Projective Drawings as Measures of Psychosocial Functioning in Siblings of Pediatric Cancer Patients From the Camp Okizu Study

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This research was conducted at a summer camp for siblings of children with cancer. Participants included 77 siblings (ages 6-17 years) and their parents. Before attending camp, 18 of the siblings had experienced the death of their brother or sister with cancer. Projective measures were administered before attending camp and 3 months after camp. These included the Human Figure Drawing (HFD) and the Kinetic Family Drawing-Revised (KFD-R). Siblings were administered both the HFD and KFD-R; parents were given the KFD-R. On the HFD, siblings’ emotional distress scores decreased significantly pre- to postcamp. On the KFD-R, nonbereaved siblings and parents showed significant improvement in family environment scores. Bereaved siblings and parents also showed improvement (although nonsignificant). These results support Camp Okizu’s effectiveness in increasing siblings’ emotional well-being yet underscore the need to implement interventions to address family communication for both bereaved and nonbereaved families.

Key words: siblings, projective drawings, camp, psychosocial functioning

The entire family system is affected when a child is diagnosed with cancer (Houtzager, Grotenhuis, & Last, 1999). Recent studies have focused on the increased psychological risk posed to healthy siblings of pediatric cancer patients (Sahler & Carpenter, 1988), and investigators have found that the emotional needs of siblings of cancer patients were met at significantly lower levels than those of other family members (Spinetta & Deasy-Spinetta, 1981). Although the pediatric patient is most directly affected by the disease, cancer upsets the normal family patterns and activities of the entire family system. Siblings are significantly affected, because they are asked to assume greater familial responsibility and are often given much less attention from their parents (Powell & Ogle, 1985). Often, siblings become jealous and angry.

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about the extra attention espoused on the cancer patient, followed by guilt for having these negative feelings toward the sick sibling (Houtzager et al., 1999). In a study examining donor and nondonor siblings of pediatric bone marrow transplant patients, investigators found moderate to severe levels of posttraumatic stress in one third of the sibling sample (Packman et al., 1997). Furthermore, it has been shown that siblings of pediatric cancer patients are at an increased risk of developing emotional and somatic problems unless an intervention focusing on the siblings’ well-being is implemented at the time of the family crisis (Bearison & Mulhern, 1994).

In a study by Cohen, Friedrich, Jaworski, Copeland, and Pendergrass (1994), an increase in social support was correlated with fewer adjustment problems in siblings. In a related vein, Heiney, Goon-Johnson, Ettinger, and Ettinger (1990) found that support groups for siblings of pediatric oncology patients allowed siblings the opportunity to express their feelings and talk with others as an adaptive coping strategy. A promising intervention for siblings of pediatric cancer patients is a summer camp program (Sahler & Carpenter, 1989).

Camp Okizu’s SIBS Camp is designed to help with the psychosocial issues faced by siblings of children with cancer. The goal of Camp Okizu is to provide siblings with peer support, validate their feelings, and bolster their self-esteem. We recently investigated whether participation in Camp Okizu’s SIBS Camp was associated with improvement in psychosocial functioning as measured by objective self-report measures (Packman et al., 2004). We found statistically significant decreases in symptoms of posttraumatic stress and anxiety and statistically significant improvements in quality of life and self-esteem for siblings of pediatric cancer patients.

This article further enriches our understanding of the psychosocial functioning of siblings by examining the quantitative and qualitative findings on projective measures administered to the Camp Okizu sample. In this study, the Human Figure Drawing (HFD) (Koppitz, 1968) was administered to siblings (before and after camp) and used as an indicator of emotional distress. The Kinetic Family Drawing–Revised (KFD-R) (Spinetta, McLaren, Fox, & Sparta, 1981) was administered to both siblings and parents (before and after camp) and was used to assess family environment.

Method

Participants

Families were recruited according to the following criteria: The family was enrolled in Camp Okizu for 1 of the 2001 1-week sessions; siblings were between the ages of 6 and 17 years, spoke English, and were able to understand the study instruments.

The study was approved by the Stanford University Internal Review Board. Informed written consent and assent were obtained at the time of data collection. The study instruments were administered to families in their homes, starting 4 to 8 weeks before camp for the precamp phase and 12 to 16 weeks after camp.

Precamp participants included 100 siblings. Of the original 100, 77 participants completed both pre- and postcamp measures. The 23 participants with missing postcamp data can be grouped into 4 categories: participants were lost to follow-up (n = 4), participants could not be interviewed because of weather conditions (n = 6), siblings did not attend camp (n = 3), and there were scheduling difficulties (n = 10).

Measures

Human Figure Drawing (HFD). The Koppitz (1968) system has been widely used to assess psychological stress in children (Eng & Davies, 1991) and has a high interrater reliability of 0.89 to 0.91 (Packman, Beck, VanZutphen, Long, & Spengler, 2003).

The Koppitz system contains 30 scoreable emotional indicators (EIs) divided into 3 categories. The first category, Quality Signs, consists of signs that relate to drawing quality and include such things as poor integration of parts of the figure, shading, and size of figure. The second category, Special Features, includes features such as oversized head, crossed eyes, presence of teeth, and a monster-like quality of the figure. Finally, the Omissions category looks at the absence of certain body features (eg, eyes, nose, mouth, arms, and legs) (see Appendix A for the HFD scoring system).

In the Koppitz system, a drawing that has 2 or more EIs indicates the presence of emotional disturbance. Validity has been demonstrated by comparing clinic patients with well-adjusted children. Seventy-two percent of clinic patients scored 2 or more EIs, whereas only 5% of the normative sample scored 2 or
more (Koppitz, 1968). In the present study, 2 art therapists scored the HFDs independently. Interrater reliability was high for the drawings’ overall EI scores (precamp \( r = 0.87 \); postcamp \( r = 0.85 \)).

**Kinetic Family Drawing–Revised (KFD-R).** Spinetta et al. (1981) developed the objectively structured KFD-R for interpreting the kinetic family drawings of children with cancer and their family members. There are 4 scales: family communication, self-image, emotional tone, and the KFD-R total score (overall level of family environment). The KFD-R has been used to assess family environment in siblings and parents of bone marrow transplant patients (Packman et al., 1998). The system has 19 negatively valenced items. Each item is scored 0, 1, or 2, with the higher score indicating significant negative indicators for that item. Total KFD-R scores range from 0 to 35, with higher scores indicating poorer family environment. Interrater reliability was high for the drawings’ KFD-R total scores (child’s pre- and postcamp \( r = 0.88 \); parents’ precamp \( r = 0.84 \) and postcamp \( r = 0.85 \)) (see Appendix B for the KFD-R scoring system).

**Procedure**

For the HFD, the researcher presented the sibling with a blank sheet of paper (8 1/2 × 11 inches) and a number 2 pencil with an eraser. The child was instructed to draw a whole person. “It can be any kind of person that you want to draw, just make sure that it is a whole person and not a stick figure or cartoon figure” (Koppitz, 1968, p. 6).

In administering the KFD-R, the researcher presented the sibling with a blank sheet of paper (8 1/2 × 11 inches) and a standard set of 8 markers. The researcher began with the statement, “Draw a picture of everyone in your family doing something. Try to draw whole people, not cartoons or stick people. Remember, make everyone doing something.” If questions were posed about the content, the participant was told, “Draw whatever you like.” If siblings asked whether they should draw themselves, the researcher’s response was, “Draw everyone in your family.” If the drawing was incomplete, the sibling was asked, “Is that everyone in your family?” If the answer was affirmative, no further instruction was given, even if the drawing was incomplete. The same procedure was used to administer the KFD-R to parents, who were assessed separately from the sibling; neither saw each other’s drawing.

**Results**

**Description of Sample**

The average camper was 11.7 years old and in the sixth grade. There were 42 females (54.5%) and 35 males (45.5%). Approximately 16% (n = 12) were first-time campers, whereas 84% (n = 65) had attended camp before. The sample was 75.3% White (n = 58), 14.3% Latino (n = 11), 3.9% Black (n = 3), 1.3% Asian (n = 1), and 5.2% other (n = 4). Socioeconomic indicators, family income, and both maternal and paternal education were also collected, indicating a middle income majority.

**Quantitative analysis.** For the HFDs completed by siblings, the mean pretest EI score was 4.12 (SD = 2.26) and the mean posttest score was 2.78 (SD = 1.69). The EI scores decreased significantly from pre-to postcamp (\( t_{29} = 4.85, P = .00 \)) indicating a significant reduction in emotional distress.

For the KFD-Rs completed by siblings, in parallel to their HFD scores, the siblings’ overall KFD-R scores decreased significantly from pre-to postcamp, (\( t_{15} = 3.14, P = .00 \)), indicating a significant improvement in family environment.

For the KFD-Rs completed by parents, overall KFD-R scores decreased significantly from pre-to postcamp (\( t_{22} = 2.98, P = .00 \)) indicating a significant improvement in family environment.

Eighteen of the 77 siblings had experienced the death of their brother or sister with cancer before camp. We compared the projective drawings of bereaved and nonbereaved siblings to ascertain whether there were differences between these 2 groups. The HFD results indicated that both bereaved siblings (\( t_{17} = 2.15, P = .05 \)) and nonbereaved siblings (\( t_{54} = 4.32, P = .00 \)) experienced significant reductions in emotional problems from pre-to postcamp.

We also compared the KFD-Rs of bereaved and nonbereaved participants (both siblings and parents). The nonbereaved participants showed significant reductions in family distress from pre-to postcamp (siblings \( t_{57} = 2.96, P = .00 \); parents \( t_{54} = 2.38, P = .02 \)). Bereaved siblings and parents also showed reductions in family distress; however, they were not...
Discussion and Illustrative Drawings

Human Figure Drawing (HFD). Both bereaved and nonbereaved siblings in our sample showed significant reductions in emotional distress. The HFDs of a bereaved sibling are shown in Figures 1 and 2. The precamp drawing by this 12-year-old male sibling is notable for shading of the face, body, and limbs. It is a very tiny figure placed in the upper left of the paper. The precamp drawing received an EI score of 4. In contrast, after camp, the drawing is a larger figure that is more centered on the paper (EI = 1).

The drawing elements of each figure drawing are similar: large head, ears and eyes placed high, arms reaching out to the sides, feet turned to the left, and shaded stripes and fill-ins on the clothes. These are elements present in child drawings between ages 7 and 12, when the child’s head is full of thoughts, when there is trauma and anxiety present for the child, and when the child feels insecure and oriented toward the past. The changes from pre to post states are significant: the figure is almost twice as large and placed lower down on the paper. This suggests an increase in self-esteem and fewer feelings of isolation and anxiety. In support of this change is the improvement of the sibling’s score on both the self-report self-esteem measure and anxiety measure. In the postcamp drawing, there are pupils in the eyes, eyebrows, and an open smile, suggesting less trauma, more positive feelings, and a sense of presence (ie, being able to see and be seen). Additionally, in the postcamp drawing, the legs are separate, indicating an ability to move more freely. Even though the arms are still short for the body, they are a little lower and the fingers are more defined (ie, more active, less weak and helpless).

In our sibling sample as a whole, the scores on the HFDs reflect significant reduction in emotional distress postcamp. These findings are not surprising in light of the supportive environment provided by the camp. Camp Okizu is designed to provide siblings with peer support, to validate their feelings as normal in the context of serious illness in the family, and to bolster their self-esteem. On the second day of each session, the siblings meet for a facilitated discussion of their family situations and to share tips on coping. This establishes a bond of understanding that grows throughout the week. There are opportunities to acquire new skills or improve camping skills.
Counselors reinforce positive behaviors and ensure that all campers experience success during the week. Older campers also participate in trust activities and team initiatives to allow them to experience success in the context of strong peer support and adult mentoring.

At Camp Okizu there is a special time for peer support for the bereaved children. Siblings share memories of their brothers and sisters who have died and talk about how the death has affected them and their family. At the end of camp at a ceremony called Inspiration, the community gets together to reflect on the week. Each cabin group gathers on the stage at the amphitheater with their counselors and shares some memory of the week. Later, at an open forum, anyone is invited to say whatever they would like to the group. This is often a time when siblings share their feelings about having lost a brother or sister or their fears that they may lose a brother or sister. The willingness of the children to speak to the whole community suggests that they feel very safe in the camp environment and feel supported by the other campers and the staff.

In our view, the siblings’ opportunity to communicate and bond with a true peer group, as well as the positive feedback, reinforcement, and recognition from supportive counselors, may account for improvement in emotional functioning as measured by the HFD. This finding, coupled with our previously reported findings on objective measures, suggests that participation in camp activities may be linked to improved self-esteem, emotional functioning, and interpersonal relationships. It is important to point out that in the Koppitz system, 2 or more EIs indicate emotional distress. Although the siblings showed dramatic improvement, their posttest overall HFD scores suggest that siblings of cancer patients are still an at-risk group in need of targeted mental health services in addition to the camp intervention. This finding is validated by the posttest scores of the objective measures such as the PTSD measure, which also indicated that although dramatic improvements took place, the siblings were still an at-risk group.

Kinetic Family Drawing—Revised (KFD-R). In relation to the KFD-Rs, there was also statistically significant reduction in family distress for both sibling and parent nonbereaved participants and statistically nonsignificant reductions for both sibling and parent bereaved participants. Thus, in contrast to the HFD findings, the pre- to postcamp KFD-R drawings of the bereaved participants did not show statistically significantly improved family environment. This was most likely attributable to the small sample size of the bereaved subset. It is most encouraging that the scores improved postcamp for both nonbereaved and bereaved groups. These findings suggest that the peer validation and social support received by siblings at Camp Okizu may be an effective resource in the adjustment of siblings of pediatric cancer patients and may contribute to improved family environment.

To illustrate improvement in family functioning, the pre- and postcamp KFD-Rs of a nonbereaved sibling and a nonbereaved parent are shown. Figures 3 and 4 were drawn by an 11-year-old sister of a 2-year-old cancer patient. The precamp KFD-R received a score of 15. This sibling is struggling with isolation, fears of death, and anxiety. She has placed herself on the far left in the drawing. She is feeding a squirrel on the other side of the tree; her mother and father are independently gardening outside and looking out from inside the house. Her sister is drawn underneath the scribbling, anxious green lines of grass; the top of the tree is above her sister and touching her head almost like a blank “talk bubble” in a cartoon. No one in this family has eyes, suggesting they may be afraid to see or be seen—this is a common
feature expressing trauma and distress. Everyone is separate: the sibling is feeding a squirrel, next to a sturdy tree; the sister is lying on the ground and the grass is drawn over her with anxious, scribbling lines. This drawing could express unconscious fears of her sister being sick (lying down) or possibly dying (below baseline of the grass). The mother is watering the grass and sprinkling seeds at the same time (nurturing the sick child). The father is distant in the window of the outlined (not colored-in) house, which perhaps is showing no current warmth.

The postcamp drawing illustrates a very different family constellation (score = 7). The 11-year-old sibling is now sitting on the grass holding a blue flower and her sister is standing up holding a purple flower. There are sun and clouds in the sky—this family has a “place in the sun”—and flowers are growing in the grass and ground. The dad is going to give the mom a flower, reaching in the mom’s direction; and the mom is going to give the dad a hug (this was all stated by the artist). The mom and dad still have no complete eyes and are not fully filled in with color, but they show connection, just as the girls are near each other in this drawing. This configuration of people is more age-appropriate than the precamp drawing, showing less stress and tension.

The drawings of a nonbereaved parent are shown in Figures 5 and 6. In this example of a parent’s pre- and postcamp KFD-R, the compositions are vastly different. In the precamp drawing (score = 16), this parent draws everyone alone except a younger daughter (not the patient or sibling study participant) with a friend. Everyone but this child with her friend has no hands, suggesting helplessness and inadequacy, and is drawn in black. Everyone is busy: the parents are doing chores and the children are engaged in activity (piano, baseball, horseback riding, and playing with a friend). This adds up to compartmentalization or isolation even though the barriers are not “walls” drawn between the lone figures. Looking at this drawing gives one a feeling of a former time, when even the patient is busy playing baseball. The artist, mother, in the top row center, is cooking and has the keys to the car in her other hand. This scene is typical of a family, especially the mother, being very busy when one child is very ill.

The post-KFD-R drawing by this mother is much brighter, drawn in color with everyone outlined in the color of the sun, yellow (score = 3). There is no baseline for the family members, but the mother has the patient on her left, with the other children all around her, and all are holding hands. The tree is sparse and stands only as an outline with some disconnected lines (perhaps showing the mother’s depletion), and there is a noticeable absentee person, the father. There are no hands drawn for most family members, even though they are implied through figures being linked together. The feeling of strength is apparent with all drawn figures standing up straight and together. This suggests that, perhaps, the situation is better but not easy.

As noted, on the KFD-R, the nonbereaved siblings and parents showed significant improvement in family environment scores postcamp. Bereaved siblings and parents also showed improvement (although nonsignificant). However, even with reductions in family distress as measured by the KFD-Rs, the mean scores...
are still very high postcamp for all groups, indicating that there are still high levels of family distress that need to be addressed. In fact, on closer examination of the individual data, it is clear that a large subgroup of both nonbereaved (29% for both) and bereaved siblings (22%) and parents (25%) actually showed increases in family distress postcamp. These increases in family distress for these subgroups not only statistically affect the size and significance of the reductions in distress seen for the whole sample but highlight one of the dangers of group analysis, in which subgroups can be overlooked.

Our KFD-R findings suggest that the experience of living and coping with cancer as well as experiencing a child’s death has a profound impact on siblings, parents, and the family system (Grootenhuis & Last, 1997). Indeed, caring for a child with cancer often requires a significant change in the family system, with much of the family’s resources and attention focused on the affected child. In addition to fears of death and the threat to the affected child’s physical well-being, cancer treatment itself introduces a myriad of daily hassles and stressful life events (Dockerty, Williams, McGee, & Skegg, 2000). How families manage this process of adaptation is greatly influenced by the degree of communication and cohesion in the family as well as the amount of support the family receives from extended family members and friends (Davies, 1999). These conditions very much affect how siblings adapt to living with a chronic, potentially terminal illness.

Moreover, research suggests that several factors are associated with successful and unsuccessful psychosocial adjustment among siblings of cancer patients. Several studies have reported the need for siblings to maintain communication within their families, to receive age-appropriate information about their sibling’s illness and treatment, and to be active participants in their sibling’s care (Sahler & Carpenter, 1988). Open communication in the family is especially crucial in the aftermath of a sibling death. Unfortunately, in families where children are not allowed to frankly express their feelings or talk about their sibling’s condition, the children often feel overlooked and alone (Horsley & Patterson, 2006). The presence of open family communication, along with the candor with which cancer is discussed, provides a supportive environment for the remaining children, helping them work through a range of emotions (Siegel, Mesagno, & Christ, 1990). With respect to bereaved siblings, most children can benefit from opportunities to talk about their responses not only at the time of the death but for many years to come as they reach new developmental levels of understanding death.

Our KFD-R findings may identify a subgroup even more at risk for whom camp is not nearly enough. It is possible that the awareness of potential death among the nonbereaved may have as damaging an impact on family functioning as actual death. With advances in medical practice, the psychological dilemma for families has been altered from one of adapting to the imminence of death to one of coping with uncertain survival (Koocher & O’Malley, 1981).

It is possible that the opportunity afforded siblings at Camp Okizu to express feelings about their brother or sister’s cancer experience or death is not available to them at home either before or after camp. The assessment measures in the current study were administered to siblings and parents before and after camp in the siblings’ homes. The KFD-R measure assesses family environment. Many of the drawings by the subgroup of nonbereaved and bereaved participants that became worse after camp are notable for isolation and closed family communication (compartmentalization and barriers between family members), low energy, and emptiness (barely visible drawings or small figures with big areas of white paper between figures).

The results from the KFD-R are especially salient. Our earlier findings on objective measures suggested that siblings clearly benefit from Camp Okizu, as evidenced by increased self-esteem and quality of life and decreases in posttraumatic stress and anxiety. Results from the HFD mirror the findings on objective
measures. Of importance, the KFD-Rs for the groups as a whole do show a reduction in family distress after camp. However, the KFD-R is also sensitive to picking up a subgroup of participants who may be a particularly at-risk group. Other factors at play for this subgroup could be lack of family support, lack of additional therapy, strained finances, and the medical condition of the patient at the time of the assessment. Unfortunately, we could not capture these possible factors for this study, but this is worth exploration in a future study.

There are a number of limitations to our study. First, the lack of a control group limits the internal validity of the results. Thus, we cannot rule out the effects of history and maturation. It is also possible that the passage of time may have contributed to the changes noted. In addition, because the study contained no formal assessment of support services used by siblings and/or parents, it is possible that some participants received supportive services, in addition to Camp Okizu, which contributed to improvement. Finally, interpretation of the current findings must be made cautiously given the absence of a second follow-up assessment phase.

Major strengths of this study include novelty in the area of research on siblings’ camp experiences, a relatively large sample size for camp research, and the administration of measures to the participants in their homes before and after camp. Our findings provide very promising support for the effectiveness of Camp Okizu in increasing sibling well-being, self-esteem, and quality of life. Future research should be conducted in a randomized control trial. Additionally, a longitudinal follow-up of siblings might show whether a long-term reduction in psychosocial functioning occurs.

Implications for Practice

Siblings of pediatric patients have been identified as the most emotionally neglected member of families during serious childhood illnesses (Spinetta et al., 1981). Summer camp appears to be a promising intervention for these siblings. Our overall results support Camp Okizu’s effectiveness in increasing sibling well-being, self-esteem, and quality of life for both bereaved and nonbereaved siblings. However, there is clearly a subgroup of participants (nonbereaved and bereaved) that may be a particularly at-risk group. Siblings would benefit from opportunities to meet with health care providers to discuss their feelings about living with a brother or sister with cancer and to talk about their reactions to and fears of death. It is especially important to develop programs for both nonbereaved and bereaved families (including family therapy) that address family relationships, frank expression of feelings, and open communication. In Appendix C we list specific art therapy recommendations that could be incorporated into the Camp Okizu program.

Our research found that siblings’ drawings often portray emotional distress and a need for family support. To gain a richer view of the lives of siblings and their families, we recommend the use of both quantitative and qualitative methodologies such as projective drawings. Art therapy techniques can be powerful tools to facilitate the child’s expression of complex, traumatic experiences such as living with a brother or sister with cancer (Case & Dalley, 1994; Council, 1993; Long, 2004). For example, the Pain Management/Complementary Medicine Clinic (Children’s Hospital, Oakland) has worked with such children and their families using a multidisciplinary approach to assessment and treatment. The HFD and KFD-R were used to assist in determining the level of distress felt by all family members. Art therapy was then used as a treatment modality to help reduce pain, stress, and depression. This model has been presented at national and international conferences (Long, 1995; Long, 2001; Long & Sedberry, 1994), and programs like this exist at other medical centers.

Enhancing and healing communication among family members involve creating a safe and trusting environment. Art therapists provide this environment and create nonthreatening art experiences for clients affected by life and death situations. Exercises like the Gestalt Family Collage, Mandala drawings, Family Roles drawings, Family Sculpture, and Sculpt-a-Helper figure reveal family dynamics, personal perceptions of roles and responsibilities, and personal perceptions of feelings and alliances within each family. Once these feelings and ideas are shared, each member of the family, especially siblings, can continue to express fears, worries, and concerns, and a door opens for help in handling feelings particular to the family’s cancer coping style during diagnosis, treatment, and recovery.

Siblings need individual, peer group (eg, Camp Okizu), and family therapy opportunities to share their feelings and perceptions about such questions as “What causes cancer?” “Did my family or I cause my brother or sister’s cancer?” “Why am I left to do all
the work at home while my mom or dad is at the hospital with my brother or sister?” “Why am I sad all the time?” These are the type of statements and questions that can be addressed by making art—getting the feelings out while creating expressions addressing concerns and possible solutions.

As we learn more about the traumatic effects of pediatric cancer on siblings and family members, we note that a multimethod assessment and treatment approach that takes into account the overall presentation of the child’s and family members’ psychosocial functioning in projective drawings has important clinical utility. Health care providers need to be able to support these families and be aware of the families’ special needs. It is important to offer them resources such as Camp Okizu and interventions such as art therapy. Art therapy can contribute to the better psychosocial adjustment of all family members coping with the stress of life-threatening illness. In the aftermath of a sibling’s death, art therapy interventions would be especially useful to help siblings and parents work through their grief.

Appendix A: Human Figure Drawing Emotional Indicators (EI)

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Appendix B:
Kinetic Family Drawing—Revised (KFD-R) Scoring System

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<td>Self-image: A, B, C, E, M</td>
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<td>Overall Family Support/KFD-R Total</td>
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</table>

Source: Spinetta, McLaren, Fox, & Sparta, 1981. Adapted with permission of the authors.
Appendix C: Art Exercises for Siblings That Can Be Facilitated by Camp Counselors and Health Care Providers

   Materials: 9 x 11 inch white drawing paper; colored markers, pastels, and crayons

   Drawing directions:
   A. Draw yourself playing with your sick brother or sister. To do this, divide the paper into 3 spaces; draw each theme; discuss what you drew.
   1. Before he or she became ill
   2. Now (during illness)
   3a. [For bereaved] The last time you remember playing before he or she passed away
   3b. [For nonbereaved] How do you want to play in the future?

   B. Now, draw a picture of the reasons you think someone develops cancer (eg, why they get sick). You can also use words in your drawing.
   Discussion: Does your drawing include anything you did to your brother or sister? If it does, this is a misconception—no one can cause someone to fall ill with cancer. No one knows the reason for this illness but we do know that brothers and sisters question why and how someone falls ill. We all feel guilty that we did not treat the ill person perfectly and kindly all the time. This is human.

   C. Now, draw a picture of some way you treated your brother or sister unkindly—it’s OK—we have all done this. On the other side of this drawing, draw how you would change the way you behaved in that situation now. Discuss the drawings. (For example, we all wish we had been more “perfectly” behaved after someone gets a serious illness. We also need to learn that our sometimes unkind behavior does not cause anyone to fall ill with cancer.)

   D. Using colored clay, sculpt a small figure to represent your positive feelings about your brother or sister. Now sculpt a small figure to represent any current wish you may hold in your mind. Tell the story of each sculpture if you wish.

2. Drawing exercise: Added responsibilities in home—for use in family session afterward:
   Draw a picture of any added responsibilities you’ve been asked to take on around your house (eg, chores) since your brother or sister became ill. Now, write or draw what you would like to show or tell your parents about this added work. Include how you really feel about this added responsibility. (Share these with parents when appropriate.)

3. Drawing exercise: draw your world and supports.
   Materials: sets of colored markers, pastels and crayons; two 18 x 24 inch white drawing papers with a large circle predrawn in the center of each.
   A. First circle: draw your world inside the circle. Include anything you think and feel is important (good or bad) to you and your family.
   B. Second circle:
   1. Draw everything that you feel supports you in your world inside the circle, for example, people (family, friends, teachers), activities, time with others or alone, pets, groups, camps—anything that helps you feel like yourself while coping with your brother’s or sister’s illness.
   2. Add any support you would like, but don’t experience now, outside the circle (on the sides and corners).
   3. Discuss your circle drawing. This exercise is to be followed with sharing the drawing with the family.

Art Exercises for Parents

Drawing exercise 1:
   Draw, in whatever style is comfortable for you, how you feel about your child’s illness. Now, draw how this feeling affects your other children. Think about how the whole family shares the grief of the illness, and make a list of how your life has changed since the diagnosis. Now, make a list of how your other children’s lives have changed.

Drawing exercise 2:
   Think of the stressors present from exercise 1 inherent for you and your children after a cancer diagnosis. Draw a picture of a stress-reducing activity
   a. For yourself
   b. For your spouse
   c. For your other children
   d. For all of you

Try to think about and do some stress reduction everyday. Plan and put in place a stress-reducing activity for your non-ill children. Encourage your spouse to also try a stress-reduction activity each day.

Drawing exercise 3:
   Using Crayola Model Magic Clay (all colors), sculpt a small figure (representational or abstract) to represent you and every other member of your family (between 1 1/2 and 3 inches high). Now place all the figures on your 8-inch paper plate. Ask yourself these questions and enact any conversations that might follow:
   a. Who is the “boss,” or who are the “bosses” in the family?
   b. Who is (are) the peacemaker (peacemakers)?
c. What other roles do people have in your family (hard worker, clown, most well-behaved, trouble maker, intellectual, caretaker, athlete)?

d. If one person would lead the others, who would follow? Who might resist?

e. Enact dialogues between the people represented by the clay figures.

f. What might be a conversation between the cancer diagnosis and treatment?


g. What would the people say to each other now about the cancer experience?

h. What is left unsaid?

i. How does each person show his or her grief and pain?

j. If a child has died, and you have represented this child via a clay figure, what do you think this child might think and feel about the current situation in your family?


Now

k. Make another figure of this deceased child at peace.

Now

l. Make a drawing of how you would like your family members to relate to one another.

References


