SCRENNING CHILDREN AND ADOLESCENTS FOR DEPRESSION THROUGH DRAW-A-STORY*

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There is an urgent need to identify children or adolescents who may be depressed or at risk for suicide. Although it is generally agreed that most suicides are committed by depressed individuals, perceptions of depression vary. It is not well known that children as young as six suffer from depression. As McKew, Cytryn, and Yahraes (1983) have pointed out, problems in school are likely to mask depression, and these children may go undiagnosed or misdiagnosed.

Among adolescents, suicide ranks second to accidents as the leading cause of death. Even though many depressed adolescents could be treated effectively if identified in time, their suicide rate is increasing (Frederick, 1985).

Could drawings be used for the early detection of depressive illness? People tend to be less guarded about expressing themselves through drawings than through speech. Thus, drawings can offer glimpses into the ways individuals see themselves and their worlds.

In four studies involving over 600 children and adolescents, we noted that a few drew pictures of suicide when responding to a drawing task, and that more than a few drew fantasies about death, dying, or hopeless situations (Silver, Lavin, Boeve, Hayes, Itzler, O'Brien, Terner, and Wohlberg, 1980; Silver, 1983b, 1986b, 1987). Were these children depressed? Have drawings been studied for attributes typical of depressed individuals?

A review of the literature found a study of artwork by depressed adults in a psychiatric hospital (Wadeson, 1980). Patients were asked to make spontaneous drawings with colored chalks. Those who had difficulty deciding what to draw were encouraged to develop scribbles into pictures or draw with eyes closed or the wrong hand. The findings indicated that artwork by depressed adults showed more empty space, less color, less investment of effort, and either more depressive affect or less affect. Wadeson's approach seems more concerned with the form of artwork than with its content or message.

Using a different approach, Stimulus Drawing techniques are more concerned with content than form, and are structured rather than spontaneous (Silver, 1981, 1982, 1986a). Stimulus Drawings consist of 50 sketches of people, animals, places, and things presented as a task: instructions are to choose two of these picture ideas, imagine something happening between them, then show what is happening in a drawing of your own. When a drawing is finished, the individual who drew it gives it a title and discusses it with the art therapist, whenever possible, so that meanings can be clarified. Rating scales are used to evaluate response drawings for concepts of self and others. The techniques have been used in studies involving children, adolescents, and adults (Sandburg, Silver and Vanstrup, 1984; Silver, 1983b, 1987).

A new study, reported here, proposed to explore the use of Stimulus Drawings in screening children and adolescents for depression. With this in mind, certain Stimulus Drawings were selected for a new test booklet and the rating scale revised and amplified. This new instrument was presented to 254 children and adolescents in various parts of the United States by the volunteers listed above. Responses were then evaluated and compared.

This paper will report the results that were obtained.

Method

The Instrument, Draw-A-Story (DAS)

The test booklet included 14 stimulus drawings selected from 65 used in two previous instruments (Silver, 1983a; 1986a). These sketches were chosen because they seem to have prompted negative fantasies in the earlier studies.

The drawing task remained essentially the same: look over the sketches and choose two, imagine something happening between the subjects you choose, then draw a picture of your own. Make your drawing tell a story. Show what is happening. Feel free to change the drawing and to add your own ideas. When you finish drawing, write a brief story in the space provided.

Although this task is structured, it is open-ended, leaving one free to choose among the 14 subjects. The task is less structured than projective techniques that...
specify what one should draw, such as
Draw-A-Person (Harris-Goodenough, 1963); Draw a Whole Person (Koppitz, 1968); and Draw Your Family Doing Something (Burns and Kaufman, 1972). Copying is discouraged and expressiveness encouraged.

The visual and verbal responses are evaluated on a rating scale adapted from the earlier instruments. The scale is a 7-point continuum ranging from strongly negative themes, such as suicide (1 point) to strongly positive themes, such as honeymoons (7 points). Scores of 2 and 3 points are used to characterize moderately and mildly negative themes; 5 and 6 points to characterize mildly and moderately positive themes. The median score, 4 points, characterizes content that is ambivalent, unclear, or unemotional (neither negative nor positive). Formal attributes, such as line quality, empty space, and placement on the page, are not scored but may be evaluated when they seem relevant in particular drawings.

Validity

What is the validity of this rating scale? How can be inferred from scoring responses to the drawing task?

The score of 1 point (strongly negative content). This score is based on observations by suicidologists as cited below. Although they did not refer to behaviors such as drawing, their observations about the behavior of depressed individuals serve as a paradigm for evaluating responses on the DAS scale.

Shaffer and Fisher (1981) studied 100 consecutive suicides in Great Britain of which all but a few had shown signs of psychiatric disorder before their deaths, the most common diagnosis having been depression. He also found that a majority of children who committed suicide had manifested antisocial behavior, indicating that suicide is related directly rather than indirectly to aggression. He concluded it is unlikely that the expression of aggressive feelings will deter a child from suicide.

Pfeffer (1986) notes that depressive affect is correlated with suicidal behavior in children, although not all depressed children become suicidal. She distinguishes suicidal from nonsuicidal children by their feelings of depression, hopelessness, worthlessness, and the wish to die.

McNee, Cytyn and Yahraes (1983) also examined the fantasies of depressed children, noting the prevalence of violence, explosions, annihilation, and death. They cite characteristics of depressive illness listed by the American Psychiatric Association, including sadness, hopelessness, aggressive behavior, and suicidal thoughts or actions.

The widely used Beck Inventory (1978) is also concerned with negative affect, such as feelings of sadness, hopelessness, and thoughts of death or suicide. Beck, Rush, Shaw, and Emery (1979) find three major cognitive patterns of depression: negative views of self, a tendency to interpret one's experiences in a negative way, and a negative view of the future.

To summarize the observations of these specialists, the characteristics of depressive illness include expressions of aggressiveness, hopelessness, and sadness; suicidal ideation and fantasies of violence and death.

The DAS rating scale is based in part on these observations. The score of 1 point is used to characterize strongly negative response drawings with principal subjects who are dead, dying, helpless, thwarted, sad, isolated or cruel; environments that may include dripping knives, smoking guns, prisons, or tombs; and futures that seem hopeless.

Figure 1 shows some of the stimulus drawings that were selected from the DAS booklet. Figures 2 through 8 are examples of response drawings that were scored 1 point.

This report concentrates on the analysis of responses scored 1 point. Although the validity of responses scored 2 to 7 points is beyond the scope of this paper, interested readers are referred to a book now in press (Silver, 1988).

Procedures

We asked two questions:
1. Are strongly negative responses linked to clinical depression?
2. Do negative responses tend to be temporary or do they persist over periods of time?

Subjects

Subjects for the study included 254 children and adolescents between the ages of 8 and 21. Of these, 111 were presumably normal, 27 were clinically depressed, 31 learning disabled, 61 emotionally disturbed with nondepressive psychopathology, and 24 normal children who responded to the drawing task on two occasions. They resided in Arizona, Montana, New Jersey, New York, Oregon, and Pennsylvania. The task was administered between October, 1986, and April, 1987, by 19 art therapists, teachers, and school counselors.

Results

Approximately 56% of the depressed subjects responded with strongly negative fantasies, characterized by the score of 1 point, compared with 11% of the normal subjects, 21% of the emotionally disturbed, nondepressed subjects, and 32% of the learning disabled subjects.

To determine whether these differences were significant, the chi-square test was
Figure 1. DAS stimulus drawings that were selected by the children or adolescents whose responses are shown in Figures 2 to 8. Reproduced with permission of Rawley Silver.

Figure 2. "Delicious Corporal . . . Corporal Kristy has just passed an airborne test and ready for the real thing. On a Monday morning, Kristy and other jumped from an airforce plane. Kristy jumped and he saw a monster mouth. Oh shoot, he blew air and cooked me in the air. He ate me and felt contented." Allen, age 16, clinically depressed.
Figure 3. "Mr. Henderson was found guilty of murdering his wife, whom he was married to for 4 years, and got sent to Ryker's Island prison where he was to stay for 50 years. After two weeks there, he got beaten, stabbed, and raped by his inmates. Since he couldn't take any more abuse, he decided to take a knife and stab himself to death with it. He enjoyed his last smoke before he died." Paul, age 15, clinically depressed.

Figure 4. "The Dead Man." Bobby, age 8.

Figure 5. "The Knife." Otto, age 11, learning disabled.

Figure 6. "Murder." Andy, age 13.
used. Results indicated that the proportion of depressed subjects who scored 1 point was significantly greater than the proportion of normal subjects who scored 1 point; the chi-square was 27.63, p <.001. The proportion of depressed subjects scoring 1 point was also greater than the proportion of emotionally disturbed subjects scoring 1 point but to a lesser degree. The chi-square was 10.54, p <.01.

The proportion of depressed subjects scoring 1 point was not significantly greater than the proportion of learning disabled subjects scoring 1 point. The chi-square was 3.269, p >.05.

**Discussion**

Based on these findings, there appears to be a link between depressive illness and strongly negative responses to the Draw-A-Story task. Although strongly negative responses do not necessarily indicate depression, and, conversely, positive responses do not exclude depression, the findings seem to indicate that a child or adolescent who receives the score of 1 point may be at risk for depression. A second observation is that those children that were retested demonstrated that negative responses seem to persist over periods of time, suggesting that they reflect characteristic attitudes rather than passing moods.

A third observation is that a comparatively large proportion of learning disabled subjects received the score of 1 point. No significant difference was found between their scores and the scores of patients diagnosed as clinically depressed.

A similar finding was reported by Peck (1985), who examined all adolescent suicides in Los Angeles over a three-year period. Out of 14 individuals, 7 had been diagnosed as having hyperactivity, perceptual disorder, or dyslexia. Although learning disabilities may occur in 5% or 10% of the population, as Peck observed, in his sample it was 50%.

It is hoped that these findings will invite further investigation. It is also hoped that others will examine the potential of the DAS instrument in psychotherapy as well as in the early detection of depressed individuals.
REFERENCES


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