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A critical appraisal of the draw and write technique

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Abstract

The draw and write technique is increasingly popular in health education research with children. It is generally employed in the setting of the school classroom and is promoted as a 'bottom-up' approach which enhances participation by children. In this paper we critically appraise the use of this method. Against the background of a consideration of carrying out qualitative health promotion research with children we examine the origins and use of children's drawings in a number of disciplines and practice environments. We argue that, although the draw and write technique has made an important contribution to health education research, it fails to reflect the processes involved in the construction and collection of such data. A range of methodological, analytical and ethical issues are raised. We conclude that health education research with children must involve taking children seriously as social actors and query the assumption that drawing enables children to communicate their thought any more than does conversational language. We suggest that the development of research should be premised upon an appreciation of the social context and the world of the child.

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Introduction

The draw and write technique is a relatively recent addition to the repertoire of methods available in health education research. It is generally, although not exclusively, employed with children and was introduced to health education circles by the 1989 publication *A Way In: Five Key Areas of Health Education* (Williams *et al*., 1989). The technique has been described as an 'innovative' method and able to 'provide an empirical demonstration of the high quality and sophisticated nature of data which can be collected from young children' (Pridmore and Bendelow, 1995). It is also claimed to be 'a bottom-up approach' which 'has the potential to enable all children to participate and improve the quality and relevance of the curriculum' (Pridmore and Bendelow, 1995). Thus the draw and write technique appears to offer a number of opportunities to explore meanings of health and illness with a group which is socially distanced from, and yet necessarily close to, adult worlds (Shaw, 1996).

Given the increasing focus upon health promotion in schools (Parsons *et al*., 1996), the active involvement of children in health-promoting curricula and activities (Collins, 1995), and the exhortation to empower children by involving them more directly in the promotion of their own health (Kalnins *et al*., 1992), it is not surprising that a method which offers the potential to work with children is receiving much attention. After all, there is, as Shaw (Shaw, 1996) argues, no body of qualitative research findings with children to consider when attempting to develop evidence based health promotion practice (Nutbeam, 1996).

In this article we consider the origins of, and subsequent claims for, the draw and write technique. We have defined 'children' as those under 12; the age at which children in Scotland move from primary to secondary school. Our concern is to reflect on this technique as a research method rather than to critique its utility as a pedagogical tool. Thus, although our appraisal should help teachers and educationalists to reflect on practice and the limitations of the 'evidence' on which it may be based, our principal aim is to raise some questions about the increasing use of this technique in researching with children.

We begin with a brief background consideration of carrying out qualitative research with children in health promotion. Charting the origins of the use of children's drawings it is evident that this is derived from a number of disciplines and subject areas such as psychology, anthropology, geography and art therapy; and has been employed in a number of practice environments (e.g. participatory learning) and research tasks (e.g. conceptions of space and place in geographical research). Considering the application of the method in health education research we go on to argue that the combination of drawing with writing fails to reflect the complex development of drawing skills amongst children (Lange-Kultner, 1995), and potentially denies the social context and processes involved in the construction and collection of such data (Shaw, 1996). A range of methodological, analytical and ethical issues concerning the use of the draw and write technique in researching with children are then discussed, and we conclude by considering how reflective and appropriate health promotion research with children might be developed.

Qualitative research, health promotion and children

Mason (Mason, 1996) notes that whilst there is a rich variety of qualitative research strategies and techniques, it is possible to identify key characteristics of the approach, i.e.

- It is grounded in a philosophical position which is broadly 'interpretivisit' in the sense that it is concerned with how the social world is interpreted, understood, experienced or produced.
- Methods of data generation are flexible and sensitive to the social context in which data are produced.
- Methods of analysis and explanation building involve understandings of complexity, detail and context.

Through following these principles the qualitative research practitioner will be a questioning person (Mason, 1996):

> ... [they] will be asking 'why?', 'how?', 'what are the consequences?' and producing for themselves a constant echo of 'yes, but it's not as simple as that'.

This self-interrogation in qualitative research generally has been developed by researchers invariably considering research questions which involve work with adults. Apart from feminist literature on the relationship between the researcher and researched (Stanley and Wise, 1983), and until the publication of the Ottawa Charter (WHO, 1986), much health education research did not consider the potential for the active participation by lay people in the design and process of research projects. However, there has been relatively little space for hearing children's voices in the development of health education and promotion strategies, and research (Kalnins *et al*.. 1992).

In the last decade there has also been a notable growth in sociological, psychological and health education research with and for children (James and Prout, 1990; Thomas and Silk, 1990; Wetton, 1995; Scott *et al*., 1996). Despite this, Whitehead (Whitehead, 1997) and Nutbeam (Nutbeam, 1996) note the continuing mismatch between research and health promotion practice, with practice often based upon stereotypes which have grown up around different sections of the population. Furthermore, although the increasing call for evidence-based health promotion has impacted upon many areas of practice, in all these debates research with

children has rarely been considered, except as potentially problematic.

Consequently there is a tendency for unfounded assumptions about children and childhood to persist in health promotion policy and practice. One of these, which is increasingly challenged by research, is that childhood is somehow a homogeneous entity (Shaw, 1996). Moreover, Shaw argues that a 'deficit model' of research has evolved in some quarters. In this model children are perceived as having limited abilities, according to age and developmental stage, to comprehend language and articulate experiences. There are notable exceptions to this model [see, e.g. (Nelson, 1986), and her work on event knowledge and cognitive development]. However, for many researchers and practitioners qualitative research with children, especially younger children, can appear problematic. Will children be able to explore and explain their social context and social world? Such questions are based upon an assumption that a child's culture must be viewed according to how closely it approximates to the culture and world of adults (Jenks, 1992). Shaw (Shaw, 1996) concludes:

> We must accept children's world views as a legitimate, lived reality, and yet also accept the significance of the constant change and growing that occurs in childhood.

It is against this background of increasing attention to the need for reflective practice when researching with children that we now turn to a critical appraisal of the draw and write technique.

The origins and development of the draw and write technique

Origins

Drawing is often considered an enjoyable, participatory activity in which children of all ages can take part; and certainly the draw and write technique is partly premised upon these factors. However, in aspects of psychology and child development studies, drawings by children have been imbued with a range of meanings concerning their intellectual, emotional and mental development and well being. For example, the Goodenough–Harris 'draw-a-man' test was developed as an intelligence test with the outcome of the test based upon the appearance of the realism of the final drawing (Thomas and Silk, 1990). The classic personality assessment test developed by Machover (Machover, 1949) was also based upon the assessment of drawings of the human figure.

In the wider literatures about children's drawings the ways in which they have been analysed were influenced by epistemological understandings concerning what they were held to represent and by assumptions about what children would be able to articulate by other methods of communication. Classically, as Irene Levin (Levin, 1995) has pointed out, drawings have been viewed as 'coming from the world of the child' and as reflecting the inner emotional life. They have been used to project what is not overt. In this respect they were analysed to assist with understanding emotional issues, to gauge the child's stage of development or to provide pictorial indicators of the child's experiences, e.g. to investigate sexual abuse or views of divorce (Goodman and Bottoms, 1993). Drawings have also been used to assist communication between children and adults, particularly if it was felt that this involved conceptual or linguistic difficulties on the part of the child or that the issues were too difficult or challenging for the child to talk about. Essentially, therefore, drawings have been used as indicators, to reveal information that it was deemed too difficult for the child to talk about or to facilitate adult/child communication.

Participatory learning and action methodologies in health education have also used drawings and picture composition as a means of facilitating discussion and agenda setting on health issues with children and other age groups (Barnett *et al*., 1994; Meharg, 1994). Whilst it is argued that oral cultures depend upon visual codes and drawings for some exchange of information and communication (Fuglesang, 1982), issues of spatial awareness are increasingly considered in community profiling. In

geography children's drawings have been used to explore their 'ways of seeing' their environments (Matthews, 1995). Techniques of free recall mapping and sketching have produced findings which have been analysed quantitatively and qualitatively. The researchers concluded that, especially if based on 'real world experiences', young children *can* express place 'whereness' and spatial awareness in some detail through free-recall drawing. Moreover, they felt that verbal reporting was inhibiting for young children and that [(Matthews, 1985), p. 276]:

> ... by using inappropriate methods of assessment in the past the young child's capacity to structure environmental information has been severely underestimated.

However, Freeman's (Freeman, 1980) contention that intelligence tests based upon outcome deny the process of drawing, which can play a crucial role in determining the final product, would seem to have wider application to the use of children's drawings generally in research. Picture making requires both knowledge and skill. Some knowledge is required of the appearance and structure of the subjects or objects to be drawn. The skills necessary to draw are also specialized. It is a truism that several people observing the same object or considering the same topic will produce differing final products. But what does this tell us about the social world and context of the person producing the drawing? Without interpretation by the drawer how might the social meanings, processes or practices be identified or understood? Does a life-like drawing of an adult necessarily demonstrate emotional and mental maturity or particular personality traits? Thomas and Silk (Thomas and Silk, 1990) comment that:

> Even within mainstream developmental psychology, the notion that children's drawings could be taken as a faithful reflection of mental contents was surprisingly influential until relatively recently.

In addition, Thomas [(Thomas, 1995), p. 107] argues that there is:

> a naive tendency, to which we can all fall victim, to regard children's drawings as if they are direct translations of mental states and images onto paper ... drawing is not an easy skill to acquire ... young children generally become more skilful in their drawing as they grow older and more practised.

Several studies also confirm the conclusion that children's drawing is significantly influenced by the 'pictures' that are available in their environment (Thomas and Silk, 1990). This evidence reinforces the argument that drawings, copied from past pictures or discovered and developed by trial and error, are the essential basis for picture-making in both children and adults (Freeman, 1980). In summary, current debates in psychology express concern with the process and interpretations of children's drawings as the vehicles for establishing meanings and views, especially as what children draw is influenced by the 'pictures' they see in their environment. So, applying these critiques to the arena of health, it is likely that children will reproduce images of the dominant discourses of health and health education associated with the culture of which they are members.

Implementation

The draw and write technique itself has been used in a variety of settings and as a stand-alone task or as part of a wider set of research methods. For example, it has been used in an extensive school-based studies as a classroom task administered by the teacher or be researchers (Bendelow and Oakley, 1993; Wetton and McWhirter, 1995); as part of a wider interview schedule with follow-up group interviews and discussions administered by the researchers themselves (Hendry, 1995); as part of an art competition about health (Meharg, 1994); as a discussion starter about a sensitive topic (Barnett *et al*., 1994; Young, 1994); and with siblings in the home setting administered by carefully briefed parents and subsequently used by the researcher essentially as an ice-breaker ('tell me about your picture') to open a semi-structured qualitative interview (Backett and Alexander, 1991).

There has also been considerable variation in the subject matter addressed, types of cognitions being investigated and ages of children involved. For example, the technique has been used to tap generalized beliefs about what makes you healthy, keeps you healthy or causes illness, specific beliefs about particular illnesses and their aetiology (such as cancer), and knowledge about specific health-relevant behaviour (such as food choices, and fruit and vegetable consumption).

The draw and write technique was, however, developed in the first instance for use in schools and continues to be widely implemented in that setting. Its popularity paralleled the development of the health-promoting school (Parsons *et al*., 1996) which itself was part of the expansion of health promotion generally and of healthy public policy. With these developments health promotion has shifted it's practice base largely from topics to settings and a key environment for health promotion work—the school—has been identified. However, the setting of the school, and educational cultures, are only a partial representation of children's lives.

The introduction of the national curriculum, and in Scotland the 5–14 curriculum, heralded debates on the place and role of personal and social development as a cross-curriculum theme; a theme which could be developed through a range of subjects and related aspects of school life (National Curriculum Council, 1990). In its broadest sense personal and social development is concerned to prepare young people to take up the wide range of activities and roles in adult life (National Curriculum Council, 1990). Thus key elements of personal and social development are health and health education. The curriculum guidance notes place an emphasis upon the child's individual responsibility, awareness and decision making, and recognize that the provision of information is unlikely to provoke appropriate changes in health and related behaviours. As a result, Wetton and McWhirter (Wetton and McWhirter, 1995) contend that teaching methods are crucial and should seek the active involvement of the child. A popular example of the development of health education as a school activity employing inter-active teaching techniques is contained in the two booklets *Health for Life*, and the related guide for teachers, school nurses and other health professionals. Within each guide the draw and write method is proposed as a technique, used to 'tap children's changing perceptions of becoming and staying healthy' [(Wetton and McWhirter, 1995) p. 14].

It is evident, therefore, that children of all ages have been producing their drawings and statements on a range of topics, in quite different research settings (classroom, small group, home), with a range of different facilitators (teachers, researchers, parents) and with a variety of stimulus statements (what makes you healthy, what keeps you healthy, what keeps you yourself healthy?, etc.). In addition, some children knew that they were going to be asked to give more information or talk to someone about what they had produced, either on an individual basis, in a small group or as part of the wider class. Others knew that they were required only to complete the draw and write task. Pridmore and Lansdown (Pridmore and Lansdown, 1997) have explored the different findings that emerge from drawing, writing and labelling. In order that these techniques are properly evaluated it is now necessary to reflect on how different research contexts might affect what children produce as 'data' and to identify whether this is an accumulating body of knowledge or simply a series of totally different research exercises tapping quite different dimensions of children's views united only by the methodological technique itself.

Social and contextual influences on the construction of data

Researchers are paying increasing attention to the social contexts and processes involved in the construction of data. This entails understanding how the research subjects themselves define and make sense of the research task and how their modes of expression are influenced by the setting and means of data collection. In addition, other methodological issues such as access, rapport, ethics, and asymmetrical relationships

between researchers and research subjects may have a heightened significance when working with children (Hood *et al*., 1996; Ireland and Holloway, 1996). Therefore, when assessing the contribution of the draw and write technique, it is important not to let the fact that children *can* produce drawings and statements about health-relevant topics mask critical reflection on what these data actually mean and how this has been affected by all aspects of the research process.

The important theoretical point to be considered is that, although researchers have been keen to establish a *medium* through which, it is suggested, children can communicate their beliefs, perceptions and knowledge, the social and contextual influences on the data generated have not been viewed as problematical. The emphasis has been on methodological techniques and practical and ethical issues at the expense of epistemological and analytical concerns [see, e.g. (Pridmore and Lansdown, 1997)].

Thus, for health researchers and health promoters, the focus has been on the method itself despite the fact that research in psychology and anthropology (James and Prout, 1990) has emphasized that how children define and perceive the research task and what it means to them can have a considerable effect on the substantive material they then portray. For example, in her critique of the adequacy and meaningfulness to a child of Piagetian developmental and intelligence tests, Donaldson showed that the child's construal of the adult researcher's words and actions affected his/her response and performance in experimental conditions (Donaldson and Elliot, 1990).

In fact, the subtle ways in which these factors might influence the data produced by the draw and write technique have been remarked on by researchers working in schools in Botswana (Pridmore and Bendelow, 1995). In two of the schools children drew only foodstuffs in response to the question 'what makes you healthy?'. It was suggested that this might be because the facilitator had used a tone of voice and body language implying strength when explaining the chosen word for 'healthy'. It is interesting, however, that such issues of meaning were remarked upon in a research situation involving a foreign language and have seldom been viewed as problematical when the language has been shared. Donaldson (Donaldson, 1990) also showed that young children found it more difficult to carry out 'disembedded tasks', i.e. tasks which did not make social or empirical sense, or 'human sense' to use Donaldson's terms. We would suggest that having to consider the abstract concept of being or keeping healthy might in fact be somewhat challenging in this respect.

Other researchers have also pointed to the particular nature of classroom interaction in structuring children's explanations. Donaldson and Elliot [(Donaldson and Elliot, 1990), p. 47] point out that teachers ask questions not because they want to extend their own knowledge but usually to see if their pupils know the 'correct' answers. In this way:

> The pupils perceive their task as being to figure out what the teacher is 'getting at', and so classroom interactions can become elaborate guessing games. In everyday conversations, speakers usually ask questions in order to extend their knowledge, and questions are addressed to people who are assumed to be more knowledgeable about that topic. But in the classroom, the roles are reversed: the person who asks the questions is the one who is assumed to be more knowledgeable.

It is thus extremely important to consider how the interactional complexities of the setting, in this case the classroom, might affect what is happening when a researcher asks children to carry out a specified task.

Finally, as acknowledged by Pridmore and Bendelow (Pridmore and Bendelow, 1995), children's drawings must be seen in the context of the wider culture of which they are part. This is supported by psychologists, e.g. Wales [(Wales, 1990), p. 147], who, when considering cross cultural variations in children's drawings more generally, pointed out that:

> To make sense of what children might do pictorially in the context of their culture, some knowledge of their cultural world view is needed.

However, these caveats were made largely on the basis of world-wide cultural comparisons and less attention has been paid to reflecting on (1) how children's drawings about health and illness in Britain are affected by the dominant adult discourses, or (2) whether the drawings reflect differing sub-cultural experiences of health as affected by, for example, gender, class or ethnicity.

To sum up, in their drawings using this technique do children simply give us back what they feel we want to know in terms of a range of acceptable public representations of current thinking about health, as they understand it? And do those children who, like many adults, find abstract conceptualizations of health and staying healthy somewhat taxing, fall back on representing the well known individualistic health homilies such as eating lots of fruit and vegetables and taking exercise? Does this method reveal children's own personally meaningful views and feelings about health grounded in their daily experience or are these merely publicly acceptable representations, and what do these say about our culture?

It was evident from the semi-structured interviews in the study carried out by one of the authors that, following the use of the draw and write technique as an ice-breaker, for children, like adults, health-relevant knowledge, attitudes and behaviour are not necessarily related (Backett and Alexander, 1991). Having had their drawings suitably appreciated and discussed with the researcher, most children, in their responses to a variety of questions about their daily lives, activities, likes and dislikes, then proceeded to describe existences which did not reflect the health knowledge they had previously represented. Similarly, work in Canada (Kalnins *et al*., unpublished) using different methodological techniques elicited a quite different range of dominant perceptions of health from children. These focused, for instance, quite prominently on issues of danger and personal safety. We would suggest, therefore, that requesting *drawings* of what makes or keeps you healthy has tended to elicit from most children a more conventional and limited picture of health than might be discovered by other methods. Also, if follow-up group work or individual interviews are used simply to further explore the initial representations then the parameters of children's accounts of health are likely to remain fixed in the publicly acceptable adult-defined paradigm.

Methodological and analytical limitations

Perhaps one of the inherent problems underpinning our concern about the increasing popularity of the draw and write technique is that it is an essentially qualitative method which is being deployed in order to provide quantifiable information. In fact its origins in health promotion were essentially quantitative since, as we have discussed earlier, it was the main methodological instrument of a large-scale survey of primary school children's 'concerns, views and attitudes' about health and keeping healthy. In the original analysis of the survey data from 9584 children the drawings themselves were not analysed, rather, they seem to have been used for illustrative purposes, and as the researchers stated [(Williams *et al*., 1989), p. 15]:

> The invitation to draw was seen to provide children with a platform for producing a written label or statement to accompany a picture. Only the written statements were coded.

However, many researchers who have used the method subsequently seem to have worked with the drawings as well as the statements but have usually simply quantified the overt pictorial content. It appears reasonable to assume, therefore, that researchers using the draw and write method are unsure about how to analyse and make sense of the data except by counting it.

The originators of the draw and write in health education were also appropriately cautious about what they called 'the difficulties involved in the

investigation', such as: whether or not children would draw what they found easy to depict; whether recent lessons or experience would affect what was depicted; and whether the content of the children's drawings would be affected by their friends' proximity or a desire to please their teacher [(Williams *et al*., 1989), p. 15]. However, in line with a positivistic paradigm, such issues were considered as sources of bias which should be remedied by careful instructions to the teachers about the practicalities of administering the research and that, if they were controlled for, then the 'true' picture would inevitably emerge. We would wish to argue that, from an interpretivist qualitative paradigm, it is now important for those using this approach to see the findings as reflective of the variety of discourses around health in our society and to analyse these as data which children may draw upon in the context of particular settings and perceived demands, rather than as representing any absolute 'truths' about their views of health and healthiness (Secker *et al*., 1995).

However, the representations produced using this technique have usually been treated not as indicators of the child's inner world or experiences but as factual demonstrations of children's knowledge and beliefs about aspects of health and illness. That some aspects of health, such as sleeping or resting, are commonly underrepresented in the drawings has been treated more as a deficiency in children's factual knowledge than as a deficiency of the technique or its application (if it is remarked upon at all). Equally, that most studies have produced a preponderance of drawings of food, particularly fruit and vegetables, and of exercise, has usually led researchers simply to see these as representations of how children view health and, again, not to reflect on the limitations of the findings produced by the research technique or that they perhaps reveal more about the current culture of health than about children's own views or worlds (accepting that there will be interaction between the two).

Of course, what may be happening is that the most meaningful or personally relevant responses are simply not being drawn or written down by the children because the act of *drawing* them is, in some ways, just as emotionally or practically problematical for the child as would be the act of *speaking* them. Also, it may very well be the case that the development of special methods for researching with children, such as drawing, does not enable them any better to express their own cultural world but, in fact, simply gives them an apparently easier vehicle through which to demonstrate how their own views and knowledge do or do not approximate to the adult world (Shaw, 1996).

Ethical issues

Parallel with the growth of interest in researching with children and understanding their social worlds from the child's own viewpoint, social scientists have become increasingly concerned with the ethical issues involved (Alderson, 1995; Morrow and Richards, 1996). This has, of course, become even more pertinent with the acknowledgement of children's rights through the Children's Act (1989) and the signing in 1991 by the UK government of the UN Declaration of Children's Rights.

Some researchers have expressed concern over ethical issues involved in using the draw and write technique (Pridmore and Bendelow, 1995). Access is one such issue and, for example, when the technique is used in schools after gatekeepers have given consent it is difficult for a child to refuse to take part. In other settings parents might be the only gatekeepers and, once their consent has been given, a child who does not wish to take part might be regarded as recalcitrant or disobedient when in fact s/he may fear the task, dislike the method or find the whole exercise boring—all classic reasons why many adults refuse to be research participants.

There are also related ethical issues around children's rights to privacy. By the very nature of the setting this is virtually impossible to achieve in the classroom and, even if direct scrutiny of each other's work is guarded against during the exercise itself, it is a possibility that some children's efforts or reported ideas may form the butt of

subsequent teasing by others. Confidentiality is usually agreed between researcher and researched but it is less often seen as an ethically problematic issue in terms of subsequent interactions amongst respondents themselves. Importantly, however, as Alderson has poignantly stated: 'risk in social research includes shame and loss of self esteem' [(Alderson, 1995), p. 56]. Confidentiality remains an issue in the dissemination of findings as the subsequent use of drawings in published material is perhaps harder to anonymise than is the written word (Levin, 1995). Also, identifiability of drawings is an issue if research reports are fed back to respondents, as is increasingly a mark of good research practice.

Alderson has drawn attention to consideration of the costs and hoped-for-benefits of researching with children [(Alderson, 1995), p. 2]. Importantly she asked if there would be any risks or costs to the children of research participation such as time, inconvenience, embarrassment, intrusion of privacy, sense of failure or coercion or fear of admitting anxiety. It is not too difficult to identify some of these potential risks when drawings are requested about sensitive subjects such as cancer or family breakdown. During such exercises researchers have been concerned to acknowledge and attempt to deal with any emotional reactions or upset which might be provoked by the research. However, little is known about any subsequent emotional reactions from the children involved, and it could be argued that these may be potentially as great for those children who choose to conceal and keep their knowledge private as for those who reveal and may be identified as needing support.

However, ethically, there may also be costs for children where less overtly sensitive topics are being researched. It should not be underestimated that health and keeping healthy may be as much moral issues for children as they are for adults (Backett and Alexander, 1991). As Wetton (pers. commun.) has pointed out, how might a child feel when asked to draw 'healthy' and 'unhealthy' items and s/he is aware at the same time that in his/her life the 'unhealthy' predominates. In the Edinburgh interviews (Backett and Alexander, 1991) very few children felt able to identify things that their parents did which were 'unhealthy' (the *lack* of mention of smoking was noteworthy). One little boy was especially memorable when he protested that, 'my mummy would never give me anything unhealthy to eat'. When, as in our culture, healthism has become imbued with making moral judgements of others, the impact of this on children's feelings or wishes to reveal their experiences, even in response to an ostensibly non-emotive research area such as 'what makes you healthy?', should not be under-estimated.

In our view these ethical issues should be considered and publicized more broadly so that anyone using this technique is aware of its potential problems. In particular it should not be assumed that drawing is the easiest option for children when, in fact, a long research tradition in other disciplines suggests that, as a medium of expression, it has the potential to tap into emotions sometimes more powerfully than the spoken word. Given the ethical issues around access and consent, it is vital to reflect on whether particular methods, such as drawing, in fact cause children to reveal more than they might otherwise choose. As Williamson and Butler (Williamson and Butler, 1995) have pointed out, for some children non-communication *may* be a deliberate strategy rather than a perceived deficit. From their research, which did not involve drawings they claimed that [(Williamson and Butler, 1995), p. 305]:

> Increasingly, our research suggests, children and young people endeavour to conceal the problems of their social worlds from adults in order to avoid being 'humiliated' by misunderstanding, misrepresentation and misplaced responses.

Evidently, this wider ethical point also supports our critique of the content of data produced by the draw and write technique as it suggests that children may exercise self-protective agency to censor information which they choose to represent to adults.

Concluding remarks

Shaw (Shaw, 1996) argues that there is no previous body of qualitative research findings with children to consider when designing and undertaking research. As a consequence the draw and write technique would appear to offer a way forward for the development of health education research with children. Yet, as Shaw (Shaw, 1996) also suggests, there exists a 'deficit' model of research with children in which they are perceived as having limited abilities, according to age and developmental stage, to comprehend language and articulate experiences. Often research is premised on the assumption that a child's culture must be viewed according to how closely it approximates to the culture and world of adults. Certainly adult perceptions of drawing are that it is a participatory activity which most children enjoy, and researchers have further developed these perceptions to consider children's drawings, writing and labelling as research data secured in a 'bottom-up' fashion (Pridmore and Bendelow, 1995; Pridmore and Lansdown, 1997).

However, critics of the use of children's drawings in psychological research have noted that the focus is on the drawing rather than the process of producing the drawing, and that there are skills specific to drawing which will evolve at different times and to different levels for children (Thomas and Silk, 1990). These should be accepted as restricting factors in the use of drawing with children in research and ones, moreover, which might appear to support the notion of a 'deficit model' of children (Shaw, 1996). What is also required is an appreciation that drawings are not direct translations of 'mental states or images' (Thomas, 1995), and that they are significantly influenced by the manner in which children are asked to draw and the 'pictures' that are available to them in their environments. Thus the setting and culture of the school and curriculum is likely to influence the nature and process of drawings and writing.

Why then have many researchers been so attracted to research methods which involve projective techniques rather than exploring the worlds of children through being with them (participant observation) or talking to them (using qualitative methods)? Funding issues aside, could it be that, as Lansdown (Lansdown, 1994) suggests, in the West we simply 'do not have a culture of listening to children'. Are researchers avoiding their own inadequacies or being unwilling to invest the time and patience necessary to qualitatively investigate children's own social worlds of health and illness on their own terms? Is 'draw and write' simply a quick fix, a child version of rapid appraisal; and, as such, is it not only effectively reducing children's potential to participate fully in collaborative research with adults but also resulting in a superficial, misleading and inaccurate representation of their social worlds of health? As Morrow and Richards [(Morrow and Richards, 1996), p. 13] have pointed out:

> Using interactive and participatory research methods may also be a useful way of researching children ... and it is interesting to note that much of the impetus for participatory methods is coming from developing countries, where children are participants in society (at least at the level of production) to a much greater extent than in the UK.

However, perhaps these adultist cultural impediments should simply be acknowledged and worked on as a fieldwork development issue rather than as an insurmountable obstacle. For instance, Waksler [(Waksler, 1991), p. 62] has suggested that 'adults routinely set themselves up as the understanders, interpreters and translators of children's behaviour' rather than accepting children's competencies as 'different' rather than lesser. Morrow and Richards [(Morrow and Richards, 1996), p. 10] conclude that just as it has been found that children can give reliable testimonies as witnesses and philosophers have begun to investigate children's philosophical thinking, so:

> Sociologists too can and should take children seriously as social actors in their own right, as sources of valid sociological data.

In conclusion, the draw and write technique constituted a major step forward in researchers' attempts to gain access to childrens' conceptualization of health-related issues using child-appropriate methods. However, especially in the light of the popularity of the technique and its perhaps unquestioning application to a variety of topics and settings, it is now necessary to begin a debate about what it does and does not achieve. Most importantly, we would suggest that health education research with children must be premised on an appreciation of the social context and world of the child. It should avoid the trap of an 'adultist', top-down, approach to the research and the choice of methods, and not seek to approximate the child's world to that of the adult's. The possible limitations in language and articulation of younger children may, in fact, actually be reinforced by adult attempts to place their own interpretation on the words and drawings of children. Rather, health education researchers need to create the potential for children to have their own ideas and explanations heard and understood.

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