The use of drawing for psychological assessment in Britain: Survey findings

Nawal S. Bekhit*1, Glyn V. Thomas2 and Richard P. Jolley3

1Faculty of Education, Department of Psychology, Menoufia University, Egypt
2School of Psychology, University of Birmingham, UK
3Department of Psychology, Staffordshire University, UK

The current study reports previously unpublished data on drawing as an assessment tool obtained from a survey of broader assessment practices of British clinical psychologists (Bekhit, Thomas, Lalonde, & Jolley, 2002). A questionnaire was completed by 158 clinical psychologists practising in Britain concerning their use of, and views about psychological assessment and the use of drawings in such assessment. The results were compared with those of a similar survey conducted in the United States by Lubin, Larsen, Matarazzo, and Seever (1985) and Watkins, Campbell, Nieberding, and Hallmark (1995). Drawing tests are used extensively by North American clinical psychologists despite controversy over their reliability and validity. In contrast, the current survey’s results indicate that British clinical psychologists hardly ever use formal drawing tests, but approximately half of them reported using drawings as an informal assessment aid. The frequent but informal use of drawing as an aid to assessment by British psychologists is consistent with their overwhelming preference for clinical interviewing as opposed to formal testing in the psychological evaluation of their clients. The more widespread use of drawing tests by American clinicians is consistent with their greater willingness than their British counterparts to include projective testing in their assessments.

The potential uses of drawings in clinical practice, particularly with children, are immediately persuasive. Unlike other assessment procedures, such as psychometric tests, drawing requires little or no training for the client or for the psychologist to administer. For many children, drawing represents a natural activity that is spontaneously and frequently participated in, usually with much enjoyment. When

* Correspondence should be addressed to Nawal Bekhit, Faculty of Education, Department of Psychology, Menoufia University, Egypt (e-mail: nawalsbekhit@yahoo.com).

DOI:10.1348/147608305X26044
applied in the clinical setting, therefore, it is likely to reduce the child’s anxiety about the situation and the nature of the investigation. Its potential use is particularly highlighted for children with developmental disabilities in which learning or language difficulties may prevent other forms of activities. Furthermore, the drawing literature is littered with formal drawing tests that claim to assess children’s intellectual ability, personality, current emotional state, or their feelings towards the important people in their life. Although research evidence has seriously questioned the reliability and validity of most of these tests, recent surveys conducted in America suggest that drawings are still frequently used as projective assessments (Camara, Nathan, & Puente, 2000; Cashel, 2002; Watkins et al., 1995). The present paper reports a similar survey conducted amongst British clinical psychologists to examine whether a similar disparity exists between research and practice in the use of drawing tests in this country.

Psychological testing represents an important activity for many practising clinicians (see, Chan & Lee, 1995; Watkins et al., 1995). However, recent surveys in North America (Watkins et al., 1995) and in Britain (Bekhit et al., 2002) indicate widely differing approaches to assessment, with British clinical psychologists using psychometric and projective tests relatively infrequently. The comparison is most stark for projective measures. For instance, while it is clear from surveys conducted in the last 10 years that drawing tests as projective techniques are widely used by North American clinical psychologists (Camara et al., 2000; Cashel, 2002; Watkins et al., 1995), the majority of British clinical psychologists only spent 1% of assessment time on projective procedures in general (Bekhit et al., 2002).

It is worth noting, however, that drawing tests include both projective techniques and objective measures, and their development has often swung between the two. Initially, the study of children’s drawings took a direction closely linked theoretically to the psychometric study of intelligence. Drawing was incorporated into general IQ tests, most notably by Burt (1921), and the first dedicated IQ test was the Goodenough Draw-a-Man Test (Goodenough, 1926) in which children’s drawings of a man were scored against objective criteria to generate an intelligence quotient. As Harris (1963) discusses, practitioners then began to consider children’s human figure drawings as projections of the child’s self-image. Machover’s (1949) Draw-a-Person Test, for example, attempts to assess the personality of the child from their drawings of two human figures on the assumption that children project their self-image when drawing the human figure. Asking children to directly draw themselves was later included in Harris’ adaptation of Goodenough’s work (the Goodenough–Harris Test) as a measure of intellectual maturity. The original Goodenough Draw-a-Man Test has also been used as a qualitative aid to diagnose specific disorders, to supply evidence of severe intellectual and conceptual retardation of young children, and to study children with hearing handicaps and suspected neurological deficiencies (Harris, 1963). Also, it can provide a very general idea of the level of emotional adjustment of children (Anastasi & Urbina, 1997). Thus, the development of drawing tests has shown close interactive links between the objective and projective assessment traditions.
It is perhaps in the projective tradition that most drawing tests have been conceived. Several attempts have been made to use drawings as symbolic projections of the unconscious, leading to a diagnosis of the child’s maladjusted personality (e.g. see Machover, 1949). In the Machover Draw-a-Person Test the client is asked to draw a person and then a person of the opposite gender. A description of the child’s character is formulated through subjective interpretations of a variety of facets of the drawings. These facets include the sequence of gender (i.e. male or female drawn first), differences between the two figures, size, movement, distortions, and omissions. In addition, particular attention is given to the body parts and clothing, as well as the formal properties of the drawings such as pressure and direction of the pencil strokes. During the drawing the clinician notes the child’s comments and upon completion of the drawing a series of questions is given to elicit specific information about the person they have portrayed. The child may also be asked to make up a story about that person. A personality description of the child is then generated on the basis of the clinician’s projective interpretation of aspects of the drawings and what the child reports.

As is common with projective techniques, there are problems with the reliability and validity of personality assessments derived from children’s drawings. Machover (1949) and others (e.g. see Hammer, 1958) gave little attention to whether a similar personality description was derived over a number of drawings made by a child over a short period. In addition, Anastasi (1976) noted that different clinicians did not agree on the interpretations of certain characteristics in the drawings. Similarly, validation studies have failed to support the diagnostic interpretations of the Machover Draw-a-Person Test (Anastasi & Urbina, 1997).

Other projective drawings tests have attempted to examine wider issues beyond how the child sees himself or herself. The Kinetic Family Drawing (KFD) is usually administered to children (Burns & Kaufman, 1970) and is considered to project the child’s feelings about their role in the family unit. A child is asked to draw a picture of everyone in his or her family, including him/herself, doing something. The distance and the interaction between the figures in the drawing are thought to be among the most psychologically meaningful features of the drawings. Malchiodi (1998) notes that the body of research produced on children’s drawings of their family, including the KFD, is minimal with poor replication shown in larger samples. A further projective drawing test which makes wider interpretations than merely the child and family is the House-Tree-Person Test (Buck, 1948). The child is asked to complete separate drawings of a house, a person and a tree. In particular, the house and tree drawings are considered to be projections of issues relating to the child’s feelings of the home and environment respectively. Again the criticism of both tests is similar to that of the Machover Draw-a-Person Test – the lack of an objective scoring system (e.g. see Hampson & Kline, 1977; Harris, 1963; Kline, 1986).

One test that does provide an objective scoring system is the Koppitz Test (Koppitz, 1968) which assesses a child’s current emotional state from a single human figure drawing. The drawing is measured for the presence or absence of 30 emotional...
indicators of emotional disturbance. Each emotional indicator was included having met the following criteria: (1) occurred more often in the human figure drawings of disturbed children than in those of normal children, (2) were unusual in the human figure drawings of normal children, and (3) were not solely related to age or maturation. In a recent and important test of Koppitz’s theory, Catte and Cox (1999) found that emotionally disturbed children did draw significantly more indicators than control groups, but that the number of indicators was low. Furthermore, Cox and Catte (2000) showed that when the emotional group was matched on drawing ability to a new control group, the difference disappeared.

The usefulness of these projective drawing tests is not only questioned on their lack of objective scoring methods, but also on their reliance on the body-image assumption (see Thomas & Jolley, 1998), that is, when the child draws an unidentified human figure they project themselves. Neither criticism can easily be levelled at the Goodenough–Harris (Harris, 1963) Test of Intellectual Maturity. Harris took into account sex differences in children’s human figure drawings, such as girls tending to include more detail, and created separate tables for boys and girls. Separate norms were also provided for male and female drawings. Evidence of its reliability and validity is more promising than the projective tests, having been investigated several times and found to be adequate and high (e.g. Anastasi & Urbina, 1997; Harris, 1963). For instance, some recent studies found that the scores on the Goodenough–Harris Test correlated significantly with the WISC-R as well as the Stanford-Binet scale (Abell, Von Briesen, & Watz, 1996; Bensur & Eliot, 1993). Nevertheless, it is questionable whether the correlations are high enough to be regarded as safe measures of intelligence (see Light & Barnes, 1995). A further problem is that as children beyond 10 years of age tend not to include further details in their drawings, the test cannot predict IQ beyond this age. Also, intelligent children may not draw well, and conversely, some children who are artistically gifted may have a low IQ score.

Despite the problems associated with the aforementioned drawings tests, clinicians may still frequently ask children to draw under more informal conditions. In addition to drawing acting as an ‘ice-breaker’, drawings may facilitate the discussion of their thoughts and feelings, particularly for children who have moderate learning difficulties (Lewis, 1995). This can be especially useful where the child provides information about a traumatic event experienced. Indeed, several studies have mentioned the extensive use of drawings to assess maltreatment and neglect of children and to help them to recall important events (e.g. Veltman & Browne, 2002), as well as a tool for assessing and accessing traumatic memories (Burgess & Hartman, 1993). Indeed, drawings have been found to cue more accurate recall of an event compared with a standard interview in which drawings are not made (Butler, Gross, & Hayne, 1995).

In conclusion, the research evidence does not support the extensive use of formalized drawing tests, particularly those using projective techniques, currently adopted by North American clinical psychologists. We are not aware of any systematic surveys in Britain of the extent of psychologists’ use of drawings. The current research
had two broad purposes. The first was to report data on the use of formal and informal drawing in clinical assessment in Britain. Supplementary to this was to report which drawing tests, if any, that clinical psychologists suggest that students should learn about. The second purpose was to compare the use of drawing tests as tools of psychological assessment by British and North American clinical psychologists.

Method

Participants

The data used in the present study was based on a previous survey conducted by Bekhit et al. (2002) to explore the use of psychological assessment in clinical practice in Britain. Questionnaires were posted to 270 clinical psychologists, who were honorary tutors for the clinical psychology training course at the University of Birmingham, of which 162 (60%) replied. Four replies could not be used in the study giving a usable return rate of 58.5%. Participants were classified in four groups according to their principal area of clinical work: 16 (10.1%) older adult, 91 (57.6%) adult mental health, 33 (20.9%) child, and 18 (11.4%) learning disability.

The course records of the clinical tutors were reviewed for differences between the respondents and non-respondents in terms of specialty area and geographical location; we found there were no significant differences between them. Consequently the results obtained may be taken as representative of the population of clinical psychologists serving in the Birmingham clinical psychology course. The course is a large one and draws on the services of the majority of clinical psychologists working for the National Health Service in the West Midlands region. As clinical psychology training courses are accredited by the British Psychological Society according to standard guidelines, there are no reasons to suggest that clinical psychologists in the West Midlands differ in any systematic way from psychologists in the rest of the UK. Further details regarding the workplace and qualifications distribution of the respondents, and their years of service, can be obtained from Bekhit et al. (2002).

Instrument

The questionnaire and procedure developed by Watkins et al. (1995) were followed to aid comparison with North American practice. The questions were amended to remove obvious American references. In a preliminary pilot study, Watkins et al.’s list of tests, which included projective drawings, was sent to four clinical psychologists to be reviewed. They were asked to indicate which of the tests/ measures were very unlikely to be used in Britain, and to add the names of any tests likely to be used by British clinical psychologists but not included in the list. Watkins et al.’s questionnaire had been amended to include individual drawing tests rather than general ‘projective drawings’ as stated in their survey. We included the five most widely used formal drawing tests: House–Tree–Person Test (H–TP), Kinetic Family Drawing (KFD) Test, Machover
Draw-a-Person-Test (D-A-P), Koppitz drawing Test, and Goodenough–Harris Drawing Test (Draw-a-Man Test). In addition, we included free drawing as an informal assessment aid to check its use among the British clinical psychologists. The drawings tests and free drawings were represented among 44 assessment procedures in the final survey. Participants had to indicate for each procedure how often they used it.

Furthermore, the original questionnaire contained questions relating to six main areas, (a) professional information about the respondents; (b) the percentage of their working hours devoted to clinical work and individual assessment, including the percentage of their time spent on four types of assessment (objective, projective, clinical interviews and direct observation); (c) the importance of various factors in their decisions to use psychological tests; (d) their views on why clinical psychology trainees should learn about assessment; (e) the objective assessment procedures and projective techniques in which they believed clinical psychology trainees should be competent; (f) their own usage of particular tests and assessment procedures.

This study will focus mainly on the use of drawing tests in assessment in Britain compared with that of North American clinical psychologists as reported by both Lubin et al. (1985) and Watkins et al. (1995). Further details of the other areas of assessment in Britain are available in Bekhit et al. (2002).

**Results**

Respondents were asked to state how often (never, occasionally, moderately, frequently, always) they used each of the drawing assessment procedures listed in the survey. Table 1 presents the percentage responses for each of the formal drawing procedures by client

<table>
<thead>
<tr>
<th>Drawing Test</th>
<th>Never (%)</th>
<th>Occasionally (%)</th>
<th>Moderately (%)</th>
<th>Frequently (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>C</td>
<td>LD</td>
<td>A</td>
</tr>
<tr>
<td>H-T-P Test</td>
<td>97.8</td>
<td>72.7</td>
<td>88.8</td>
<td>2.2</td>
</tr>
<tr>
<td>KFD Test</td>
<td>100</td>
<td>90.9</td>
<td>94.4</td>
<td>0</td>
</tr>
<tr>
<td>D-a-P Test</td>
<td>100</td>
<td>78.8</td>
<td>94.4</td>
<td>0</td>
</tr>
<tr>
<td>Koppitz Test</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>D-a-M Test</td>
<td>97.8</td>
<td>54.5</td>
<td>83.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Mean (%)</td>
<td>99</td>
<td>79</td>
<td>92</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. A = Adult; C = Child; LD = Learning disability; H-T-P = House–Tree–Person Test; K-F-D = Kinetic Family Drawing Test; D-a-P = Machover Draw-a-Person-Test; D-a-M = Goodenough-Harris Draw-a-Man Test. 'Always' percentages were all zero for all client groups. Older adult excluded as 100% never used any of the formal drawing tests.
group and frequency of use. Table 2 presents the percentage responses for the use of free
drawing by client group and frequency of use.

Table 2. Percentage of British clinical psychologists use of Free Drawing by frequency and speciality
area (mean percentages of Formal Drawing Test usage from Table 1 in brackets)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>OA (%)</th>
<th>A (%)</th>
<th>C (%)</th>
<th>LD (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>50.0 (100)</td>
<td>74.7 (99)</td>
<td>18.2 (79)</td>
<td>55.6 (92)</td>
</tr>
<tr>
<td>Occasionally</td>
<td>6.3 (0)</td>
<td>12.1 (1)</td>
<td>18.2 (15)</td>
<td>22.2 (8)</td>
</tr>
<tr>
<td>Moderately</td>
<td>18.8 (0)</td>
<td>7.7 (0)</td>
<td>15.2 (5)</td>
<td>5.6 (0)</td>
</tr>
<tr>
<td>Frequently</td>
<td>18.8 (0)</td>
<td>4.4 (0)</td>
<td>36.4 (1)</td>
<td>11.1 (0)</td>
</tr>
<tr>
<td>Always</td>
<td>6.3 (0)</td>
<td>1.1 (0)</td>
<td>12.1 (0)</td>
<td>5.6 (0)</td>
</tr>
</tbody>
</table>

Note. OA = Older Adult; A = Adult; C = Child; LD = Learning disability.

The survey revealed that the formal drawings tests were used infrequently by most
client groups. Unsurprisingly, they were used most often by those working with
children, but even within this client group most respondents never used them. In
respect of differences between the formal tests, the Goodenough–Harris test was used
most often, followed by the House-Tree-Person test. Both the KFD and the D-a-P were
rarely used, and the Koppitz Test not at all. In contrast, drawings as an informal
assessment aid (see Table 2) was used to some extent by all client groups, with over 48%
of those working with children using it frequently or always.

Table 3 presents the percentage and rank of total mentions of tests used by clinical
psychologists working with different groups in Britain. All the formal drawings tests for
all client groups featured well outside the top 10 ranked procedures. Nevertheless,
drawing as an informal assessment aid featured in the top 10 of tests for all client groups

Table 3. Percentage and rank of total mention of Drawing Tests used by British clinical psychologists by
Client Group

<table>
<thead>
<tr>
<th>Instrument</th>
<th>All</th>
<th>A</th>
<th>OA</th>
<th>LD</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Interviews</td>
<td>90.0</td>
<td>88.9</td>
<td>96.8</td>
<td>94.4</td>
<td>93.9</td>
</tr>
<tr>
<td>Drawing (as informal assessment aid)</td>
<td>42.4</td>
<td>9</td>
<td>25.3</td>
<td>50.0</td>
<td>44.4</td>
</tr>
<tr>
<td>Goodenough–Harris Draw-a-Man Test</td>
<td>12.7</td>
<td>27</td>
<td>25.3</td>
<td>16.7</td>
<td>18.5</td>
</tr>
<tr>
<td>House-Tree-Person Test</td>
<td>8.2</td>
<td>31.5</td>
<td>22.5</td>
<td>11.1</td>
<td>22.5</td>
</tr>
<tr>
<td>Machover Draw-a-Person-Test</td>
<td>5.1</td>
<td>37</td>
<td>0</td>
<td>5.6</td>
<td>30</td>
</tr>
<tr>
<td>Kinetic Family Drawing Test</td>
<td>2.5</td>
<td>39.5</td>
<td>0</td>
<td>5.6</td>
<td>30</td>
</tr>
</tbody>
</table>

Note. r = rank; All = All Participants; A = Adult; OA = Older Adult; LD = Learning Disability; C = Child.
except those working with adults. The popularity of informal drawings with the child client group is seen by it being the forth most popular assessment procedure.

Table 4 compares the pattern of use of drawing tests to those of a similar survey conducted in the United States by both Lubin et al. (1985) and Watkins et al. (1995). Comparing the total number of mentions and rank for each test between countries shows clearly that while formal drawing tests usually ranked among the top 10 instruments by American clinical psychologists, they were in the tail of the list of the frequency of use in Britain. It appears that psychologists in America use drawings as projective techniques while their British counterparts use drawings more informally.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>r</td>
<td>%</td>
</tr>
<tr>
<td>Drawing (as informal assessment aid)</td>
<td>42.4</td>
<td>9 a</td>
<td>a</td>
</tr>
<tr>
<td>Projective Drawing</td>
<td>a</td>
<td>–</td>
<td>80</td>
</tr>
<tr>
<td>Goodenough–Harris Draw-a-Man Test</td>
<td>12.7</td>
<td>27 a</td>
<td>a</td>
</tr>
<tr>
<td>House-Tree-Person Test</td>
<td>8.2</td>
<td>31.5 a</td>
<td>a</td>
</tr>
<tr>
<td>Machover Draw-a-Person Test</td>
<td>5.1</td>
<td>37 a</td>
<td>a</td>
</tr>
<tr>
<td>Kinetic Family Drawing Test</td>
<td>2.5</td>
<td>39.5 a</td>
<td>a</td>
</tr>
</tbody>
</table>

a = Tests were not mentioned in survey.

British respondents were asked to list the objective assessment procedures and projective techniques in which they believed clinical psychology trainees should be competent. The number of psychologists recommending drawings was very low: informal drawing (N = 6; 3.8%), HTP (4; 2.5%), Goodenough–Harris Draw-a-Man Test (2; 1.3%) and the KFD (2; 1.3%). In contrast, 96% of American clinical psychologists stated that trainees should be competent in projective drawings (Watkins et al., 1995).

Discussion

Our results show that formal drawing tests are used infrequently by British clinical psychologists. The HTP, the KFD and the D-a-P are only at best used occasionally by those working with children and learning difficulty client groups, and not at all with adults. The Koppitz Test was not used by any of the respondents. The Goodenough–Harris Draw-a-Man Test was the most popular test, but even here the test was used by only 15% of respondents (all of which worked with children) at a moderate level or above. Furthermore, drawings tests were hardly recommended at all as important for clinical psychology trainees to be competent at. In contrast, drawings as an informal
assessment aid were used across all client groups and with a reasonable level of frequency.

The limited use of the formal drawing tests by British clinical psychologists is consistent with their relative infrequent use of either projective techniques or psychometric tests in their assessment. As reported in the full survey, Bekhit et al. (2002) found that on average 20% and 1% of respondent’s assessment time was spent on objective/psychometric tests and projective techniques, respectively, compared with 69% on clinical interviews. Furthermore, the wider use of the objective scoring method of the Goodenough–Harris Draw-a-Man test compared with the very infrequent use of the projective drawing tests is reflected in the difference in time spent on objective and projective assessments.

There are marked differences in the pattern of use of drawing tests by the British clinical psychologists in the present survey compared with those used by American clinical psychologists. Of the American clinical psychologists surveyed by Watkins et al. (1995), 80% used projective drawing tests, and 56% to at least a moderate degree of frequency, making these tests the eighth most popular used in his sample. This was consistent with Lubin et al.’s (1985) earlier survey reporting that both the H-T-P and the D-a-P were ranked in the top 10 tests used in America. Other American surveys have also shown that during the last 15 years drawing tests such as the H-T-P and those based on human figure drawing as projective drawings have consistently ranked among the top 10 instruments used (e.g. Archer, Maruish, Imhof, & Piotrowski, 1991; Camara et al., 2000; Cashel, 2002; Piotrowski & Keller, 1989, 1992).

There are a number of possible factors to account for the low usage of drawing tests in Britain compared with America. The little time given to projective techniques in general shown in the full survey (see Bekhit et al., 2002) suggests that British clinical psychologists do not trust such techniques. Their lack of use in Britain is therefore consistent with the lack of research evidence for their reliability and validity (see Anastasi & Urbina, 1997), and psychologists may believe that this kind of technique is a part of a folk psychology (Thomas & Jolley, 1998). One would assume that projective drawing tests would be judged in the same way. In contrast, it seems that many American clinical psychologists have resisted the reliability and validity problems of projective techniques argued by academics (see Piotrowski, 1999; Watkins et al., 1995), instead believing such tests benefit an understanding of the client’s clinical profile and in treatment planning (see Cashel, 2002). Of course, they may have a misleading subjective impression of the usefulness of projective measures (see Thomas & Jolley, 1998), but the aforementioned resistance is most likely to come from those who practice psychodynamic approaches. According to the Watkins et al. survey, 21% of the American clinical psychologists surveyed reported using a psychodynamic model as their primary therapeutic orientation (which was second only to the eclectic approach). Projective techniques such as found in the formal drawing tests fit in well with this psychodynamic approach, but not in the cognitive-behavioural and systemic models most commonly found in British clinical practice.
One should not neglect the more practically-based explanation regarding the training clinical trainees receive on assessment. Cashel (2002) comments that most American Psychological Association-approved internship programmes continue to teach projective measures to American trainee psychologists. In respect of drawings tests, Watkins et al. (1995) found that most American clinical psychologists recommended clinical psychology trainees should be competent in such tests, whereas they were hardly mentioned by British clinical psychologists in this respect in our survey. Hence, American clinical psychologist may use projective drawing tests because they know about them and how to use them, whereas British clinical psychologists’ infrequent use of them may be due to a lack of familiarity or awareness of such tests (Hall, 1979; Velzen, Luteijn, Scholing, Van Hout, & EmmelKamp, 1999).

A further explanation for the difference in the use of formal drawing tests may relate to the different biases towards public and private health care in the two countries. As Bekhit et al. (2002) note, health care in America is dominated more by the private sector, and in Britain the public sector. Consequently, there is more onus on American psychologists to provide assessments in order to be reimbursed by health management organizations and medical insurance companies. British clinical psychologists do not have such privilege (or burden). A recent survey by Piotrowski, however, suggests that American health management organizations have begun to restrict the range and frequency of assessment tests in American clinical practice by not authorizing assessments and reducing the reimbursements for those tests that have been used (Piotrowski, 1999; Piotrowski, Belter, & Keller, 1998). These financial constraints, Piotrowski argues, are leading clinical psychologists to use measures that are shorter and quicker to administer. To date there is no evidence that drawings tests are included in those that have begun to suffer in their frequency of use due to reimbursement issues. It may be that the comparative speed of administering, scoring and interpreting drawing tests (relative to, for example, the Minnesota Multiphasic Personality Inventory, see Camara et al., 2000), will leave such tests relatively unaffected. More generally, assessment practices are likely to remain unaffected in American public health care where health care management policies are not an issue (Piotrowski, 1999). A related issue is the greater need for assessment to satisfy health-care related litigation such as preparing reports and testimony in courts in the US.

In contrast, British clinical psychologists’ concern in their assessment is more likely to be related to their patient categorization and outcome evaluation (Bekhit et al., 2002). The outcomes include the duration of treatment, the amount of staff effort absorbed, and the contribution (or cost) of the patient to the community after release. All of these may affect their clinical decisions for using tests (Cronbach & Gleser, 1965).

Despite the difference in the use of drawing tests, both British clinical psychologists and American clinical psychologists recognized the usefulness of drawing activities. For British clinical psychologists the preference seemed to be to employ them as an informal aid to assessment, especially with children. The survey does not tell us for what purpose or activity drawing was used. One possibility is that as free drawings are an intermediate...
activity between play and story telling (Semeonoff’s New developments in projective testing; as cited in Kline, 1973) they could be used by British clinical psychologists as a rapport-building device to facilitate the interpersonal engagement with a child and to gain his/her cooperation for more subsequent complex tasks (Joiner, Schmidt, & Barnett, 1996) and/or as a focused activity to enable the child to talk more comfortably about him/her self (Gross & Hayne, 1998; Thomas & Jolley, 1998). There may even be instances where the psychologist uses the drawing to facilitate their diagnosis of the child. The empirical evidence for doing so is even less than for the use of formal drawing testing, and would no doubt be purely based on the psychologists own subjective interpretations. Indeed, Gross and Hayne commented that psychologists may choose drawings in their interviews with their clients based on their own clinical practice and not on objective empirical research.

A future survey is required to ascertain more precisely how drawings are used informally by British clinical psychologists and the reasons behind why a large minority (or a majority in the case of those working with children) use them in their clinical assessment. If informal drawings are being used to facilitate diagnosis we need to know what kinds of information in the drawings are being used for assessment. It is would also be interesting to investigate the future pattern of the use of drawings within British clinical practice. The handful of British psychologists recommending that trainees should learn the use of drawings (informal or otherwise) in assessment procedures suggests that even informal drawing procedures will decline in Britain. In contrast, Watkins et al. (1995) survey in America shows that drawings are likely to continue to feature strongly in the armour of tests used by psychologists working in that country. We may see, therefore, a widening disparity in the use of drawings by clinical psychologists working in Britain and America.

Acknowledgements

The authors wish to thank Dr Simon Lalonde for his advice in planning and conducting the research.

References


Received 23 December 2003; revised version received 29 June 2004