Further Evaluation (Quantitative Score ≥ 6.0 = “Suspicious/Refer”)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.0 to 9.5 yrs</td>
<td>3</td>
<td>23.1%</td>
</tr>
<tr>
<td>10.0 to 10.5 yrs</td>
<td>3</td>
<td>17.6%</td>
</tr>
<tr>
<td>11.0 to 11.5 yrs</td>
<td>2</td>
<td>14.3%</td>
</tr>
<tr>
<td>12.0 to 14.0 yrs</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Number of Children Rated As Being At Risk for Family Discord by Qualitative Indicators and/or Quantitative Score on the Kinetic Family Drawing (Total sample = 57 children)

<table>
<thead>
<tr>
<th>Identification Method</th>
<th>Children Identified by Qualitative Score Only (Children having more than 4 'red Flag' Indicators)</th>
<th>Children Identified by Qualitative Score Only (Children with Score &gt; 6.0)</th>
<th>Children Identified by Both Qualitative and Quantitative Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Identified by Qualitative Score Only (Children having more than 4 'red Flag' Indicators)</td>
<td>6</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3. Number of Children Rated As Being At Risk for Family Discord by the Kinetic Family Drawing and/or Physician Rating (Total sample = 32 children)

<table>
<thead>
<tr>
<th>Identification Method</th>
<th>Children Identified by Kinetic Family Drawing Only</th>
<th>Children Identified by Physician Rating Only</th>
<th>Children Identified by Both KFD and Physician Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Identified by Kinetic Family Drawing Only</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 4. Questions that can be used in an extended interview with a child with diabetes

Possible Extended Interview Questions:

1. What’s the hardest thing about living with diabetes? Is there one thing that makes it easier?

2. Sometimes kids wonder why they got diabetes. Do you ever wonder?

3. Has your diabetes changed things in the family?

4. If you could have something different about home, what would it be?

5. All kids do things that make their parents happy and sometimes mad. I sure did! What makes your parents happy or mad? What happens then?

6. Who in the family makes the most trouble for you?

7. What do you like best about yourself? How has the diabetes routine made you a better person?

8. If you could have three wishes, what would they be?
APPENDIX B: Screening Inventory

SCREENING INVENTORY FOR KINETIC FAMILY DRAWING

Name: __________________________ Date: ___________ Age: ___________

Qualitative

I. QUALITY OF OVERALL DRAWING
1) Peculiarity/Strangeness ☐ Very peculiar ☐ Somewhat peculiar ☐ Not at all peculiar
2) Feeling/Mood ☐ Depressed/Angry ☐ Mixed emotions ☐ Happy/Content
3) Order ☐ Unorganized ☐ Partially organized ☐ Orderly

II. CHILD PERCEPTION OF FAMILY MEMBERS
1) Size ☐ Very disproportionate ☐ Some disproportion ☐ Proportionate
2) Shape ☐ Very disproportionate ☐ Some disproportion ☐ Proportionate
3) Distortion ☐ Excessive ☐ Some ☐ None

III. CHILD SELF-PERCEPTION IN FAMILY SYSTEM
1) Size ☐ Very disproportionate ☐ Some disproportion ☐ Proportionate
2) Shape ☐ Very disproportionate ☐ Some disproportion ☐ Proportionate
3) Distortion ☐ Excessive ☐ Some ☐ None

Because of the complexity of the KFD and the lack of quantification for peculiarity and order, always interview the child if the drawing shows excessive disorder (chaos) or peculiarity, as these are not factored in the scoring system.

Quantitative

IV. STYLES (Note which figure on dotted line)
1) Encapsulated Present (2.0) ......................... Absent (0)
2) Compartmentalization Present (4.0) ......................... Absent (0)
3) Writing words on picture Present (1.0) ......................... Absent (0)
4) Edging Present (1.0) ......................... Absent (0)
5) Underlining individual figures Present (0.5) ......................... Absent (0)
6) Lining at top of paper Present (0.5) ......................... Absent (0)
7) Lining at bottom of paper Present (0.5) ......................... Absent (0)

V. TREATMENT OF FIGURES (Note which figure on dotted line)
1) Transparency Present (2.0) ......................... Absent (0)
2) Missing person or self Present (2.0) ......................... Absent (0)
3) One or more figures drawn on back of paper Present (1.0) ......................... Absent (0)
4) Erasures Present (1.0) ......................... Absent (0)
5) Floating Present (1.0) ......................... Absent (0)
6) Hanging Present (1.0) ......................... Absent (0)
7) Falling Present (0.5) ......................... Absent (0)
8) Slanting Figures Present (0.5) ......................... Absent (0)
9) Incomplete figures (omission of parts) Present (0.5) ......................... Absent (0)
10) Extensions/Long legs, arms, equipment Present (0.5) ......................... Absent (0)

VI. ACTIONS WITH NEGATIVE ASPECTS (Note which figure on dotted line)
1) Sexualized Present (2.0) ......................... Absent (0)
2) Aggression/Weapons Present (2.0) ......................... Absent (0)
3) Fear/Anxiety Present (2.0) ......................... Absent (0)
4) Withdrawal/Isolation Present (1.0) ......................... Absent (0)
5) Blame/Ridicule Present (1.0) ......................... Absent (0)
6) Submission/Competition Present (0.5) ......................... Absent (0)
7) Barriers Present (0.5) ......................... Absent (0)


Notes

These results are NOT diagnostic for physical, sexual or emotional abuse. The results provide clues for the clinician for further investigation by child interview, physical exam and forensic evaluation. © 1995 Peterson/Hartin

(Adapted from Burns & Kaufman, 1972)

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APPENDIX C: Case Examples

The artist of figure 2, Monica, is 11 years old and newly diagnosed as diabetic (3 months prior). The quality of the overall drawing is somewhat peculiar; the feeling is happy, content and the picture is orderly. The child’s perception of family members and herself in the family system are proportionate. The figure noted as “sad” is emphasized. The child places herself distant from the father. Sexual identity is appropriate. There is no interaction among family members. The staff working with this new diagnosed child at camp describe her as cooperative. She has been compliant with her diabetes care and the physician reports that the mother is supportive to the child. The father has not come to the clinic nor participated in the child’s medical care. In the quantitative analysis of the drawing, one notes the words “love child” on Dad’s shirt and Dad’s down-turned mouth. Writing on a picture and a down-turned mouth subtly draw attention to a person of importance (positive or negative). In this case, the physician would ask the child: “Who do you think you are most like in the family? Who makes the most trouble for you in the family?” Note whether the child says “Dad” or does not mention Dad. Ask: “Tell me more about your Mom. Tell me more about you Dad.” If the child is reticent to speak, inquire as to whether: “a kid would get in trouble if they told more about this person? What could happen if they did?” Note that the questions are in the second person (“would a kid,” not “would you get in trouble?”) Ask, in a matter of fact tone, first about a non-emphasized person (Mom) before asking about an emphasized figure (Dad). The indicators in this picture were writing words on picture (1.) erasures (1.0) and incomplete figures (missing hands) (0.5) with an overall score of 2.5. The scoring is “undetermined,” and requires a brief interview. It would be important for the clinician to stay open minded and not over interpret from one drawing.

The child who drew figure 3 is an eleven-year-old girl who was diagnosed with diabetes one year previously. Her physician described her family as very supportive and was unaware of any distress. Note the peculiarity of the overall drawing. Of particular note is the isolation of the patient, the barriers between family members, and the direction of movement toward the father who has his back turned. The quantitative indicators include encapsulation (2.0) and compartmentalization (2.0); lining on top of the paper (0.5) erasures (1.0); omission of hands on herself (0.5); withdrawal/isolation of self (1.); and barriers between family members (0.5). The score on the Peterson/Hardin scale for art indicators was 7.0 (suspicious/refer). This is a child for whom an interview by herself would be appropriate using the questions shown in Table 4.
The nine-year-old female artist in figure 4 composed a somewhat peculiar, happy, and orderly drawing of her family “floating down the river.” The figures of self and family are proportionate. There are four quantitative indicators: encapsulation (2.0), erasures (1.0), missing arms on Mom (0.5) and missing feet/legs on Rachel (0.5). Finally, the figure of herself is isolated from other family members. The total score for this drawing is 4.0 (undetermined). On interview, it was discovered that this family frequently goes on “float trips” on the river. The child drew her mother somewhat separate from herself and her two brothers, ages 16 and 18 years on the same side of the page as herself. Mom is the only figure rafting head down and the artist has a tube with double lines. This could simply be the artistic rendering or it could subtly hint for more information about the mother-daughter relationship. When the mother was questioned about the family, she stated the child is closest to her brother Joel and less close to her brother Dan. The child has never known her father from whom the mother separated before the child’s birth. The mother indicated that she has had to work throughout the duration of the child’s life and has not been able to closely bond to this child due to her work circumstances.

The artist in figure 5 picture portrays stark violence toward the brother as well as eight other significant indicators. The picture is very peculiar, with mixed emotions but an orderly presentation. Words are written on the paper (1.0); lining occurs at the bottom of the page (0.5); a person (Dad?) is missing (2.0); erasures are present (1.0); and barriers (0.5) exist. A child interview indicated for this child with a suspicious score of 9. The father in this family and the brother both have diabetes. The artist was diagnosed for diabetes 2 1/2 years previously. He has severe mood changes which deserve investigation. One should ask the child to “Tell me more about your picture.” In addition, an interview should look for the triggers to mood changes which could include diet, exercise, interpersonal stressors and school performance. One could also ask: “What kinds of things make you really mad?” “Do you notice you get more mad at certain times of the day than other times of the day?” What do you do when you get mad?” “Can you remember a time you got mad and you handled your anger well?” “What was happening then?”
Any of you have requested references regarding trauma’s impact on learning, behavior and intervention needs.

References


Perry, B. (2000). *Violence and Childhood: How Persisting Fear Can Alter the Developing Child’s Brain.* Available online at <www.childtrauma@bcm.tmc.edu >


Recently my caseload has included clients who have had problems exacerbated by a recent dramatic trauma incident, such as a car accident. As I attempt to provide these clients with therapy, I have found success with an approach that is helpful much of the time. I present this idea to the reader as a therapeutic tool that is useful in the period immediately after the initial trauma work has been completed. It is imperative that the therapist first provide a form of containment that is structured, but not limiting, within which the client can re-establish the direction of their therapy.

A severe trauma lessens most persons’ abilities to organize their priorities and set realistic goals for the therapeutic conversation. Clients often remain bewildered as to where to start examining the difficulties that still are problematic in their lives. I wish to reiterate that it is essential that early, proper attention to a serious trauma should be attended to with the best approach possible. I believe the steps that are offered through the TLC program are ideal as well as the use of Eye Movement Desensitization and Reprocessing (EMDR) for some clients. However, although the trauma event is still pressing, the other problems that impact the client also need to be addressed.

I have found by helping the client to accept the recent trauma as a life changing event (which it is) and reframing it as possibility for change allows the client to use the traumatic event in an unusual way. By acknowledging the trauma, by reframing the impact, and by providing the opportunity to see it as an event that can be an occasion for change, the client can perceive the event through new lenses. I believe that this event can be represented convincingly by the client through visual representations. Art expression is more easily accepted since the client has found that becoming aware of the recurring images of the trauma is an important part of reducing post traumatic stress symptoms. Transforming this phenomenon into a visual tool for the client’s benefit is the subject of this brief example.

A young woman came into the clinic requesting therapy because she was having difficulty “getting on with her life” after a severe auto accident. She had been to a trauma expert, had a course of EMDR, and felt that the shock of the accident was no longer intruding on her day or night dreams and general functioning. However, she felt that she was infinitely more dissatisfied with her life than she had been before the casualty. In addition, she claimed that she had more trouble concentrating and felt that she couldn’t make decisions even in simple situations.

Her history was one of multiple difficulties and a troubled family constellation, which I will not elaborate upon for this brief article. It was a challenge to sort out her goals, and her attention span in the first interview was alarmingly brief. It became impossible to decide with her which issue was the most pressing at this point in time. She clearly stated that the accident was not the major topic she wished to discuss.

Given this confusion, and in light of my belief

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system of conducting therapy in a collaborative, relational style, I was not certain where to focus since she was not able to help. I was heartened by her interest in the oil pastels on the table, which she held and admired for their intense color. In addition she was attracted to the explanation of a collaborative approach to the therapeutic relationship, since she had felt her last therapist was just a friend giving advice.

The second session began with my request that she make a mark in the center of the page that indicated the car accident. She made a heavy black line that divided the page into equal parts. At a slow pace as she reviewed the multiple stressors she found difficult, she made small abstract squiggles that had variety and had clear identification of the problem. Soon the left side of the page, which she had indicated as her past, was filled with many colors that represented these difficulties. We then turned our attention to the black divider, the “trauma.” I suggested that it was such a major event that it acted like a major point of redecision. She had the opportunity to imagine how she would like her life to recommence, to take what she wanted from the old, but fill the empty side of the drawing with her new resolutions. The client found this concrete visualization of her past, present, and possible future an exciting concept. She left the session with the drawing and the intention to look at it during the week and find one of the issues represented as the focus of our next session.

Summary

The concept of a “marker” for change, translated into a visual product, has been used for incidents such as divorce, death of a family member, work loss, and other life changing traumas that destabilize many of the clients that seek therapy. Looking at a traumatic incident as a positive opportunity for change was useful for a variety of reasons: it instilled hope; it provided a structure to contain random thoughts; and it gave a goal setting opportunity by suggesting a selection of past issues to be considered worthy of carrying over to the new life or left behind. The thought of having the power to regulate her life-choices stimulated her curiosity and creativity. Rather than a traumatic incident that evoked depression, the trauma was renamed a marker for change. The therapist was able to build on this drawing and this concept to continue therapy in a manner that provided a frame for more art experiences and more collaborative dialogues.

The author presents an interesting possible approach to some very real problems with getting accurate, useful data in trauma research. The vast majority of our knowledge of the short- and long-term effects of traumatic stress and the multiple other effects of disasters has been developed through the study of patients, survivors and victims after the traumatic event has occurred. Several problems are inherent in this type of data collection, which in turn, make it difficult to define specific contributions of the severe stressor itself to subsequent adjustment and remediation efforts. Among the inherent problems discussed by the author are: problems with specifying baseline adjustment, getting representative samples of victims, and finding applicable control groups. The author proposes a rather bold but intriguing solution to the issues routinely encountered in post-hoc research. He suggests using ongoing longitudinal and multimeasure studies of psychosocial development. Such an approach would allow the study of the effects of severe and traumatic events as they occur to individuals during their participation in such studies. Such studies would make systematic and multiple measures of baseline adjustment of victims and nonvictims available, as well as pre-planned assessment for post event adjustments.

There are obvious difficulties with this unique proposal, and the author addresses several of these as well as offering solutions. He also clearly outlines barriers to such research and is certainly not naive regarding the inherent opposition to this type of data collection and research. A most interesting point he makes is that 7% - 10% of the population, about 20,000,000 plus individuals, experience severely traumatic events annually. This is an enormous population. What has to happen is the cooperation of epidemiologists and longitudinal researchers in the area of trauma and disaster in collaborative efforts to address these issues. By including some trauma and disaster-specific measures in many types of different longitudinal studies, the potential for amassing data that would lead to a better understanding of the very complex relationships of severe stress to a wide array of developmental issues clearly exists.

The article is well written, well researched and causes a considerable evaluation of the use of "longitudinal research as usual" paradigm. This is the kind of stretching of the limits that needs to be done if we are ever to gather the kind of comprehensive data necessary for appropriate assessment and intervention.

John G. Jones, PhD, ABPP, ATR-BC, was born in New Mexico and grew up in northwest Texas. He attended Hardin-Simmons University, Texas Tech University, and received his PhD from the University of Wisconsin-Madison. He completed internships in counseling and clinical psychology at the University of Texas-Austin and Bethesda Navy National Medical Center, respectively. He has had extensive clinical experience working with a vast range of trauma victims and has made multiple presentations and published articles in this field.

This article written by eminent researcher Dr. Allan Schore (Department of Psychiatry and Biobehavioral Sciences, University of California at Los Angeles School of Medicine, is a two-part work in which he integrates data from attachment studies on affective communication, neuroscience on infants’ right brain development, the psychophysiology of stress systems, and psychiatry to help readers understand the mechanisms of infant mental health. Schore notes that over the last ten years the basic knowledge of brain structure and function has vastly expanded, and its incorporation into the developmental sciences is now allowing for more overarching models of human infancy.

In the first of these two paper’s abstract, the author details the neurobiology of a secure attachment, an exemplar of adaptive infant mental health, and focuses upon the primary caregiver’s impact on the infant’s maturing limbic system, the brain area specialized for adaptation to changes in the environment and dominant for the human stress response. In the second paper (Part II), Schore continues his exploration with thoughts on the negative impact of traumatic attachments on brain development and infant mental health, the neurobiology of infant trauma, the neuropsychology of a disorganized attachment pattern associated with abuse and neglect, trauma-induced impairments of a regulatory system in the cortex, the links between cognitive dysfunction and a predisposition to posttraumatic stress disorders, the neurobiology of dissociation, the effects of early relational trauma on enduring right hemispheric function, and some implications for models of early intervention.

Many researchers and psychologists have offered a number of possible explanations for why early attachment experiences influence development at later stages of life. For example, an early attachment relationship may serve as the basis for regulation of emotional responses; it may also influence early formations of the infant’s internal representations. Schore believes it is possible that the experiences within the early attachment relationship influence the developing brain, resulting in lasting influences on how the brain reacts to new situations, including stressful experiences. Effective right brain function is believed by the author to be a factor for resilience and for successful development throughout an individual’s lifespan. Schore’s findings suggest direct connections between traumatic attachment, inefficient right brain regulatory functions, and both maladaptive infant and adult mental health. While at times a difficult read for the average trauma specialist, this article is important for any helping professional who works with traumatized children as well as adults.

Cathy A. Malchiodi, ATR, LPAT, LPCC, is the Director, Institute for the Arts & Health and advisory board member, The National Institute for Trauma & Loss in Children, author of numerous books including, Understanding Children’s Drawings (1998) and The Art Therapy Sourcebook (1998), and published over 50 articles and chapters on the use of art intervention with children. Cathy has given more than 140 invited keynotes and presentations throughout the US and the world and is the editor of Trauma & Loss: Research & Interventions.
The second edition of *Approaches to Art Therapy: Theory & Technique* is a testament to the ever expanding and innovative process and application of the profession of art therapy. As in the first edition, author Judith Rubin reflects upon the varied psychological theories that are integrated into the understanding and delivery of art therapy services. The format of the second edition has been altered from the first edition by updating previously published chapters and adding six new chapters and seven new authors. The most innovative and significant contributions in this new edition are the brief commentaries and addenda that follow the series of chapters. This book definitely fulfills its multiple intents: to represent the psychological theories most widely accepted and utilized in the practice of art therapy, to reveal the intrinsic connections between theory and practice, to provide an introduction to the application of theory, and lastly, to call attention to the ever growing variety of ways in which art therapy may be practiced.

*Approaches To Art Therapy: Theory & Technique* is divided into five major parts: 1) Freudian psychoanalytic approaches, 2) humanistic approaches, 3) psycho-educational approaches, 4) systemic approaches, and 5) integrative approaches. Each part, or section, contains chapters written by prominent art therapists who have pioneered the particular approach represented in that section. For example, Part I: Freudian Psychoanalytic Approaches, begins with a chapter on discovery and insight by Judith Rubin. This is followed by a chapter on sublimation by Edith Kramer, a chapter on symbolism by Laurie Wilson, a chapter on object relations by Arthur Robbins, and a chapter on self-psychology by Mildred Lachman-Chapin. The chapter by Lachman-Chapin is followed by an addendum by psychoanalyst Eleanor Irwin. Part I also includes Jungian perspectives with chapters by leading art therapists Michael Edwards and Edith Wallace. A commentary from British art therapist Joy Schaverian expresses the conviction that psychoanalytic theory continues to contribute to both art therapy practice and inquiry today. It supports the use of scientific terminology, without pathologizing the image, to authenticate practice and validate the aesthetic tradition.

Part II examines humanistic approaches: the phenomenological approach to art therapy by Mala Betensky, the Gestalt art experience by Janie Rhyne, and the humanistic approach of Josef E. Garai. New chapters include the person-centered expressive arts approach by Natalie Rogers, and the spiritual path through the open studio by Pat Allen. Allen’s chapter is followed by a commentary from Bruce Moon, in which he reviews the commonly held beliefs regarding the inner wisdom of the human being, the resilience, as well as the natural quest toward health and fulfillment. Moon addresses the common emphasis on the process of “being” with one’s self, with one’s imagery, with others, and the world.

Part III reviews psycho-educational models that include behavioral art therapy by Ellen Roth, cognitive-behavioral art therapy by Marcia Rosal, developmental art therapy by Susan Aach-Feldman and Carol Kunkle-Miller, and the assessment and development of cognitive skills through art as pioneered by Rawley Silver. The postscript in this section is written by Frances Anderson. She reviews the commonalities among these models including their short-term duration basis in research and their useful application of these models with people with disabilities.

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Part IV examines systemic approaches such as family and group art therapy approaches. Barbara Sobel and Katherine Williams are featured authors, and Shirley Riley provides the commentary. In systemic approaches the focus is diverted from primarily intrapersonal work to interpersonal work. The art therapy interventions are therefore designated to facilitate systemic change and to shift the therapists into collaborators with their clients. Shirley Riley’s commentary reviews the art therapist’s contribution to this innovative shift to a contextual team perspective.

Part V reviews integrative approaches such as variations on a Freudian theme by Elinor Ulman, an eclectic approach by Harriet Wadeson, the use of imagination in all the creative arts by Shaun McNiff, and David Henley’s lessons for therapeutic growth in creative education. Robert Ault provides the commentary for this section. Ault examines the commonalities of integrative frames of reference, the focus of technique on the needs of the client, the influence of therapists’ personalities on their theoretical choices, and finally the power and ability of the client to direct the focus of therapy.

In conclusion, Rubin surveys the individual contributions of the authors and each chapter content. She reports on the common ability of the contributors to apply theoretical constructs by synthesizing the therapeutic power of art with their understanding of various theories of psychotherapy. Both the therapist’s personality and the needs of the client influence the theoretical basis chosen. All authors agree on the following three truths: 1) the importance of the image, 2) the need to create a therapeutic space in which people can safely create, and 3) the complexity of both the person and the process of art therapy. Rubin reiterates the importance of theory because it enables the therapist to make sense of data and be thoughtful about technique.

Although Rubin apologizes for the theories that are absent from this edition, I think it would be remiss not to mention at least two theoretical orientations that do not merely “represent an aspect of patient’s identity” or “have not proven to be lasting” (p. 5). First, the Expressive Therapy Continuum (Kagin & Lusebrink, 1978), developed by two renowned art therapists, is a sound theory based on psychobiological development and the intrinsic qualities of the arts media, and which creates a framework for intervention and application of the model. Second, it is my opinion that “brief” therapy/art therapy is an orientation with some distinct aspects that have been enumerated in the professional literature since the 1970’s. These include but are not limited to: 1) time limitation, 2) contract on a specific problem, 3) organization around a task, and 4) monitoring of the design for modification (Calisch, 1981).

Despite the exclusion of the aforementioned orientations, Approaches to Art Therapy: Theory & Technique does provide a relatively comprehensive and exceptionally informative text on different perspectives of theory toward the implementation of technique. It is a commendable accomplishment that will certainly become another Rubin classic volume. The volume not only stimulates options for the therapist’s thinking and avenues for the client’s exploration, but will also impel further thinking and application within our discipline.

References
was only hours away from beginning the book review of The Healing Companion by Jeff Kane when a good friend incurred a serious accident. As I prepared to be part of her caregiving circle, I called upon some of the simple but important points Dr. Kane talks about in his book and took the role of a healing companion. I had read the book months ago and had intention to share this pearl, so I was familiar with the themes Dr. Kane so clearly and passionately presents.

Dr. Kane is a medical doctor who often cures many patients. Sometimes, however, he cannot. Illness, disease, accidents may be managed but what he calls healing, that of paying attention to the sick person’s feelings and emotional experience, is what a companion or caregiver has the opportunity to do. Dr. Kane compliments the descriptive word “caregiver” as it suggests that those who gather and take the role of caregiver are not passive observers but people who engage in the process to alleviate suffering. Medical doctors, he states, are not the main characters in the caregiving community.

Throughout the book and derived from his own life stories and from his vast experience as a physician, Dr. Kane gives examples of how one can help a person to heal. With his clarity of thought, vignettes and presentation we learn how we can be effective when we understand that healing, by his definition, can lead to and actually is the attainment of inner peace. Healing is distinguished from cure, a physical process that restores human tissue to a healthy state. Kane says diseases may be cured but only people can be healed; both are essential to well being.

Dr. Kane is sensitive in knowing that we might love someone; and yet, we may not address what is so critically needed: connection, understanding, and the ability to listen and be present. We may feel helpless, frightened, and in reaction we do not always stop and quiet down to be of true help to another. Silence is often spoken about in the therapeutic community: sessions with long pauses when the client does not speak. In the case of the healer, silence means quieting oneself from self-expression, movement and even mental activity so that we can truly listen. Dr. Kane gives strategies to do this and more. He says that healing is simple and that it is available to everyone. All can learn.

The book is in eight chapters: 1. Healing, 2. Illness, 3. Being Present, 4. Listening for Meaning, 5. Using Your Ears, Eyes, and Heart, 6. Speaking with TLC (truth, leanness, and compassion), 7. Welcoming Mystery, and 8. Healing Yourself. At the end of each chapter is a page of points that were presented; they are an easy referral, well spoken and organized. I want to emphasize that The Healing Companion is not a usual self-help book but truly a book of companionship. It is small, pleasant to carry and healing to the caregiver as well as the one who is suffering. Its application is

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so diverse that physicians, as well as their patients, would benefit from reading it. It can be transformative and useful to the readers of this journal.

Within trauma is loss. How do we regain an equilibrium and regain or build strength? As adults we seek tools; for our children we can model behavior. Not only can we assist through a crisis but we can also provide skill-building activities and demonstrate with self-skills how everyone can be a healer, even a child to another child. I believe you will find this book, with its stories of compassion, to be very readable. It speaks with mindful attention, therapeutic listening and truth. Much welcomed references to literature, authors, scientists and philosophers are dotted throughout the text making this book part of a continuum in the history of man’s exploration of life and human activity.

As an art therapist The Healing Companion hits the mark. Many therapists are conflicted as to how much of the emotional self needs to be verbalized during art making. In addition, therapists struggle with words to voice when looking at the art product. This book provides thoughtful material on which to base decisions on how to behave and respond. On the cover of the book it says, “Simple and Effective Ways Your Presence Can Help People Heal.” The Healing Companion delivers that message. Anyone who wants to ease someone’s pain and in the process feel at peace will see this book as relevant. ♦
The Secret of the Peaceful Warrior is a book that I find invaluable for working with children who have been traumatized, as well as children who are feeling bullied or powerless in their lives due to everyday events. Whether at school, home, or in their neighborhoods, every child is going to encounter a bully at one time or another in their development. Whether they approach this event as victor or victim depends in large part on their previous life experience and the training they have received in coping skills.

Children who have been traumatized in some way inevitably think and walk with the attitude and mentality of a victim. This creates a perfect target for a bully. It is similar to painting a bull’s eye on their chest! When I meet with these children, I use the Secret of the Peaceful Warrior to help them recognize their own strengths and their power within. With small children, I read the book to them, and they follow along with the beautifully done, simple illustrations that move throughout the book. With older children, I ask them to read, but I stop the text at significant points. A place I emphasize is how the hero of the story, Danny, learns that “The secret of courage is to act brave, even if you are not feeling very brave.” (12)

In this story we follow Danny as he starts a new school and is immediately confronted with a bully on his first day. We see that his new friend Joy, even though she is “a girl!” can run like the wind to escape the bully. Danny learns that Joy’s grandfather taught her to run, and he wants to learn to run fast also. He however, learns two important lessons from Joy’s grandfather: (1) You have to develop your own skills, internally, not just emulate someone else; and most important, (2) “If you run from the problem, even though you get away for awhile, it keeps chasing you.” (12)

At this point, the child has been sitting, reading and talking for quite a while, so I incorporate physical activity with this story. The goal is to generalize the principles of the story into the muscle memory and verbal repertoire of the child. I start with a physical martial arts drill in “front stance.” I face the child, both of us putting our right hands out, palms forward. Our feet are in “horse stance” with the right foot forward balancing with the left foot back, shoulder width apart. We touch palms and walk circling each other. The point is to teach the child to match the pressure of his/her hand against mine. When confronted, utility of effort is required: use enough force to match, not over power another. Next, I have the child strike my arm lightly in slow motion, and I parry the strike out of the way (also in slow motion) so as to avoid being actually hit. Once we have practiced this 3-4 times with them striking at me, we reverse the activity. I now strike at them; they parry my arm, and we continue circling as they defend themselves.

Once we are walking easily in the circle, physically relaxed, I add a verbal component. I have the child call a name or use a hurtful statement such as, “hey sissy” or “you’re ugly,” and I defend against it vehemently, such as “oh ya, well, you’re uglier!” Then we reverse roles, and I call out the insult, and the child retaliates defensively, verbally. I point out to the child after we have both taken a turn that these kinds of responses escalate fights rather than getting ourselves free of fighting. I ask: “Can we
cool this down?” “Watch.” The child repeats the exercise playing the part of the bully, and this time instead of counter attacking, I say something like “sorry you see me that way. I like myself the way I am.” We then reverse roles and the child practices this method of response. It usually takes a bit for the child to be able to say a positive statement in response, but as we practice it gets easier. I tend to keep moving in a circle and continue the parry action so we blend the two learning components. We use the “bullying” words this child hears in his world, so generalization is more likely.

The important skills to develop include confidence deflecting either physical or verbal assault. The verbal component is most difficult for children. They are not used to making a positive matter of fact response. They are delighted however when they learn that by doing so they take all the “fun” out of fighting! By incorporating the physical and verbal training simultaneously, children seem to remember better when they get into a real life situation. Furthermore, the child has fun saying things not normally allowed to an adult in a safe setting, as well as being able to physically stand their ground against an adult.

In reality, we hope the child can imagine themselves as the “Peaceful Warrior” as Danny became. With repeated practice, the majority of children discover that “no fear can withstand the courage and love of the peaceful warrior.” (28) Many children who practice this philosophy and physical response show noticeable physical changes in the way they walk, move and approach people. They have their shoulders back instead of rounded or collapsed; their heads are up, and their eye contact is more direct and confident.

I have found this story to be an invaluable therapeutic tool to explore what kind of bullying a child may have experienced, as well as emphasizing the point that they are not alone. Victims are built when children believe that they are all alone and that no one else in the world has experienced what they are enduring. This book beautifully conveys how to ask for help from someone who may know how to help and to build a network of support. It also brings forward, gently, the concept of listening to your own inner voice, whether in dreams or thoughts to control your own life. This is an easy book for any age child to understand and relate to - from pre-readers through junior high level, because all children, no matter their age, want new ways to empower themselves with other children and their world. ☚
NoNo and the Secret Touch, a timeless storybook and audiocassette, is invaluable in treating sexually abused children. It can be used therapeutically for prevention, disclosure, and healing. Through the use of metaphor, authors Sherri Patterson and Judith Feldman have found a way to break through the defenses of victimized children.

It is often difficult for children to address issues of sexual abuse directly. The animal characters in this story provide the child a safe distance and an effective way to talk about uncomfortable feelings and situations. NoNo’s (a young seal) behavior subsequent to being molested by his favorite relative, parallels the experience of many of the story’s readers. Children empathize with the range of feelings, from anger and fear to confusion and guilt expressed by NoNo. The little seal is empowered through his discussion with Wise Whale, the “helper” in the story, who assists the little seal in distinguishing between “good and bad secrets.” “Tattling,” the Wise Whale offers, “is just to get someone in trouble. Telling is to get help for yourself.” NoNo is encouraged to talk about what has happened to him through his interaction with this character.

This story can be used as a catalyst for discussion between the child client and the trauma specialist or therapist. A book is included which provides discussion questions and follow-up activities. Remember that children are often the best creators of therapeutic interventions subsequent to the sharing of the story. Children can use puppets to communicate their own story and experiment with new behaviors modeled by the characters or puppets who can be interviewed by the clinician.

Subsequent to sharing the story with her clients, Eliana Gil, internationally recognized author and child and family psychologist, assists clients in constructing a safe environment for NoNo. She has adapted a technique developed by art therapist, Barbara Sobol, in which children create a safe haven for NoNo. Herein they are provided with a small seal (available from nature stores) and art supplies which might include a cardboard or foam board base and materials such as colored paper, stones, wood, glue, pipe cleaners, glitter, fabric, beads, and similar items the child might utilize. Children may choose to make creature-comforts that could include props and toys. The helper might query about what would make this a safe place, or about friends or wonder about who the seal might turn to when afraid. Dr. Gil comments that children are themselves nurtured, and a concrete image of safety can be integrated into their coping repertoire through symbolic play, paying attention to the needs of NoNo, and providing comfort to the little seal.

A young reader identifies with NoNo as he moves from a position of immobilization to feeling empowered. Children relate to this childlike creature and seem to develop a certain confidence to tackle the challenges presented in the story. Utilized by the clinician for its educational value and in the journey toward healing, NoNo and the Secret Touch is an asset for every clinician in the trauma field.◆

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