

**ART IN THERAPY WITH NEUROPSYCHOLOGICALLY
IMPAIRED CLIENTS**

by

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SUMMARY

The research process illustrates the interaction between the therapist and the neuropsychological impaired client in the therapeutic context where we utilised drawing and painting as a creative medium. I describe the interaction from a systems paradigm. New paradigm research is used as the researcher is included in the research findings. The focus is on new meanings that the therapist and clients generated. Three case studies are described in this study. A circular description is given of the use of drawing and painting in therapy. The losses that the clients suffer are described and explained to make sense of the interaction. The use of art is described and incorporated in the therapeutic process as creative exercises were important ways to connect with the clients. This study illustrates that creativity should always be part of the therapeutic endeavour, especially when understanding the verbal expression of the client is difficult.

Keywords:

Meaning; Co-construction; Loss; Neuropsychology; Brain injury; Art; News of difference; Joining; Enactment; Representation; Narration; Unique outcomes; Systems

CHAPTER 1

INTRODUCTION

“The true mystery of the world is the visible, not the invisible.”

Oscar Wilde, The Picture of Dorian Gray

The value of the arts within society need not be justified. Art has, through the ages, acted as a reflection of society. The only justification needed in this study is the use of art in therapy. Art has offered so many possibilities and comments that the creative use of art in therapy can surely be one possibility for use.

The use of drawing and painting in therapy is a very personal inclination that has its roots in my own belief in art as a therapeutic tool. From childhood all of us have used art in many ways, from drawing stick people to the art of making mud cakes. Children need expression of the self and to describe their contexts. The child gives the child's own perception without risking too much. We stop drawing and painting at approximately the age of 12. At this age we start to evaluate the creations that we make and unfortunately this critical attitude towards our own work deters us from further exploration.

After exposing my creative side by drawing with an artist friend, I regained the ability to self-express through art. The process was so valuable to me that I made the assumption that it might be a useful contribution to therapy. It has become clear that the ability to respond to the arts is in all of us. Art has, in many ways, given me the opportunity to experience and express myself and the contexts I find myself participating in, in a different way. I experience that it frees me from cognitive explanations and is an alternative way of expressing myself.

Emotionally, I get a sense of connection and wholeness when I experience that others understand me. By drawing and painting, I express myself and make comments without the fear of being misinterpreted, for that is the aim of the whole exercise: to show myself. Any person

who draws and paints will tell of the experience of switching into a different mode of thinking.

The assumption that I make is that therapy should always include a creative component. These creative components need not always manifest in a visual reproduction, but can be a creative contribution to a conversation. Art is a way for the therapist and the client to have a dialogue about an expression that they gave. I have taken great pleasure in finding a way to combine the use of art in conjunction with psychotherapy. This study is a contribution of the systems theory to the field of art in therapy.

The aim of the study is to describe the use of drawing and painting in therapy, with clients who do not respond verbally or who are passive in therapy. The client population consisted of patients in the neurological rehabilitation ward of One Military Hospital.

Disability, injury or handicap often leaves the ability to respond to art relatively unimpaired. People who have difficulty in communicating, and even making sense of communication with the environment, may discover that the arts open a pathway to a greater sense of expression (Payne, 1993). This perception moved me to explore the use of art in therapy with clients who had suffered neuropsychological damage.

In this study, the use of the words "drawing" and "painting" implies that this creative medium has been involved in the therapeutic process. As the therapist, I tried to engage the clients in an experiential approach within the mediums of pencils, paint, crayons and pastels. The term "art therapy" will not be applicable to this study as I do not claim expert knowledge of the art form that we used. I do claim the ability to participate with the client in the therapeutic context so that it might be defined as creative. Emotional reaction might be part of the creative process, but the main ingredients of the therapeutic process are activity and participation.

Literature shows that the most common perspective towards art is from a linear scientific perspective. The influence of art is investigated. The goal of art therapy is to assess the themes that the patient grapples with in order for a cathartic release of emotions to take place. The subconscious is often described as only entered through the art medium. The literature also

describes drawing and painting as a right brain function that enables the patient to have access to that part of the brain. The humanistic tradition focuses on characteristics such as self-reflection, purposefulness, language and culture (Payne, 1993).

The approach that I will use acknowledges these perspectives, but focuses on the relationship between the therapist and the client. The process of creating art together and dialoguing about it is the main concern of this study. The art that the clients create is an expression and an alternative way of communicating. The art is seen as a way in which the clients comment on their relationships rather than an indication of a subconscious need. The emphasis will also be on the symbolic value of the artwork. The reflective aspects of creativity cannot be denied in this study. This dialogue about the drawings and paintings implores both the observer and “observed” to be respectful of each one’s unique experience and expression. The focus of this study is not on the nonverbal communication that was found in the therapy when art is included. The focus falls on the dialogue that the drawings and paintings facilitated in therapy. The narrative approach is the most useful approach to describe the observer’s participation in the dialogue that enters news of difference to the narrations. I attempt to carry through these aspects in all the chapters.

This study contains a valuable quest for the use of art and drawing in a verbal therapeutic context. The therapeutic research process provides for the opportunity to construct different meanings about the interaction between the act of creating art and therapy. An aim of this study is to demystify the arts. Art in therapy should be an approachable path to connect with clients who find it difficult to connect. The use of art encourages healing, expression and dialogue. The study will illustrate how these components of art manifest in a therapeutic context.

The study will use a qualitative research methodology within the naturalistic research paradigm. This paradigm is congruent with the second-order cybernetic and social constructionist theoretical assumptions. These assumptions are that we construct reality in the dialogue between people (Lincoln & Guba, 1985). The focus of this type of research is on the process of interaction between the researcher and the research. An aspect that is characteristic of qualitative research is the emergent and unpredictable nature of the research process and research results. Thus, the research process evolves as the therapeutic process evolves. This type of research also includes

self-reflexivity. The researcher and the subject can never be separated and the relationship between the researcher and the co-researchers needs to be described.

On a personal note, I find the practical integration of systemic thinking and the use of art in therapy significant. This study provides me with the opportunity to investigate my assumption explicitly that art in therapy provides the therapist and the client with a magnitude of different perspectives by which change is evoked. The meaning that I derive from this study might be significant for use in other therapeutic contexts.

Chapter 2 opens the study with the author's description of the losses that clients suffer when subjected to neuropsychological damage. I give a structural description of the types of head trauma. The phases of head injury receive attention and a detailed description of the cognitive losses that the clients suffer is given. I describe the different systems affected by damage to one of their members in order to give a holistic perspective of the trauma that the client has to endure.

Chapter 3 reopens the study with a different topic, namely the use of art in psychotherapy. A presentation is given of recent and more established developments in the field of art therapy and goes on to explain how the systems approach might be integrated with art.

Chapter 4 offers an explanation of a basic model by which certain concepts of the systems theory can be used to describe the use of art in therapy. I explain certain concepts through the use of certain art therapy based on practical procedures. This chapter aims to give structure to the systemic description of art in therapy.

Chapter 5 gives a detailed review of the process that occurred in three case studies. This discourse not only consists of descriptions, but also of drawings and paintings that the therapist and clients created during therapy. A circular depiction is given of the therapeutic process. The backdrop to the descriptions will be the model as discussed in chapter four.

Chapter 6 aims to trace the process that the study followed. I use meta-descriptions about the

study in order to elicit more questions and meanings. I will clearly portray the deficiencies and use of the study in this chapter.

CHAPTER 2

BRAIN INJURY AS DISRUPTION

"The world breaks many of us and in the end many are stronger in the broken places."

Ernest Hemmingway

It takes but a brief moment for one's life to change forever. People suffering from head injury are becoming an everyday occurrence with the high speeds that vehicles can reach and the emphasis on time; this age can assuredly be termed the age of speed. Drenth (1991) is of the opinion that most lesions after an accident are situated in the brain, skull or back. Rimel, Jane and Bond (1990) mention that the occurrence of brain injury is twice to three times higher in men than in women. Brain injury is mainly caused in motor vehicle accidents, motorcycle accidents, domestic accidents, work related injuries, recreational accidents, sport, attacks, and war-injuries. It seems obvious that more men are part of these activities than women and are thus more prone to head injury. Fouche (1996) states that South Africa has one of the highest incidences of head injury in the world. Another factor that contributes to the high incidence of brain injury is the rate of violence in South Africa. Violence on the streets is becoming a major contributor to the rising rate of neurologically dysfunctional patients. With this higher incidence of head injury, working with people that have sustained some sort of head injury becomes inevitable for the psychologist.

The Trauma: A Structural Description

If head injury is associated with change then it is important for the therapist to see how this change is described; the mechanism of the change contains its own meaning and process.

Descriptions of how this change is brought about will subsequently be given. Lezak (1988) describes most brain-injured patients as suffering from behavioural disturbances as a direct result of tissue destruction and "associated metabolic and neuro-humoral alterations" (p.112). These alterations effect behavioural and emotional changes. Traumatic brain injury

can be described as closed or open. The latter implies the type of penetrating injury-associated with gunshot wounds, while the former implies deceleration or acceleration of the brain within the skull as is often found in car accidents (Rose & Johnson, 1996). A hit to the head would entail a closed head injury. Closed head injury will be the primary focus of discussion as it is the most common type of head injury.

A closed head injury does not expose the actual contents of the skull. Another useful description of closed head injury is to “denote an injury in which the primary mechanism is one of blunt impact to the head”, whereas in an open head injury, “the dura matter that is the membrane that lines the interior of the skull, is torn and consequently the content of the skull is exposed” (Richardson, 1990, p.2). Closed head injuries are a major cause of impairment and morbidity among survivors. Damage at the site of the hit to the head would be described as a “coup” connection, damage to the other side of the impact zone is described as a “contrecoup” impact - the brain is forced to the other side of the skull.

Movement of the brain within the skull produces lacerations and contusions in the region of the sphenoidal ridge, which produces damage to both the frontal and temporal lobes. Movement of the brain is also likely to produce a variety of surface lesions, especially by causing tearing (or avulsion) of the veins that leave the upper borders of the cerebral hemispheres (Richardson, 1990, p.41).

The brain also can tear and turn on its axis - according to Fouche (1996), the most common injury pertaining to this type of damage is temporal and frontal damage. Diffuse axonal injury occurs when the skull rotates relative to the brain. Such a movement will produce contusions and lacerations as the region of the sphenoidal ridge (which is the bone that separates the frontal lobes from the temporal lobes) preordains the mentioned areas to damage. “The rotational component of head injury is usually for consciousness to be impaired and for diffuse damage to occur throughout the brain” (Richardson, 1990, p.41). The brain stem is the structure of the brain involved in rotational injuries.

Cerebral traumas are the most common phenomena when it comes to head injury (Kolb & Whishaw, 1990). The brain can be affected in different aspects of functioning. Direct

brain damage can occur. Thus, the neurons and support systems are directly affected and damaged. Blood can be prevented from reaching the brain. Thus, haemorrhage may also be the result of impact to the brain; this would entail a loss of blood to the neurons (Richardson, 1990). Trauma can cause bleeding within the skull that can lead to intracranial pressure and subsequent damage. The impact to the brain causes bleeding and because no draining of the blood occurs, a blood mass (haematoma) develops within the skull - pressure is consequently exercised upon the brain. Patients who have sustained deep intra-cerebral haematomas run the risk of diffuse axonal damage. The brain itself may swell after trauma and increase intracranial pressure that could mean that the brain swells against the skull, resulting in damage. Impact to the brain can also result in concentration or accumulation of fluid in the area of impact (oedema) (Richardson, 1990).

An open fracture increases the possibility of infection in the brain. Cerebral trauma could result in epileptic fits as the connections between the neurons are affected. According to Richardson (1990) diffuse brain damage that results from closed head injury includes diffuse axonal damage, hypoxic damage (loss of oxygen), and brain swelling.

Loss of Consciousness: A Prognostic Factor

Loss of consciousness is often associated with closed head injury. The length of the coma is an important prognostic criterion as it has a direct connection to the intensity of the damage. The Glasgow Coma Scale assesses the extent of the patient's impairment of consciousness and is of major importance in evaluating the severity of injury. The severity of the injury is measured during the initial phase by the degree and duration of consciousness. The Glasgow Coma Scale is utilised to measure the above-mentioned and includes three components: the minimal stimulus necessary to elicit the opening of the eyes, the best motor response to command or painful stimulation such as pinching, and the best verbal response (Teasdale & Jennet, 1974).

Phases of Head Injury

After the patient emerges from a coma, he or she may experience a phase of disorientation

and confusion. Oddy and Alcot (in Rose & Johnson, 1996) describe how the patient is frequently unable to recall any events pertaining to the accident, or after the accident - these types of amnesia are called retrograde and post-traumatic amnesia (anterograde amnesia). There is strong interaction between the linguistic abilities and the cognitive status of the patient. The level of speech gives an indication of the cognitive status of the patient. This phase is also characterised by low levels of tolerance towards others. During the so-called middle phase of recovery the patient may seem more alert but the various cognitive deficiencies manifest rapidly. The losses that the person has suffered became more evident, thus the life-threatening phase makes way for the reality or rather the constructed reality to be faced. The last phase entails the rehabilitation of the head-injured person and family.

Therapist's Role

It seems as if great effort has been put into the diagnosing of brain dysfunction. Diagnosis focuses on the cognitive status and personality characteristics which answer questions about the person's adjustment to his or her disabilities in order for caregivers, family and friends to know how the neurological condition has affected the head-injured person's behaviour. My question became, what is the function of the therapist, if it is not an evaluative role? The answer is that I have to focus on cognitive skills such as memory, perception and understanding which are needed for the brain to gain information. The psychologist then makes sure that the cognitive retraining exercises that have been done are aiding the client to regain skills lost. Sometimes a different way of life has to be developed. Feeling excluded from the management of his or her own life is quite normal for the client. The main focus of the psychologist in this thesis will be to help the client cope with the changes caused since the accident (Gronwall, Wrightson & Waddell, 1990), that is, the rehabilitation of the "neuro-patient". These clients go through all kinds of psychological changes and need support and understanding from the therapist. Yet, because of the damage sustained, many clients have difficulty in expressing their needs or conveying information about their experience of themselves. Lezak (1995) reports that most people who sustain brain injury experience a change in self-awareness and emotional functioning "but because they are on the inside, so to speak, they may have difficulty appreciating how their behaviour has changed and what about them are still the same" (p.11). Because clients with neurological

damage cannot predict their lives, they often become self-doubting, consequently the patients often do not manifest interactionally and may seem vague about life goals, values and future plans. This pattern acts as a crippling agent and the client becomes more confrontational or "schizoid". The role of the therapist or rather, the role that I took responsibility for, was to be in interaction with these clients in order for them not to accept the role of dependent, expressionless patient.

The Effect of the Injury on Brain function or Cognitive Losses

Effects on function usually follow damage to certain parts of the brain. A detailed discussion of the structural function of the brain will be avoided, yet it is necessary to know that weakness in the arm or leg opposite to the side of the wound does occur (hemiplegia) and that damage to the left side of the brain frequently tends to impair speech. Injury in the frontal area usually accompanies changes in behaviour and loss of insight and inhibition. Another aspect that should be kept in mind is that when brain cells are destroyed, which is called necrosis (Richardson, 1990), these cells do not grow again. On this bleak note as a therapist, I am confronted with the uselessness of my actions.

Motoric and Sensoric Incapacity

Motor functioning is usually the first aspect of a person's behaviour which is affected. This includes spasticity (an abnormal tonus and stiffness of the muscles), ataxia (loss of coordination), and apraxia (loss of balance). Sensoric incapacity also occurs which may mean an enhancement in sensation or a loss in sensation. Patients with head injury usually become easily fatigued because of changes in sleeping patterns. Changes occur in regulatory function that explain the fatigue, the changes in sleeping patterns, the excessive sweating that shows a deficit in regulating body temperature, and problems regarding bowel control.

Attentional and Focus Loss

Poor concentration and attention might also be associated with neuropsychological impairment. According to Gross and Schutz (1984), most judgements about the self require

the examination of context within which behaviour is taking place, in order for it to be meaningful. To perceive context, it is often necessary to make several shifts in attention, for instance, the process and the content should be taken into account simultaneously. Patients thus frequently misunderstand behaviour in the broader context and because of the cognitive passivity, the patient often fails to look for an explanation of the context. The patient does not “connect” with the self-referential loop and therefore does not manifest in the context. Gross and Schutz (1984) explain it as follows: “ Thus not only has the person lost ability to recognise the appearance of personal characteristics, but she has also lost the need to look for reflections of herself in what she is doing” (p.7).

Memory

Memory is an important component in psychotherapy and if memory is defective, the therapeutic process may be endangered. The frontal and temporal lobes are involved in lacerations and contusions because of the rotational movement of the brain within the skull, and, as already explained, the sphenoidal ridge produces damage to the above-mentioned lobes. These areas are likely to constitute the area with the greatest cortical damage, despite the site of impact. Higher cognitive functions such as memory are impaired by damage to the temporal lobes. According to Richardson (1990), memory depends on three consecutive stages namely: “ input (encoding) storage (retention) and retrieval” (p.72). Patients with closed head injury may show difficulty in any of the above-mentioned stages.

Schachter (1974) is of the opinion that the formation of any concept is dependent on the availability of information. The self-concept is, among other things, a concept. Thus, the formation of self-concepts is dependent upon the individual’s access to information about the self in the past. I interpret it as information about the process between the self and others that co-construct the self-concepts. If the interaction between the individual and others is not remembered and the “others” are still in interaction with the individual because of the feedback loop, the individual is left in a state of confusion because the discrete occurrence that the “others” are commenting on has no relationship with the self-concept. Gross and Schutz (1984) put it more concisely in the words: “ In order to achieve an accurate concept of one’s self, one needs to have an active fund of memories from which some can be selected and recalled” (p.3).

Amnesia

The disturbances in memory are of prognostic value to clinicians and psychologists. Retrograde amnesia refers to an impairment in memory for events that took place directly before a closed head injury. A long period of retrograde amnesia is usually an indication of intense brain damage. The implication is that many clients cannot remember the accident where they sustained the brain damage. This enhances the confusion and disorientated state.

Post-traumatic amnesia refers to a state of disorientation (i.e. an inability to locate oneself with regard to time, place and situation) (Richardson, 1990). Russel and Smith (1961) describe post-traumatic amnesia as “the interval during which current events have not been stored” (p.16). The development of retrograde amnesia is quite rapid, that is, within minutes after a closed head injury, and it usually persists after emergence from a coma. The duration of post-traumatic amnesia can range from a few minutes to several months (Hartley & Levin, 1990). Post-traumatic amnesia is marked by anterograde amnesia; this state is also known to infer difficulty in consolidating new information in long-term memory (Richardson, 1990). Patients thus store new events and information with difficulty. Clients would frequently not remember my name or that they had been for therapy before; this makes one disheartened about one’s therapeutic ability and interactional appeal.

Learning and Remembering

Learning and remembering may be the most “frequent subjective complaint and the most prominent residual deficits” (Richardson, 1990, p.126) among patients who have sustained a closed head injury. The Wechsler Memory Scale demonstrates the more pronounced and persistent memory dysfunction. The ability to analyse a situation links up with the ability to learn and to categorise certain events or information in order for it to be called a certain concept. When the memory function is impaired, the ability to analyse is frequently “hijacked” (Gross & Schutz, 1984). The ability to form abstract concepts from information, implying integration of information in the feedback loop, is often impaired, thus leaving the client with inaccurate and impaired conclusions from the feedbackloop. A characteristic of brain-injured people is that they are cognitively passive; the blatant manifestation of this

deficiency is helplessness. The patient will not easily be moved to change or think about information (Gross, 1982). Learning takes place quite haphazardly and is frequently characterised by confusion and passivity.

The inability to learn from experience is often a confusing and debilitating feature of the brain-injured person. Although patients suffer from certain experiences, for example, not tidying their rooms, they do not seem to learn from the experience. Lezak (1988) states that caregivers will often allow the patient to make bad decisions, with the idea that the patient may learn from the loss, only to discover that the decision is repeated with the same consequence.

People who have sustained brain injury frequently have an inability to plan and to take charge of their lives. Lezak (1988) describes how this disability or loss is “structure dependent” (p. 17); this means that external guidance and support are needed in those areas that usually require planning. The extent of the damage regulates the severity of structure dependency. People with mild to moderate damage will have no trouble performing tasks that are part of their usual routine, but help will be needed to perform new or complex activities independently. Severely damaged people will not be able to perform daily living activities. Thus, new and complex contexts and the interactional appeal of these contexts cannot be met by brain-injured individuals. Younger people who have sustained brain injury often find it very difficult to adapt to the loss of being independent and to being unable to perform planned exercises. On a practical note, this will mean that the balancing of a cheque book will become increasingly difficult, and the brain-injured individual will not suggest new and novel ideas. This might be mistakenly interpreted as lack of motivation, whereas it is a manifestation of structure dependency, a need to perform in a predictable world.

Emotion and Personality

Emotional and personality changes are a common occurrence (especially with frontal damage). This would include a decrease in motivation, depressive feelings, disinhibition, low frustration tolerance, aggression, and unreasonableness. “Depression affects most of these patients, at least transiently; for some, depression becomes chronic” (Lezak, 1978, p.112).

Many patients are victims of despondency as they gain so-called insight into the loss of individual freedom, mobility, skills and other physical, and emotional losses (Gronwall et al., 1990).

Yet this despondence that the patient endures can be interpreted as a sign that the patient has achieved insight into the disruption. It can also, to my mind, be a manifestation of the frustration and anger that the patient feels, as he or she is cut off from normal conversation and normal daily activities. Patients frequently experience feelings of inadequacy, loss of control, fears of abandonment, and dependency (Lezak, 1988). It is suspected that tissue damage evokes depression on an organic basis because of neurohumoral alterations.

The patient thus resists any interactional efforts to relieve this so-called depression. The patient does not manifest an interactional relationship mainly because the relationship can no longer be predicted. It can also be said that the patient does not manifest interactionally. Lezak (1988) claims that the patient becomes anxious when the experience of the self has unaccountably changed. He or she does not feel in control of the situation nor of his or her life. The patient becomes withdrawn, fearful, and easily upset, and mood swings occur. This is a demonstration of the anxiety that is internalised and, rather than verbalising the anxiety, a self dialogue is enhanced that manifests with the above-mentioned symptoms. Thus, anxiety is reactive to loss of control over one's life.

Clients often manifest with impulsive behaviour, as already mentioned. They do things for no apparent reason or even with the intention of doing something quite the opposite; they will say and do something different from that which was intended. Anger outbursts are the most commonly reported manifestations of impulsive behaviour (Lezak, 1988). Gross and Schutz (1984) describe the causal relationship between intentions and behaviour as impaired; discontinuity is experienced between the self-experienced intentions and actions. The reaction of the client might be to discount own experienced motivation in favour of accepting the meaning of the "objective" evidence.

Family members often do not understand the fluctuations in emotion that the clients exhibit. Prominent emotions that are difficult to understand are "apathy, silliness, heightened

reactivity, and irritability” (Lezak, 1988, p.119). The family assumes that the patient has control over these emotions, and conforming behaviour would occur if only the patient would put his or her mind to it. Ideas that the behaviour or fluctuations in emotion are deliberate often cloud the understanding and tolerance of family members.

Language

Language is the aspect of therapy that is often emphasised as the talking cure. The left side of the brain controls the ability to speak in most people. A diverse range of speech problems may arise because of head injury. Incapacity of language and speech would include receptive aphasia, expressive aphasia and global aphasia. Hartley and Levin (1990) comment that aphasia is more prominent among closed head-injured persons in the rehabilitation centres as they are more likely to have severe injuries. Aphasia is characterised by concrete use of language, difficulty in following instructions, and difficulty in answering; yet these patients do understand conversations and written language. Paraphasia is another disorder that is found among closed head-injured individuals. This means that the focus word is replaced by a wrong word. These disorders have a profound impact on the individual as the patient cannot interact effectively and social competence is impaired. Anomie, which implies word-finding problems, sometimes manifests and is the most commonly reported type of aphasia after closed head injury. Anomic aphasia includes abnormal naming although comprehension is normal. Dysarthria is a common speech deficit which implies that motor deficits inhibit the patient to self-express, for example, the facial muscles or the tongue might not have the muscle tone left for proper speech. Damage in these areas often results in problems in understanding others.

Skills of talking, listening, reading, and writing are all different ways of using language (Gronwall et al., 1990). It is emphasised that just because the patient is unable to express the self in words, it does not mean that the client does not understand what is said. The client sometimes only uses abusive language such as swearing because that is the only available emotionally laden language that is at his or her disposal. Levin, Grossman and Kelly (1976) report in their study that patients with severe injuries manifest deficits in both receptive and expressive language. Thus, the patient will necessarily have problems in

relation to discourse. Discourse production involves linguistic ability as well as cognitive and social\behavioural abilities which, as already seen, are affected by head injury. It has been found that utterances of head-injured patients are significantly shorter than those of normal speakers. According to Hartley and Levin (1990), this suggests that simplification of syntactical structures takes place.

Speech therapists explain quality of life as a means to describe subjective communicative independence and psychosocial wellbeing; a sense of wellbeing and coping skills are necessary to obtain this quality of life (Sarno, 1993). To use language effectively facilitates one's sense of self-worth and identity. My question, is what will happen when this skill is endangered? The ability to get a message across utilises social communicative competence. Many patients who are neurologically dysfunctional manifest subtle deficiencies in speech. The South African context is often a setting where a monolingual therapist is in therapy or relationship with a multilingual patient, the practical implication is that the therapist often does not speak the client's language and vice versa. The world of the client becomes smaller as interactional problems emerge, such as the incapacity to incorporate information, thus implying that the patient will sometimes not be able to understand jokes. As soon as the client cannot keep up with the pace of information, withdrawal is a common response (for all parties involved in the linguistic process). On a practical note, the language of the client may change. The client's language may be characterised by confusion, linguistic mistakes, incomprehension, confabulation, irrelevance, vagueness, fragmentation, vocabulary problems, dissociative mistakes, and incoherence (Penn & Cleary, 1988).

Summary of Neurological Problems

Fouche (1996) describes the primary problems that patients in the neurological rehabilitation present as follows:

Physical problems: hand use, balance, coordination, mobility, muscle-tone, speech, sight, and hearing.

Higher cognitive functions: concentration, understanding, problem solving and attention deficits.

Perceptual problems: spatial orientation, visuomotor coordination.

Psychosocial problems: communication, adaptation, uninhibited behaviour, interpersonal problems.

Psychological problems: emotional expression, self-acceptance, personality functioning.

Many patients describe feelings of being in the way and feelings that death might be a more dignified option; denial of any deficit also takes place as well as denial of any thoughts or emotions pertaining towards being neurologically impaired.

Occupational Loss

The neurological losses that head-injured people experience have a profound impact on their ability to return to the occupation that was pre-morbidly maintained. The client is not able to work adequately and effectively if the above-mentioned skills are not sufficient (Gronwall et al., 1990), thus head injury affects readjustment to return to work. We frequently define and relate to a person in terms of the occupation maintained. Certain status or non-status is attached to certain occupations. A person's self-worth cannot easily be separated from the working environment since individual feedback is received from colleagues\clients\managers, etc. Now the client is disconnected from that feedback loop, and the self has difficulty in returning to the self-referential feedback loop. If the client returns to work too soon, there will be at best a loss of job satisfaction, while, at worst, the person's position at work will deteriorate and lead to termination of the role at work. It is a demoralising fact that most clients in the rehabilitation ward of a hospital will not recover well enough to return to work since they do not regain the mental and physical skills needed to function in employment. The feedback loop maintained is that the client is worthless and inadequate because of the loss of the occupation.

Self-concept

We all have a self-concept constructed in dialogue with others - a picture of the type of person we are. In this thesis I will call this the "self-concept". It is suspected that it takes a long time for this image to change after head injury. Clients frequently do not see themselves as disabled. They consider themselves as having had a minor setback. This is the image

before the sustaining of the head injury. Those around the patient, including relatives, treat the person as a patient, contrary to the old way of behaving towards the person. The interaction between the person who has sustained brain injury and others is disrupted. Because of the change in physical and psychological appearances, the client may experience a loss of self-assuredness. Certain losses are evident after a head injury, namely loss of independence, loss of the ability to predict a situation, loss of bodily identity, loss of coping and adapting mechanisms, and loss of material and physical entities (De la Porte, 1988; McCabe & Green, 1987). The most basic losses the patient experiences are the loss of control and the loss of interactional predictability. This fact is often reflected by, for example, not allowing the client to have a cheque book or not allowing the client to make any decision about the daily schedule or program. A change in perception interrupts the inner dialogue about the self, which is co-constructed by interaction. This drastic change in life circumstance would, under normal conditions, prompt the person to re-evaluate and even change the self-concept. Nevertheless, the question is whether brain injury compromises this capacity to self-change. Lezak (1978) reports that as the severity of the organic damage increases, so the capacity for self-awareness and accurate self-appreciation decreases. Severe brain trauma victims are only vaguely aware of their own deficiencies. The physical self sometimes changes unrecognisably and the dialogue is lost. The client frequently cannot understand given information and the body does not or cannot respond to commands, thus such clients enhance a negative self dialogue.

In a case study, Dodd (1975) describes how the person in the study obtained a changed perception of himself after undergoing drastic changes as a result of brain injury, which changed many of his intact functions. He feels like an object and not an intact person. Fouche's (1996) study describes the voiced feelings and experiences concerning the losses the patients have experienced following head injury. It should be kept in mind that Fouche's study was done in the same context as the current study, and that the significance of Fouche's study should not be underestimated as it is relevant to the patients that are currently in rehabilitation. Feelings of being in the way and feeling that death might be a more dignified option, denials of any deficiencies or any thoughts or emotions indicating neurological impairment are voiced by some of the patients, who also voice feelings of being "secondhand".

Different reactions to being treated as a patient are evident. Some patients experience sadness and aggression towards people who are treating them differently from the way they treated them before; these persons are subsequently ignored. Agitation and uneasiness are frequent manifestations of helplessness for these patients. Another patient describes how he is less assertive and has less self confidence; another client claims that she is more emotional, weepy and isolated. Gross, Klag and Munk (1987) report in their paper that very few brain-injured people are reflective enough to express the changes that they have undergone since the brain injury. One patient describes it as follows: "Ever since my injury I have been missing myself" (p.1). It is evident from these words that although it might not be expressed as clearly, the need to regain a sense of selfhood is evident. In a case study by the above-mentioned authors, it has been found that the constant emphasis of the environment on fragments of his behaviour and not on the wholeness of his being ignores the manifestations of the person's expression and his existence as an integrated individual. His behaviour, which is quite aggressive, is unacceptable and therefore his internal experience is one of being rejected. His feelings and emotions are devaluated and have made him doubt his own experiences and emotions.

It seems as if persons suffering from head injury have lost the previous construction of the self and have difficulty adapting to the new construction. Integration of the new and the old does not take place sufficiently and a depressed state is a logical part of the feedback process. Gross and Schutz (1984) express the opinion that brain injury produces a discontinuity between the individual's "pre-injury lifestyle and their present situation. The individual is continuously confronted with powerful evidence of this discontinuity in the ways she confronts everyday events: tasks that were relatively easy premorbidly have become unmanageable after the injury" (p.1).

Family

The impact of brain injury is just as great on the family as on the individual . It confuses the present, distorts the future, and negates the past. From a systemic perspective, it should be pointed out that the whole is always more than the sum of the parts; thus, a family is much

more than the individual members. The system's balance is disrupted by head injury (Jacobs, 1989). The family goes through a grieving period, and in many instances the person with a head injury is not the same again. Stuart (1997) describes the certain phases that the family experiences after head injury. The first phase is characterised by a replacement of reality by fantasy. It is explained as an adaptive response to an incomplete mourning process. The family often expects the client to come out of the coma intact with no deficits. Verbal refusals manifest, for example, explaining the client's uninhibited temper by saying that he or she has always had a temper. The family also defends the client's normality to the outside world. This denial of change may also manifest in behavioural responses, such as expecting the client to drive. Romano (1974) describes the so-called denial phase as indicated by the above-mentioned verbal refusals, fantasies and inappropriate responses.

This period is followed by anger, which, in some cases, is directed towards the client. The claim is often that the client would improve if only he or she would make a valiant effort. Subsequently guilt concerning pushing the client who has already suffered so much follows. Anger might be directed at the nursing staff, or alternative opinions might be sought in order to make the prognosis more favourable. The next phase is characterised by overprotection. The family realises that certain deficiencies are present and takes over those functions that the client has often regained at rehabilitation. The reality of the person with a head injury is that the relationships are often unchanged with other people; the role of rehabilitation is to refer to the changes in relationships that occur and to connect them to the whole. This may often mean confronting the family and client with the physiological damage that has been sustained. The family may suffer considerable distress in coping with the traumatic event of brain injury. The family experiences emotional abandonment as the client cannot provide emotional support and reassurance.

The family routine often has to be changed in order to fit in with coping with the client. Everyday tasks, such as dressing oneself, driving a car, and planning financially, are sometimes not possible. This increases the responsibility of the family members and reduces the role of the client to that of dependant. This role is often met with aggression and frustration (McNeny, 1990).

Lezak (1988) states that the client's emotional dependency is more exhausting than the physical dependency; patients relate to the caretaker much as a young child would relate to the caregiver. The caretaker is often exhausted, as those that usually give comfort are no longer around because of the social abandonment that takes place (Lezak, 1988). Some families experience the injury as a challenge, while others are merely devastated by the change. Tyerman's conclusions (in Rose & Johnson, 1996) derived from follow-up studies, indicate that families that have suffered traumatic brain injury are less cohesive, more prone to conflict, show signs of increased enmeshment, and are less socially interactive.

The injured person tends to contribute on a decreased level with regard to social, parental, and other practical roles. The void in roles is filled by other family members. McCabe and Green (1987) have found that 40% of the family members of head-injured clients became what is pathologised as depressed, one month post injury. This is the fourth phase that is described by Stuart (1997) as the depressed state and it may continue for as long as two years after the injury has occurred. The family members are confronted with a change in the interactional pattern and have difficulty adapting to this second-order change which has been inflicted upon the system. As most head-injured patients are male and frequently the primary breadwinner, the adaptation to the void in this role sometimes evokes frustration and aggression in family members. They are uncertain as to how the medical bills will be paid and how they will survive financially. The family is frequently expected to nurse the patient at home. Oliver (1983) mentions that the family members often feel guilty and feel that they do not render enough support. The family itself may become isolated and frustrated because of the intense re-socialising that takes place.

In Fouche's (1996) study, one patient expresses that his parental figures are behaving differently towards him; the one parent highlights the differences between him and his brother by referring to the client as "nothing" and "stupid". He manifests with the perception that his parents are constantly whispering about him. Some clients experience their mothers as overprotective. Some siblings became negative towards the client because of the altered attention. Families frequently do not understand the cognitive processes or logic that the clients manifest, yet they notice that the patient is not the same and that behaviour is unpredictable or that absence is often evident with regard to social interaction.

The most demoralising aspects of loss of neuropsychological function are accepting that the interactional appeal that the person once had is changed forever. The person that once was, is gone. This aspect is very difficult to accept since the same physical and some of the same behavioural appearances are present. The literature (Gronwall et al., 1990) is of the opinion that acceptance of these losses is the key to adapting to the new life for the neurologically dysfunctional person. But how does acceptance play a role in the change from independence to dependence? Tyerman (in Rose & Johnson, 1996) describes how the client experiences loss of independence which stems from “a combination of physical, sensory, cognitive and personality changes” (p.98). The client has lost the ability in many cases to claim mobility, planning and motivation. It is difficult for the family to adapt to this new person living in their home, who appears to be the same person, but whose behaviour is unexpectedly different.

The position of the client changes in the family. A client that might have been the cornerstone of stability of a family could suddenly be evicted from this position after brain injury. Family members need to understand the client’s new, and often strange, mental changes. Characteristics that might be part of the new repertoire are irritability, self-centredness, impulsive behaviour, and even apathy (Lezak, 1995). The family goes through emotional strain as the client struggles to maintain the previously held position. It seems as if information carries a lot of weight in the rehabilitation process; the client and family have to know what the implications of the injury are. It should be kept in mind that the client is confronted with a period of loss, thus mourning takes place for the life story without the brain damage.

The Partner

The client is often a parent or a spouse\partner. There may be a critical attitude towards the spouse's management of the situation. The main source of criticism is often the injured person’s family. The process between the couple has changed after the accident which undeniably influences the meaning of the interaction patterns. The wife’s role may change from an independent supporter to caregiver. The injured husband’s role may change from breadwinner to a dependent, aggressive patient. Tyerman (in Rose & Johnson, 1996) states

that the couple may have lost shared activities, for example, walking, sport and dancing which previously constituted the so-called glue that made them a couple (Tyerman, 1996). The uninjured partner of the head-injured person perceives the pattern of the relationship as changed since the responsibility for the relationship changes. The relationship bears more resemblance to a child/parent relationship than that of two people in an adult relationship. Thus the head-injured husbands become more self-orientated and dependent, and the role of husband is lost. A wife reports that she handles her husband as if he is one of the children and that he demonstrates "sibling rivalry" when she does not give him more attention than the children. Brooks (1984) states that numerous studies indicate that the situation following head injury is frequently worse for the wife of a brain-injured husband than for the mother of a brain-injured son. The reason is that as a mother the mothering role is merely intensified, whereas with the wife the role change is radical, and even foreign to the wife. The relationship is frequently filled with tension and unrewarding uselessness. In Allen, Linn, Gutierrez and Willer's (1994) study, it was found that individuals with traumatic brain injury and their spouses manifest elements of depression and anxiety, six years post injury. In Fouche's (1996) study, a client expressed his uncertainty about his relationship with his spouse, although it should be noted that another married client found that the traumatic event stabilised his conflict-ridden marriage. Lezak (1988) claims that brain damage often prolongs the unsatisfactory marriage because of the fear of guilt and social rejection. Yet a change in roles almost always takes place. The client often fears further abandonment, and in some cases follows the partner around, almost tracing the partner's footsteps in order to keep the partner's attention and affection. The balance in the relationship is changed, thus the more the client clings, the more obvious the partner's impatience and intolerance towards the behaviour becomes, and the more frantic the client becomes in keeping the partner under control and close at hand (Lezak, 1988). One spouse describes the client's role as one that evolved from "the pillar of strength", the stable, secure role, to a dependent, unsure role.

Brooks (1991) reports that the wives often feel that the disability is a social handicap; role shifts subsequently take place including the change from a sexual partner to handling matters outside the home. The wife's experience is described as traumatic and emotionally laden. Feelings of confusion, fear and uncertainty are common. The partner usually

becomes the target of the client's feelings of fear and anger; thus, verbal and even physical abuse is often found in these relationships. For many relationships the disengagement between partners often results in divorce or separation as the disorganisation is too devastating for the relationship. Tate, Lulham, Broe, Strettles, and Pfaff (1989) have found that of 31 patients married at the time of the injury, 17 divorced within six years.

Sexual Life

In Tyerman's (in Rose & Johnson, 1996) longitudinal study which focuses on eight couples' relationships after head injury, it was found that only three couples had resumed former sexual relations, four couples experienced less satisfaction with their sexual relationship, and one couple still had to resume their sexual life. The couples blamed the head injury for the discontinuance of the past sexual relationships. Tyerman describes how sexual difficulties are attributed to an interplay between physical, interpersonal and social factors. Sexual dysfunction is evident in some clients with frontal lobe injury. Griffith, Cole and Cole (1990) are of the opinion that sexual dysfunction can be attributed to psychological reactions to the injury which have to do with the self-image. If the construction of the self is at risk, the construction of the self as a sexual being is directly implicated. Lezak (1988) states that the client may have lost the empathic sensitivity necessary to make sex mutually satisfying. Brooks (1991) has found that some spouses feel less affectionate towards their injured husbands. Sexuality is about communication - the most important sexual organ can said to be the brain since it regulates motor function. If the so-called control centre is damaged, there will be difficulty with libido control. This will entail a decrease or increase in the libido. Sexuality might also be expressed inappropriately. "Sexually impulsive patients are at best a nuisance; at worst a constant worry" (Lezak, 1988, p.115). Sexual apathy can be attributed to thalamus and frontal lobe damage whereas hypersexuality can be attributed to damage to the hypothalamus and temporal lobes. Apathy does not cause social problems as does hypersexually, but causes problems in a relationship. Anti-convulsants such as Tegretol might result in long-term sexual problems such as impotence. Changes in the body enhance changes in the self-concept (Kok, 1997).

The sexuality of the client can be disturbed because of numerous changes. Impotence

occurs quite commonly and is not easily spoken about by the client. Lezak (1988) states that these clients often describe paranoia in terms of their spouse's fidelity. Feelings of worthlessness arise with sexual incompetence, and the perception develops that they are no longer attractive to their partners. Accusations are frequently thrown at partners and their every move has to be accounted for with fanatical precision. Thus the client loses trust in the relationship which is the most significant.

The Role as Parent

As a parent, the interactional appeal is to regulate the behaviour of the children - after head injury, the parent's own behaviour is often socially inappropriate. Gronwall et al. (1990) give the example of laughing at the wrong time; subsequently roles are changed as the children monitor the parent. Avoidant behaviour starts to manifest from both parent and child. The child is often embarrassed or uncertain as to how to handle the parent's erratic behaviour. The parent is treated like a child because the behaviour, from the child's perspective, doesn't warrant parent-like responses since the function of the parent cannot be fulfilled.

The stresses of a parent of a brain-injured minor differ somewhat, according to Lezak (1988). These parents realise that they will never again have the freedom, even in their later years to enjoy, for instance, retirement. The other siblings may struggle for attention from the mother who is usually the caregiver. Marital conflict arises from disagreement as to caring for the disabled child. The spouse of the primary caregiver may feel neglected and many of these marriages end in divorce.

Social Losses

The social effect of severe head injury is sometimes devastating and manifests in the client's choice to exclude the self from social interaction. In the period after the accident, relatives and friends frequently visit the client. As soon as the life-threatening phase has passed and the realisation is gained that the person's interactional appeal has changed, possibly forever, these visits tend to become few and far between. The interactional shifts

become more evident. Tyerman (in Rose & Johnson, 1996) explains that the social system “may find the person’s conversation less rewarding due to repetition, preoccupation with a few topics or impoverished content. They may be embarrassed by the person’s physical disability, cognitive failures or lack of refinement in social skills” (p.99). It can be said that these clients demonstrate difficulty in appreciating the social requirements of certain contexts. Lezak (1988) states that the client may display a childlike egocentricity. This means that self-centredness becomes the order of the day, and that others are not experienced as subjects in their own right.

Few friends and family members can adapt to such changes in companionship. According to Tyerman (in Rose & Johnson, 1996), the social isolation is a major disruption or change for the person with brain injury. An active social life is often denied the person due to lack of confidence, difficulty with language, misunderstanding, and low tolerance of noise. A fear of rejection possibly exists as it remains quite difficult and sometimes impossible to make new friends. The client seems disinterested in social interaction and demotivated to put in an effort to socialise. Chance (1986) has found, in a Los Angeles study, that most head-injured people lead isolated lives that consist of watching television, sleeping, or just sitting. It is of vital importance that the patient still receives the feedback from the community which will form a positive self-concept. Fouche’s (1996) study brought to light that the client’s emotional states are in interaction with the feedback that is received. One client feels sad about the way his parents treat him. He feels isolated and longs for this isolation to be broken; he has the perception that people just do not care and that it is easy for them to disregard him. He experiences aggression and frustration because of the context that he finds himself in. The loss that seems to punctuate his interactions is that he has lost his worth as a human being and that utter dependency will be the end result. Sometimes it is necessary for the client to accommodate people to such an extent that he denies his own feelings. According to Lezak (1978), the interpersonal systems with which the person is involved are likely to have changed.

Religious Experience

The head-injured client often experiences a religious crisis after the accident. Patients often

manifest with existential questions, for example "Why did God allow me to live?" and "Am I being punished?". Denial of an all powerful being is often the client's reaction or rather solution to all these questions. An entrenchment in religion is also a common phenomenon as it is the only relationship that is all accepting and not a manifestation of further rejection like the other relationships that the client is exposed to. In Fouche's (1996) study, one of the clients in the rehabilitation ward describes how she struggles to think religiously; she cannot feel her spiritual side anymore. Most clients explain that they feel grateful for being alive and that the religious relationship motivates and supports them.

Conclusions of Loss

A main theme of the narratives of head-injured patients, is the loss of independence, the loss of roles, and the loss of previous interactions. A common idea is that a loss of vitality is experienced, which snowballs into uncertainty and insufficiency in obtaining certain goals and therefore becomes part of the client's daily struggle.

The losses that are experienced differ from person to person. Stuart (1997) explains that certain determinants affect the impact of the brain trauma. Yet it is difficult to distinguish between those behavioural and emotional expressions that are a result of the injury and those that are a manifestation of the client's reaction to the losses that are experienced. The first is the stage of the family life cycle. An example is that some families are still young and often do not have the resources to cope with head injury. The second determinant is "Who is the patient?", in other words, what is the role of the patient in the family? This refers to the impact of the loss of a breadwinner compared to the impact of injury on a young child.

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It is evident that the behaviour of persons with head injury often arouses negative reactions from all significant others. Clients experience all these losses as "fatiguing, embarrassing, frustrating and even frightening; and react with anxiety, irritability, bewilderment, or social withdrawal" (Lezak, 1988, p.112).

The clients evidently show some reactions in response to the losses that are experienced. These losses may be overtly physical or a more subtle loss of mental efficiency. Clients may not fully comprehend the process of loss; they are aware that they cannot perform as well as before the head injury, but are frequently unclear about the depth and nature of the losses. Thus the reactions of clients will not always be understood as their misinterpretations enhance our misinterpretations of their reactions.

I found it necessary to describe the mentioned losses that clients suffer following neuropsychological damage by means of case studies. The losses that the clients suffer are more real and imaginable to the reader and a sense of participation can be derived through these descriptions.

Case Studies

“Now its time to say goodbye, and it’s forced upon you. Just this person remaining by your side, suddenly distant.

Now the winter’s growing cold, the day is growing older. I can tell by the look of your face its all getting slower. There’s no light at the beginning, let’s all sit down and cry.”

This Mortal Coil

Mr T

Mr T was admitted on the 9th of October 1996 after a motor vehicle accident on a highway. He had a large bruise and laceration over the right eye and had a Glasgow Coma Scale of 6 out of 15 at the site of the accident. He was intubed, ventilated, paralysed and taken to the theatre. The CT-scan showed brain-swelling and intra-cerebral bleeding. A tracheostomy was administered; he manifested right hemiparesis. He was in a comatose state for 17 days.

I first met Mr T in the office of the occupational therapist, eight months after the accident. He seemed very assertive. He had been a lecturer in mechanical engineering at

a college and had won the award for best lecturer for 1996. When asked to explain how he had ended up at the neurological ward in front of ten psychology students, he did not seem anxious or upset in any way. He did admit to the group that he exhibited some aggression towards his wife and son. He described howt he was often verbally abusive towards his wife and fought over unreasonable issues. He fought with his five-year-old son about the noise that he made in the house and about his slow response. The head nurse also complained of aggressive behaviour towards her. Thus it was evident that the damage was diffuse. In therapy we discussed these issues. In an almost self-advisory capacity, he suggested that people should be more submissive if confronted and that he would be more tolerant. I explained to him that the frontal lesion might be a good explanation for this uninhibited aggression. He seemed to understand the implication of these words. It bothered me that he seemed so compliant towards me and that others described him as aggressive. Mr T described his despondence at his wife treating him like a child on the recommendation of his neurologist.

Before the accident, Mr T and his wife had discussed divorce, but the accident interrupted these proceedings. His aggression towards his wife was reframed as an attempt to regain control over his world. Mr T's wife took control of their financial situation, managing the third party claims and policies that were taken out. Financially, Mr T could not negotiate with the different organisations. He seemed adamant about returning to his post as lecturer; evidently this would not be possible in the near future as the injury entailed that his visuo-spatial abilities were affected. As a lecturer in a mechanical engineering course it was evident that his functioning was disabled in this area of expertise.

After having tested Mr T's memory with the Wechsler Memory Scale - revised, I realised that Mr T was compensating by interactionally manifesting with assertiveness and an "all is well" attitude. The tests proved that his memory was severely impaired, but that he had developed certain techniques to give the illusion of coping. He would, for instance, make up words in the memory test or say that he had not been concentrating. When I gave Mr. T my understanding of what he was doing, I could see that he understood and did not even try to hide it anymore.

Neuropsychological Tests

The Rey complex figure

The bicycle drawing test

Coding test

Wechsler Memory Scale

Trail making test

The test results confirmed that Mr T had suffered diffuse brain damage. He had problems in structuring information, and memory problems; abstract ideas would evade him and he also had auditory and perceptual problems. He was thinking very concretely and new information made him confused and was overwhelming. Visuo-spatially, he manifested with severe deficiencies - this worried me as this function was important for him to continue his former occupation.

Mr. T's Wife and Child

During a meeting between the neurological rehabilitation team and Mr T's wife, she expressed her gratitude towards the team for relieving her of so much responsibility. Mr. T's behaviour had drained her emotionally; she had to report every move that she made and found it difficult to give in to Mr T's increasingly demanding behaviour. It was clear that Mr T was fearing abandonment and that even the attention that his wife gave their son was, in his eyes, a manifestation or rather a token of her abandonment of him. A type of sibling rivalry scenario started to play out at home.

Mr T's son drew pictures of the family where the male in the picture was drawn with arms extended, dominating the whole picture. The other two figures in the picture were drawn without any arms, with a small gestalt in comparison with the male figure. The male figure also had threatening teeth.

Mr J

Mr J was a sergeant-major in the air force and he was 49 years of age. He had always been held in high regard as he was an organiser and natural leader. He was also deployed during the Angola war and thus could be described as a capable soldier. His visits to his home environment were few; it could be said that, as a professional soldier, his family life was not an aspect of his life that claimed his time.

One evening in October 1996 after a party, another car skipped a stop street while Mr J's wife was driving them home. Mr J was in a coma for six days. He suffered intra-cerebral and intra-ventricular bleeding, subarachnoid bleeding, brain oedema, and contusion at the left temporal area. He manifested with bi-frontal hygromata and bi-tempo-parietal subarachnoid haemorrhage. He was very emotional, yet awake, but did not speak and ignored family members. Mr J had never been sick before and the family - his wife and daughter - did not know what to do. He became restless, but at least began talking again; yet his sleepiness and disorientation inhibited any real interaction. After a while in the acute ward, there seemed to be a slight recovery. He kept his "pose" well, according to the speech therapist, although his behaviour was still inappropriate as he would often talk about the death of his in-laws that had taken place a few months before. He had problems with reasoning, abstract thoughts and short-term memory. Mr J was sent home the following month to enhance his orientation. His disorientation did not seem to stabilise. He was sent to psychiatry because of the persistence in disorientation and was subsequently put on medication. It was requested that the family sign a consent form to have Mr J committed to a psychiatric hospital. His wife refused and tried to cope with him at home. In 1997, on different medication and with the situation improved, he was admitted to the rehabilitation ward. Our first meeting was clouded by Mr J's disorientation and repeated referrals to the deaths of his in-laws.

Neuropsychological Tests

The Rey complex figure

The bicycle drawing test

Wechsler Memory test - revised

Trail making test

Mazes test

Auditory verbal learning test

Mr J showed problems with regards to mechanical reasoning. He could not spatially succeed in orientating his drawings and it could be derived from the tests that he had trouble with perceptual organisation and visual memory. The bicycle drawing indicated that he had difficulty in visuographic functioning. He had difficulty in learning something new and manifested with extreme memory problems. He found it difficult to obtain a strategy to learn concepts. Concentration played an important role in Mr J's low test performance. He would often confuse concepts and manifested with motor coordination problems. On a basic level he would find it difficult to remember my name and to keep appointments. He was quiet and seemed lost in confusion. His stories about his life did not make sense and one always had to recheck with his wife or the ward personnel to see if his facts were correct. He was isolated in the ward and seemed to choose not to relate interactionally. The therapists perceived him as non-cooperative, a lost case, if you will.

Mr J's wife gave an account of her interactional experience after the accident:

"J was baie aggressief teenoor my. Hy sou my partykeer heeltemal ignoreer. As ek vir hom kos of koeldrank gee het hy dit onaangeraak. Wanneer ek by 'n vertrek inkom het hy uitgeloop. Wanneer ons gestap het, het hy tien meter agter my geloop, wanneer ek stop om te kyk waar hy is het hy ook gestop. Dit het my onsettend ontstel. Dit het vir my gevoel asof hy my verkwalik vir wat met hom gebeur het. By tye het hy my glad nie herken nie en vir my gevra waar sy vrou is. As ek vir hom sê dat dit ek is, dan sê hy net nee. Ek het my meer en meer onttrek van hom en het liewers met die honde gespeel of in die tuin gewerk, sodoende het die seer in my bietjie stil geword."

Mr M

Mr M was a 30-year-old warden at correctional services where he had been for the past eight years. He was married and enjoyed his job. He described himself as outgoing and as a leader of some sort. His wife described him as intellectual and sometimes argumentative.

He has ten brothers and sisters. The marriage was good and they had one daughter. He enjoyed soccer and liked playing with his daughter.

During December of 1996, he was in a severe motor accident on his way home from work. He was diagnosed with a septic head laceration (occipital area), brain oedema, and concussion. I was requested by the nursing staff at the acute neuro-ward to focus on Mr. M's extreme aggression towards the nursing staff. He was disorientated, walked around, and laughed inappropriately. The neurologist wanted to know if this extreme aggression was because of a psychiatric disorder or because of the head injury. Mr M would not let anyone near him and fought with his wife each time she came for a visit. After about one month, Mr M was sent home to become orientated in a familiar context where everything was structured according to his needs. His wife was apprehensive about taking him home as she was uncertain as to what was expected of her. A general practitioner called me to ask again if a psychiatric disorder should not be considered, as Mr M was very aggressive towards his wife and relatives. I attributed his behaviour to the head injury and pleaded for tolerance towards him. During February of 1997, he was admitted to the rehabilitation ward. He was convinced that he was being punished for a crime he had not committed and had subsequently been put in jail. The nursing staff explained to him for hours where he was and what had happened to him. Mr M acknowledged that there had been an accident, but denied the extent of the head injury. His wife was suddenly accused of adultery and witchcraft. It seemed as if everything in his life was infiltrated by uncertainty, ambivalence and aggression. People did not know how to relate to him anymore. A moment in time and his life was changed forever.

Neuropsychological Tests

Eye tracking test

Bicycle drawing test

Digits forward and backwards

Letter cancellation test

Token test

Auditory verbal learning test

Mr M had the tendency to focus on great detail; he would rather take longer to complete a task than to be imperfect in the completion. Mr M showed problems with regard to concentration, memory, and logical reasoning.

The illustrations in the case studies all have loss in common. These men have all suffered closed head injury which in an instant changed their lives forever. The clients were trapped in different lives than what they were used to, a life of confusion and misunderstanding. They were the ones that could not express themselves in relationships, sufficiently. I found it sometimes hard to understand or even just to communicate with them as language was in many cases not the consensual domain between us.

CHAPTER 3

FROM DEPRESSION TO EXPRESSION - THE USE OF ART IN THERAPY

Introduction

This chapter will focus on the use of art in therapy. Various schools of therapy use the concept of art in therapy and the motivation for using art within these different approaches will form the backdrop to this chapter.

The Meaning of Art through the Ages

Firstly, it is important to focus on the development of art throughout the ages. The concept of art has been with humankind from the very early ages. This can be seen from the artefacts of ancient civilisations. Cave paintings are among the first artefacts that can be regarded as visual art. In Cro-Magnon cave paintings, animals are characterised clearly by horns, tusks and other features. Animals are depicted individually and schematically (Kramer, 1992). Symbolic expression has been used in ritual, myth and the arts throughout history. Symbolic expression has long been the translation of human experience. Art has been a topic of discussion for as long as there has been human cognition - from cave-paintings, through Egyptian art, late Baroque art, during the 18th and 19th century genres, until now.

The aesthetic component of art is founded in 18th century romanticism. Greco-Roman ideals of classicism, rationality, logic, and structure were rebuffed, with the focus shifting to more emotionally laden forms of expression. The emotional aspect of art drew its meaning from the presumed chaotic, magical inner world of the psyche. It was thought that the purest

uncontaminated emotions flowed in this magical untouchable part of the human psyche (Cardinal, 1972).

Artists of the 18th century focused on these romantic notions and threw themselves into a world of altered mind states that sought to mimic psychotic ideation and affective processes. These psychotic states were sought to intensify the artists' perception (MacGregor, 1989). The ideation of the insane genius was portrayed in various movements in art, from post-impressionism as seen in the work of Van Gogh and Rodin, to the surrealists such as Dali, and to the new expressionists like Jackson Pollock. The dance between madness and aesthetic purity was entwined (Henley, 1992).

Two Frenchmen, Tardieu and Simon, focused on the illustration of madness between 1872 and 1876. This means that the portraits of patients were given an aesthetic appreciation. The art works of patients were appreciated from the end of the 19th century. Three major developments contributed towards this appreciation.

In the first place Humanism began to emerge in the treatment of patients; the patient as a person was regarded as valuable. The second development was that expression was placed in high esteem through the development of modern art. An attempt was made to understand the work of patients in psychiatric institutions.

Thirdly, the theory of symbolic meaning evolved with Freud, putting the thematic and dynamic explanation of art work in the limelight. Breton expanded the idea that the mind should be made transparent through an absence of control exercised by reason (Busuttil, 1990).

The Importance of the Psychodynamic Contribution

A contrasting view was developed by Kris (1952) who maintained that it was important to control the ego in order to lend quality to imaginings. Psychodynamic thinkers such as Freud, Jung, Prinzhorn, and others utilised art therapy in exploring the personality, known to us as projective techniques (Busuttil, 1990).

It is clear that most descriptions of art in therapy are provided by psychodynamic thinkers as

they first applied it to psychodynamic processes. Virtually all art therapy is based in some variation on psychoanalytic thought (Allen, 1988).

It is believed that art therapy helps patients to sublimate energies into productive, socially acceptable channels. Thoughts, attitudes and feelings that are usually concealed are expressed (Mango & Richman, 1990).

Ego psychology, equally a concept of psychodynamism, addresses the patient's capacity for adaptation, reality testing, and defences in dealing with an acceptable integration of inner and outer realities. Object relations theory describes the enactment of internal drama derived from childhood (Dunne, 1993).

A Jungian art therapist will focus on the symbolic archetype that could manifest in the painting or the art work. Cultural symbols and innate signals become part of the therapist's focus and interpretation (Kramer, 1992). The existential perspective integrates art into therapy. It provides the therapist with the opportunity to experience the emotional climate of the client. The therapist becomes sensitive to his or her own reactions to these emotions.

Art and artistic expression have been understood to be a way of entering the unconscious mind. Existentialists utilise art and artistic expression for the purpose of discovering and actualising the meanings of the individual, couple or family (Lantz & Alford, 1995).

It seems that the interest in creative art therapy has developed over a short time. The benefits gained from the use of art in healing are still in the process of emerging. Warren (1993) suggests that individuals exercising their right to express themselves creatively exhibit signs of mental health. Unfortunately our society has isolated the arts from the individual. The arts belong to a few gifted individuals. The use of art in therapy indicates a move away from this perspective.

A Systemic View

The question is, where does that leave systemic thinkers with regard to art therapy? The challenge is to move away from the illness or psychopathology movement that seems to go hand in hand with art therapy. The emphasis from a systemic view is on the process that takes place

when art is introduced in therapy. The view that stresses the normalising aspect of art therapy is appreciated. This may be viewed as a part of second-order cybernetics, incorporating illumination of the observer's stance, externalising, narrating, and re-authoring. Refuge is taken from diagnosing and categorising, as drawing has been used extensively as a diagnostic instrument in the process of various therapeutic techniques.

The assumption from a diagnostic perspective is that the artist can be known and his or her emotions can be viewed by indexing the colour, form and content of the work. The symbolic content will give rise to an analysis of the artist and at times a diagnosis can be formulated. The context in which artwork is made is thus easily negated, which, to my mind would be punctuated by a systemic description.

There are many different underlying assumptions about art therapy from a systemic point of view. Kramer (1974) values the therapeutic process that art evokes. The systemic therapist's task is to integrate the client's manual, intellectual, imaginative, and emotional factors. Ulman (1974) focuses on art as the motivation for reorganising the client's world. From this point of view, art is viewed as "therapeutic procedures, as those designed to assist favourable changes in personality, or in living that will outlast the session itself" (Ulman, 1974, p.14). The self-motivation of the client must be exposed, as well as the client's longing to organise his or her experience and understanding thereof. Kwiatkowska (1975) underscores the theoretical principle that art is important in relationships and exploration of cultures, experiences and needs.

Historically speaking, systemic orientated therapists have always used art in therapy. Genograms have always been used as a way to join in the process of therapy with their clients. The genogram is used to map the hierarchy in the family and the structure of the family through questions, observations of family sculptures, and verbal or other art expression (Minuchin, 1974). The concept of reframing, on the other hand, can be utilised in a different way, using art expression as a way of introducing news of difference. In this way lineal punctuation is transformed into circular reciprocity, since a dialogue between therapist and client is enhanced.

The healing power of drawing in systemic therapy cannot be denied as it is an expression of the self towards understanding and experiencing the self in context with other systems. In many societies, art, as a ritual, has the power to heal, protect and balance the world, or to engender growth.

The interactional perspective values the therapeutic impact of the use of art, as it allows the client to explore and organise his or her inner world. This allows the inner world to be expressed in a concrete manner. The perception of the client with respect to his or her position and role in the family, workplace, or even ward system can be explored, as interaction is facilitated between therapist and client (Kymissis & Khanna, 1992).

The assessment of change can be facilitated through the use of drawing as the drawing is a visible way of showing change or of setting a forum for the discussion of change. Perceptions about the present, past and future are readily available by means of the visual reproduction of the client's and therapist's perceptions. Arrington (1991) describes the basic task of systemically orientated art therapists as addressing the relationships in which the clients are involved. This implies that culture, experiences and needs are expressed through art. A second task of the therapist is to - through art - facilitate a space within which inner chaos or disorganisation can be organised into a coherent form. Healing is thus facilitated.

Family therapists often also use drawings as a diagnostic tool. Drawings illustrate wishes and fears and illustrate that which is hidden. Drawings make the covert overt. Interaction is facilitated among the various family members, communication is enhanced, and the family system is aided in improving its organisation (Kymissis & Khanna, 1992).

Art as Ritual

Drawing has been used as a healing method by various cultures and religions. Most major religious traditions have come to recognise the value of looking at art to become aware of a deeper level of being or a different awareness (Lantz & Alford, 1995).

The old Indian Navajo religion makes use of sand paintings to establish contact between individual and spiritual entities. Their religion is a design focused on harmony between man and nature. Navajo spiritual practitioners utilise art to help the worshipper become more aware of various meanings and possibilities in life.

The Navajo religion also makes use of sand paintings as sacred objects to assist in healing the

sick. A sand painting is “a picture of a scene in the life of the Holy Ones, made on the floor of the ceremonial house by sprinkling dry sands coloured with natural pigments. The sand painting is an altar composed of the representations of divinity” (Reichard, 1977, p. ix).

A person sits on the sand painting and is treated by the medicine man who applies sacred paraphernalia accompanied by chants and songs. The medicine man then becomes the god, sharing its powers. The person may undergo what we call a ritual. The sand painting is a metaphor or rather personification of the Holy Ones. “Parts of their bodies in the form of the sand paintings are applied to the patient’s body, after the chant the patient spends four days absorbing the power which was brought” (Reichard, 1977, p.19).

This ritual forms an important part of the healing of the troubled person. Most of the sand of the painting is stored under the person’s bed. There it will not be disturbed. The sand painting is one of the most unusual healing rituals. It indicates that spirituality and healing are perceived as linked by painting and ritual. The holistic view that man, nature and spirituality are linked is depicted in this ritual.

Meaning

A dualistic view began to emerge as Western civilisation developed. Phenomena had to be explained scientifically and healing was approached from a scientific stance. The traditional aim of therapy is to alleviate symptoms and problematic processes. The therapist classifies problems in order to enhance understanding thereof.

(\ It should be kept in mind, according to Bateson (1972), that the map is not the territory. This indicates that the whole can never be fully known. The conclusion is drawn that a problem can have different meanings. Moreover, a so-called problem can be seen as an opportunity to generate different meanings. The generating of different meanings need not lead to the construction of more complex esoteric maps. Different meanings can be found by “putting the map down long enough to look at the passing scenery, thereby recognising its wholeness and entirety” (McClure, Merril & Russo, 1994, p. 53).

It is therefore important to utilise the more symbolic and abstract processes of art to find creative solutions to undefined problems. It is in the context of systemic theories such as those held by the post-modern movement, and of second-order cybernetic theory that I have decided to utilise the act of drawing in therapy with persons who have sustained neurological damage. Art in therapy also signifies a shift away from the digital and a move away from lineal paradigms to a more analoguous, metaphorical language, or world-view.

The global goal of humankind is frequently situated in the creation and not necessarily discovery of meaning. Prigatano (1991) maintains that the common assumption is that psychotherapy should aid people in clarifying misconstrued perceptions and faulty beliefs about the self. It is also assumed that psychotherapy will aid people in gaining access to thoughts or feelings that are otherwise not available in order to gain greater self-control.

My perception about therapy is that it is an attempt to become aware of the different descriptions of our lives. These descriptions aid in developing different metaphors to facilitate change in patterns and meanings that we attach to those patterns. Our lives consist of stories of failure, victory, confusion, and disillusionment - these are but constructions and are made up of narratives.

The drawings in therapy are metaphorical for the process that is significant during therapy. The major significance of narrations does not lie in their "relative validity", but in their social utility (Friedman, 1993, p.x). It can be said that the observer gives meaning to an object. The implication is that we create meaning rather than focus on the intrinsic meaning of each happening or experience. Wadeson (1980) argues that the construction of meaning is centrally located in psychotherapy and art. Drawing is a form of reproducing visual perception. Visual perception includes the forms and colours we integrate into meaningful experience.

Metaphorical and visual perceptions sometimes incorporate incongruous and subtle detail that could be lost amid verbal dialogue (McClure et al., 1994, p.52). Bruner (1966, p.73) refers to "the shock of recognition" as that quality which allows the individual to understand experiences differently. In other words, a transformation takes place within the client's perspective about what has been expressed.

People who have sustained a traumatic brain injury are frequently excluded from psychotherapy since they are considered not to have the cognitive capacity to change their perceptions of pattern and meaning. For a systemic-minded therapist, the idea of insight is not the focus of therapy. Expression and interaction in the therapeutic context become the focus. My goal becomes the co-construction of the impact of brain injury, the meaning derived from the incident, and the subsequent change in interactional patterns. I avoid fitting the client into a mould or label that immobilises change. The client becomes aware of a different “self-concept” that is co-created in therapy. The language of the client is often affected and this leads to misunderstanding and misinterpretation by the therapist. By drawing and creating art together, a common denominator between the therapist and client is found. A change takes place in the politics of the situation as the client begins to take ownership of the therapeutic process.

Art and/or Science

Bruner (1966, p.74) summarises the interaction between science and art as follows:

(T)he elegant rationality of science and the metaphoric non-rationality of art operate with deeply different grammars, perhaps they even represent a profound complementarity. For in the experience of art, we connect by a grammar of metaphor, one that defies the rational methods of the linguist and the psychologist.

Art and science can be seen as a cybernetic complementarity wherein the aesthetic whole connects the dualistic components. The interaction between art and science as a basis for human behaviour might show us a part of the whole and a clue as to how to approach psychotherapy. It is very difficult to scientifically describe a method of dealing with human suffering. Thus, we have to look towards other methods to complement this approach (Prigatano, 1991).

Traumatic brain injury produces an abrupt change in life. People involved frequently ask existential questions, for instance, “Is life worth living after brain injury?.” In therapy the whole of the person and the context should be taken into account. If the existential question is

addressed in an interactional way, the relationship with the person to his or her context is mirrored.

The therapeutic process includes a focus on the “disordered mind” of the patient. It is necessary to understand the interactional interference that brain injury maintains. This statement integrates interactional and existential paradigms or ways of thought.

The unity, or rather, complementarity of the duality, should be grasped in order to think truly systemically. The goal of therapy in an existential approach would be to answer the question as to how to make life worth living again (Prigatano, 1991). A systemic paradigm would address the issue of how the drastic change of the pattern could incorporate a different meaning to the pattern. Art would include the practical and personal symbols of a meaningful expression, in its introduction to a new meaning of the pattern.

The acceptance of mind-body unity has made it inconceivable that modern psychology does not give sufficient acknowledgement to the nonverbal therapeutic process. Drawing as medium of feedback during psychotherapy is thus the focus of this thesis. Throughout my journey of drawing, I realise that I have granted myself an opportunity to perceive differently. The product created within this journey is an indication of my epistemological world-view (Rhyne, 1973, p. 242).

A different way of seeing can lead to change. Simultaneously, drawing as a creative process can attach a different political frame to therapy since participation by the therapist is required. The focus shifts away from the aesthetic quality of the final product to the process of creating and recursive feedback on it. The goal of this process is heightened awareness of nonverbal messages or perceptions. Irwin (1986) argues that successful therapy is not something that is practised, but rather an intimate process between client and therapist during which both take risks and learn. The therapist’s role changes from controlling to being an equal partner. Manipulation and strategic thinking are put on the back burner as the self is used in therapy.

Rehabilitation of neurologically impaired clients is an individualised process that has to be flexible and progressive throughout the phases of recovery. It can even be said that it is holistic and goal-orientated. The rehabilitation process can take four to six months. According to Goldstein-Roca and Crisafulli (1994), it is important to focus on the needs of the client.

Assessing the patient's immediate concerns should be part of the initial therapeutic process. The assessment should also include the motivation for change, past successful experiences, interests, and hopes for therapy. The client receives an idea of ownership if his or her needs are addressed during the first phase. Information helps the therapist to utilise appropriate art methods and materials. The client will express key issues that the therapist has to recognise. Once the process has begun the therapist focuses on aiding the client in the development of the art work (Allen, 1988). The key issue for the therapist should be sensitivity towards the client's needs and towards the sometimes unverballed issues.

The Participant Observer

According to Anderson and Goolishian (1988), the therapist and client as systems are seen as participant observers. Each participant has a unique experience of what is shared. The therapist and the "problem system" are both subject to change. Change "threatens" the system. This new context seems frightening and it is only by risking mutual conversation that the therapist is permitted to evoke new understandings.

The risks that both the therapist and the "problem system" take are seen symbolically in the drawings that both systems make. The observer may attribute meanings to the image that the artist never saw. "Because of the 'over-determined' character of art, the therapist may see more, or less, or simply a different import from what someone else just as truly sees" (Langer, 1967, p.114).

The belief that there is an objective, generalised truth - as indicated by the positivistic model is questioned by the social constructionist school. This interpretation is derived from the dialogue between entities to facilitate multiple meanings. The existence of reality is also questioned by the constructivist school. Their emphasis is on the incapacity of an individual to know reality on an objective level. The observer is always part of the observed (Keeney, 1983). Thus, the therapist is not able to describe objectively what is observed. Robbins and Erismann (1992) describe therapy as a meeting of two minds taking place. There is an element of both separateness and unity. The utilisation of this dualistic space in creating a context of meaning is the goal of treatment. The client and therapist may attempt to define the self in this space.

The therapist can never extract the self from the therapeutic process. Therapist and client are both involved in the therapeutic process. Reciprocal influencing takes place. The process of creating together serves as a concrete meeting-place for client and therapist. The majority of art therapists believe that art therapy is more effective when combined with verbal therapy. It needs to be emphasised that verbal therapy will form the main focus of this study with the art serving as an evaluation or feedback technique.

Thus the emphasis is on art in therapy and not art as therapy. Verbal communication is important in forming a bridge between the metaphorical and the literal. Many therapists encourage verbalisation about the final product as it leads to two-way communication; art is seen here as a means to an end. A therapist with a strong psychological background will see art as a bridge to verbal dialogue which in turn is traditionally seen as therapy.

Art therapists see art as healing and an enhancement of the therapeutic team's efforts. These two orientations have traditionally been in conflict and the similarities they shared have been ignored. However, the complex dimensions of therapy have to be accepted without negating the contribution of art (Robbins & Erismann, 1992, p.77). It seems as if the description of drawing as method during psychotherapy does not portray the holistic context that should be the aspiration in therapy. Most art therapy models describe drawing in a lineal, causal way. This frequently gives rise to impoverished descriptions that do not consider the whole ecological context.

Phillips (1992) believes that the therapist has to manifest more in the therapeutic process, "bringing more of our own ongoing birth process via creative expression to bear in therapy" (p.295). She argues that a client will benefit more from therapy if the therapist denounces the obstacles of boundaries and roles that, traditionally, have had to be maintained at all costs.

Being involved, together with the client, in the creation of visual perceptions, the therapist's ideas and perspectives play an important part in the process of creating therapeutic art. Phillips (1992) further states that the reason why therapists do not create alongside the client lies in the power basis and distance that have to be maintained. She says a cooperative approach and the therapist's giving of own perspectives show that an encounter has been organised. The power basis that frequently serves as an obstacle to successful therapy is therefore removed.

Co-creation

Edwards (1989) describes a different way of seeing that art encourages: “(Y)ou will delve deeply into a part of your mind too often obscured by the endless details of your life” (p.5). The client and therapist create the opportunity to learn and to discover new and forgotten aspects.

Wadson (1980) describes how she tries to express the ultimate form of empathy by trying to enter the client’s world. She tries to experience the client’s point of view and symbols. At the same time she emphasises the importance of being aware of one’s own way of structuring the world so that “objectivity” or a “standing apart” to reflect on the process developing between client and therapist can be achieved. What she sees ensuing is a “dance between empathy and reflection” (Wadson, 1980, p.33).

It is part of the therapeutic process that the therapist acknowledges her own pain and communicates an emotional availability to the client. The client will feel supported and work through the despair alongside the therapist.

Atmosphere

Atmosphere plays an important role in the therapeutic process. The therapist’s role is to create an atmosphere that enhances communication. In the therapeutic context, the client and therapist have the opportunity to meet by means of art as the common denominator and the means to enhance communication (Dunne, 1993). A non-threatening atmosphere therefore has to be facilitated. The language of art describes the interaction between client and therapist and could be symbolic of the therapeutic process.

Robbins (1992, p.368) describes the process as “a meeting of two minds where there is an experience of both separateness and oneness. Making this space alive and meaningful becomes the work of treatment. This space can also be referred to as transitional in nature as it is constantly moving and changing. During this patient/therapist communication, sensory channels become potential organisers of images...”.

Goldstein-Roca and Crisafulli (1994) emphasise the importance of comfort in the therapeutic situation, with the implication that the client is given the freedom to express perspectives of expectations. This also implies that there are no rules of appropriate drawing or language, nor is artistic ability a factor. Rogers (1980) says that an atmosphere of understanding of differences and of respect towards world-views and problems are essential in the therapeutic context as a co-creative endeavour is foreseen.

Interpretation

Interpretation should not be confused with diagnosis. Applying a discursive form of interpretation to a presentational symbolic form will only lead the observer away from understanding the whole of the artwork. Interpretation is but a component of the dialogue between client and therapist. Caution should be exercised not to fall into the dualistic either-or trap when thinking of interpretation.

Interpretation is a way of enhancing dialogue, because dialogue is the basis of psychotherapy. Interpretation is therefore a tool of co-construction. Prigatano (1991) states that interpretations aid the integration process in order for clients to perceive something they had previously not acknowledged. Andersen (1990) interprets “description” to mean that in the making of a picture of a given situation, certain kinds of distinctions are drawn. The picture of the world is made by the distinctions as seen by the describer. There is always more than what is described. The artwork is but a small proportion of the whole.

Art therapists frequently focus on the client’s artwork to buffer the intensity of the therapeutic relationship. The metaphor communicates through a picture and can remain in the metaphor without being verbalised. Both the therapist and the client understand the metaphor without need for further inquiry or defensive retreat (Haeseler, 1989).

Yet, as an interactional-minded therapist, with the focus on language and dialogue, the previous approach does not fit into my way of working. The key, it seems, is that the client must feel that the creation is validated and understood.

Haeseler (1989) states that by responding to one of her client's paintings without intruding in its development, she helped to promote a therapeutic alliance between herself and the client. This alliance contained enough safety and distance for him to symbolically express in art those intense feelings he was experiencing. Without the therapist making a wild interpretation, the client could use this safety to express the unsaid.

Anderson and Goolishian (1988) developed the concept of the therapeutic conversation by defining it as a reciprocal longing for meaning. The client fulfils the role of expert and the therapist fulfils the role of the "not knowing" participant. The assumption follows that reality is not obvious, and that comprehension is a dialectic, circular process. Comprehension therefore requires sensitivity and openness to new ideas or perspectives. The client develops a new inter-subjective meaning for certain perspectives and expressions, which frequently paves the way to change - which is, to my mind, the essence of psychotherapy.

The visual image that the client creates in art therapy, frequently leads to the development of an own metaphorical repertoire. By asking the client about the created product, the first steps in co-construction are taken. Co-construction of meaning is thus typified as a clinical goal (Linesh, 1994). Art created during therapeutic sessions gains new meaning as it is exposed to different contexts and it changes circularly into new meanings by co-construction. The trap of dualism is sidestepped by keeping an eye on the aesthetic whole.

Self-Concept and Communication

A benefit derived from painting or drawing with clients is greater "self-awareness" (Hendrixon, 1986). It could be said that a sense of self-esteem or self-concept is co-created. Congdon (1990) is of the opinion that people in therapy often struggle with the idea of a loss of self-concept. They do not know who they are and where they belong. Their context does not make sense anymore. Art responds very well to these struggles. A sense of identity and a sense of where they belong can result from participation in the creation of art.

Brain-injured clients often have great difficulty in putting their experiences into words. “Both patients and therapists may perceive verbal discussions of their feelings as labourious, slow and ineffective” (Prigatano, 1991, p.6). According to Feder and Feder (1981), the search for meaning includes the longing to communicate with others and the art of drawing enhances a different way of communicating.

Language is a very poor medium for expressing our emotions. It is merely a crude way to express conceived states, the interplay of thoughts and feelings, and the perceived reality. If the therapist says that she or he understands someone’s feelings, is it not that she or he understands why the client should be sad or ambivalent and so on. We can never have real insight into the ebb and flow of the balanced feelings of the client.

When art is used in a therapeutic context, it is a form of nonverbal communication. It can make the mixed, poorly understood feelings and thoughts more clear and understandable. This also brings clarity and order to the interaction between therapist and client.

Prigatano (1991) states that the therapist must want to understand the client and the client’s response to the brain injury. Drawing is an alternative way of communicating with the client and understanding the loss that the client has suffered. It allows the client to express the self in a non-threatening manner and to formulate experiences through external representations. Kramer and Ulman (1977) state that art serves both self-expression and communication.

Family therapists frequently support the view that “digital (verbal) language is almost meaningless whenever relationship is the central issue of communication” (Watzlawick, Beavin, & Jackson, 1967, p.63). The use of art in therapy integrates the visual and auditory-verbal channels. A secondary way of communication is developed (Comfort, 1985).

To summarise, art expression is commonly assumed to address subconscious and unconscious information that is not verbally assessed. According to Naumburg (1966), art therapy is based on the assumption that conscious and unconscious feelings and thoughts can be expressed graphically. He also believes that everyone possesses the ability to self-express on paper. Disabling issues are connected and communicated through art (Allen, 1988). Art then makes the immobile more mobile and sets the context for expression and change.

Aesthetics

The aesthetic aspect of art may act as a deterrent for drawing during therapy, but it has to be emphasised that the goal of art therapy is not an aesthetic final product. Instead, in this context the term “aesthetic” will imply that the client has expressed the self and that a context for new meaning has been created. The term may refer to the artist remaining true to the self and that pressure and expectation had no part in the making of the drawing.

Although this study does not focus on the traditionally aesthetic experience of art, this aspect cannot be ignored or denied. Csikszentmihalyi (1975) describes the aesthetic experience as the uniting of consciousness, action, attention, concentration, and loss of self-consciousness. Aesthetics is found in the transformation process during which the client can communicate and send out messages. “To take advantage of this unique structure, participants require neither skill nor experience in the arts. All that is asked is a willingness to take a chance and dip into the unknown” (Robbins, 1992. p.177).

Creativity is not a synonym for art. Not everyone has the talent to be an artist, but everybody can be creative. One is exposed to creative processes and challenges throughout life. Play is part of the creative process and eliminates the anxiety of therapy or being in therapy. It enhances one’s capacity to express and experience those aspects which are unique to oneself. A sense of the whole is experienced as a sense of contact manifests the way the person is in the context. Prigatano (1991) describes that a sense of play and freedom are often interconnected, and are complementary to one another.

The Self as Therapist

As mentioned before, Edwards (1993) emphasises that the therapist must develop the skill to be aware of the self, as well as the understanding of theory to practise intellectual and pragmatic skills. The therapist may not be an objective observer in evaluating therapeutic processes. Consciousness of epistemology from which the therapist makes distinctions has to

be developed. The assumption is that the observer is also a participant, which implies that the therapist has to participate in the artwork, again with the responsibility of consciousness of both participants' assumptions.

Apthekar (1989) says the therapist has a responsibility to be aware of his or her own epistemological premises and to be truly part of the therapeutic process. "We have to believe in the value of our own experiences and in the value of our ways of knowing, our ways of doing things" (Apthekar, 1989, p.254). Adams (1992) argues that the therapist must be aware of the way distinctions are made, for example, pain, as it communicates emotional openness towards the client. The client will then feel better supported and will participate more easily in the therapeutic process of creating. Haesler (1989) describes how she creates alongside her clients and that there are times that her own artwork facilitates her clients' creative process. She is of the opinion that, in working with her clients, she makes her thoughts about artwork more accessible as well as her investment in the group. She can demonstrate how art can help identify and express emotion or tell a story. A significant trap to look out for is the temptation to become absorbed in one's own work and subsequently fail to meet the needs of the client. Haesler explains that therapists must have sufficient self-awareness to be able to recognise the epistemological basis of their own creations.

Contrary to Woods (1991), this study will show that success in therapy is not the function of the techniques or personality of the therapist or even of the therapist's ability to guide the client through verbalising suppressed emotions. The client is clearly part of the therapeutic process and not just the receiver of stimuli that link with him or her. The client's privacy and unverballed feelings should always be taken into account. An inherent respect for the image that is expressed is essential.

Kramer (1986) has developed a technique that furthers the aesthetic development as well as the psychotherapeutic process. This technique implies that the therapist should not be overly intrusive and should never dictate the intended meaning of the client's image. Pictorial ideas or styles are not imposed upon the client. As a therapist, it is important to approach the image with respect and empathy so that the integrity of the artist is maintained (Henley, 1992).

Co-construction

Wald (1986, p.30) describes in her study that the “patient’s response to his production and what it evokes in him is the most important”. The idea of the self-concept should therefore be taken into account. The person is given the space to enter into a dialogue with the self and to co-construct a new narration. The client is in a context where he or she can interpret, wrestle with and rethink life through the artwork. In sum, the artwork can be described as a personal story made public.

Carol (1993), who was a client during an art therapy experience, states that she was given the opportunity to give feedback and commentary on the various therapeutic sessions she had “received”. As her contribution was of the utmost importance, she realised that she had a sense of ownership with regard to the therapeutic sessions. A conscious realisation of the shared experience between the different participants grew. Carol’s article underscores the assumption that the client will feel a greater part of the therapeutic process if allowed to describe his or her experience of the session.

The therapist can give visual feedback during the therapeutic session by utilising drawing as a two-way communication medium. Clients can also be motivated to interpret the therapist’s work in order for the ongoing process of mutual understanding to take shape. The key, according to (Phillips, 1992), is that she sends the message, by means of her art and words, that she wants to grow and learn alongside the client. Moon (1990) describes the experience as the client feeling understood and connected when art is utilised in the therapeutic process, as the client receives a glimpse of what is often described as empathy from the therapist.

Contrary to Hendrixson’s (1986) study, which emphasises that the personality becomes accessible through art, I believe that the mode of interaction makes the relationship more accessible. The context of acceptance and expression leads the way to a comfortable space for relaxing in a therapeutic relationship.

According to Wald (1986), compliments from other patients and staff members on his or her ability to self-express will enhance the neurologically-impaired patient’s “self-esteem”.

This way of expressing himself or herself helps to maintain the co-construction that the patient is still a productive adult that can be understood. It also creates the belief that even in an activity as unstructured as drawing, he or she can perform and even express the self. The boundaries that are set during the session are safe in order for the art therapy process as a structural activity to enhance the release of emotion and focus impulsive energy. Allen (1988) claims that the patient's active participation in art therapy accelerates the therapeutic process.

Aspects of Art

Painting is seen as a representational form and presents an image in its entirety. Agell (1989) describes it as line, colour, form, and the myriad elements of composition being presented simultaneously. Feder and Feder (1981) believe that colour is a way of organising emotions and thoughts. Thus, colour is associated with emotion, and form with thought.

As verbalisation is more frequently lineal, artistic expression is without any rules of language, without rules of causality or logic. Its nature is spatial, timeless and simultaneous and in this way it duplicates experience. Closeness and distance, bonds and subdivisions, similarities, context, and process are all shown and represented in one drawing (Wadeson, 1980). Image and symbolic content, frequently expressed by colour, form and texture, provide a metaphoric blueprint of family coalitions, recursive patterns, and developmental phases (Landgarten, 1987).

Attention should be paid to the manner in which the art medium is applied. Thus, the process should be looked at as well as the content. This would entail, looking at, for example, definite strokes or unsure strokes. The content would involve the use of space, colour, details and what story the picture tells (Wald, 1986).

Process and content are of particular importance as they are a manifestation of the client's interactional appeal. The way in which the client draws, can be seen in the therapeutic context as an expression of the self. A person drawing on one part of the paper can be described as

focusing solely on a certain aspect of his life - for instance the incident that led him to this point. All these interpretations should be context-bound so as not to fall into a dualistic, diagnostic trap, however..

Wald (1986) employed all types of mediums, poster paint that is bright and stimulating to the senses as well as oil crayons which are simple to manipulate. The medium enhances the motivation to partake in this activity. It should be kept in mind that mediums should be used which are easy to handle since many brain-injured clients have fine motoric dysfunction.

Symbolism and Metaphor

Symbols are signs that are representative of that which is not available immediately. These symbols stimulate a series of memories and lead to a performed or planned action. The human brain acts as a transformer of information to accommodate strategy or fantasy. The work of the mind in perception and conceptualisation is the symbolic transformation of experiential data (Agell, 1989). Kymissis and Khanna (1992) state that an individual's drawings and use of symbols are as consistent as a signature. A symbol may act as a metaphor, which brings me to a definition of the word metaphor.

Fowler and Fowler (1995, p.856) define metaphor as "application of name or descriptive term or phrase to an object or action to which it is imaginatively but not literally applicable."

The idea of art is quite different from language in that it functions as a metaphor. The meaning of the metaphor is immediately understood and seen. Basically, a painting is a transformation of the artist's experience into a visual statement (Agell, 1989)

To my mind, metaphors are visual and I believe the insights obtained from a solid metaphor can provide the space for more questions. When the metaphor is drawn, it is tangible and thus more flexible (Witztum, Van der Hart & Friedman, 1988). The role of the therapist is to develop the client's metaphor. In this way the metaphor that is brought to and sold by the client in therapy will be used. This metaphor can be questioned and developed through co-construction

Metaphors encourage people to think and act about problems in a way that signifies power over the problem, without taking on a deliberate power position (Rogers, 1980). The metaphors are their own creations and liberate the clients from stereotypical descriptions.

. The question is whether we, as therapists, understand the metaphor that is portrayed or whether we merely dissect the image. In other words, do we translate the image and is our translation ever correct? The answer lies in the dialogue that is generated around the image and the feedback process that enhances the joining of the observer and the artist.

The answer to the above-mentioned question is somewhat paradoxical, according to Wadeson (1980). On the one hand, the opportunity is given to step outside the self, perhaps to externalise, to become part of a certain context and to feel part of the universe or the whole. On the other hand, the process of creating art is clearly an intensely personal experience and can even provide a glimpse of understanding of the individual. Wadeson integrates this twofold answer through her words: "I as creator can look at my creation and admire it, and realise that I am looking at myself." (Wadeson, 1980, p.6). It is also suspected that change might be enhanced if the clients meet something unusual but not immobilising. On a theoretical note this idea can be linked to the concept of news of difference. A different way of approaching and describing the self emerges in a mobilising expression of news of difference.

Why Drawing?

Art therapists claim to offer something that the talking cure seems to fail to address. Through art, a different context for communication is allowed. Insights and experiences are enhanced in the process of making artworks.

Communication through art is less explicit and more indirect than during verbal exchange of perspectives. Metaphorical expression is less prone to intellectualisation and suppression (Feder & Feder, 1981).

This study will not focus on the diagnostic value of art or drawing in psychotherapy. An aspect that will enjoy attention is the argument that the artistic process gives an opportunity for catharsis and the expression of suppressed emotions, with the assumption that such an expression will lead to change.

Simple catharsis or self-expression will not alone be adequate as a method or goal of treatment (Agell, 1989). This study will not focus on what is called catharsis but will also not disregard the “by-products” of metaphoric expression - which may include catharsis. The art created in therapy is a form of symbolic communication (Naumburg, 1966). Art therapy works from the premise that everyone, whether trained or untrained in art, has the ability to express inner feelings and “conflicts” in a visual form (Busutill, 1990). For example, Mango and Richman (1990) describe an assignment for psychiatric inpatients to portray their life experiences humorously which brought patients’ problems to the foreground.

The therapeutic value of art as a medium in psychotherapy is not denied. Art as a two-way visual communication medium is utilised to enhance rapport between client and therapist. Drawing incorporates the boundaries and distance that are necessary for a functional therapeutic relationship.

The shift towards a visual way of thinking frequently gives the therapist a piece of information which then gives the therapist a chance to view the client from a different perspective. The human aspect is clearly seen in Phillips’ (1992, p.296) words “...I remind myself that I am in the company of a fellow human being whose life has a meaning all its own”. Yet, there are certain prerequisites with regard to drawing in therapy as Winnicott (1971, p.54) observes: “...therapy begins when the patient is able to play and that play is essential for being creative, it is only in being creative that the individual discovers the self”. The key that Winnicott points towards is that drawing punctuates the playfulness of therapy and that this playfulness frequently inspires new perspectives that may enhance a pattern of change.

Wald (1986) applied art therapy in working with demented patients. It provided a ‘pleasant structural activity with which they can cope, in which they can take pride, and which allows them to express themselves even when language is largely lost’ (p.29). Art work focuses primarily on the nonverbal. Thus, a new way of expression is developed. The person

is no longer a patient, but someone who expressed the self and let others into his or her world. Art expression allows the clients to express their own perspectives and to make personal weaknesses and strengths transparent. Different perspectives are given a context in which to manifest. Kramer (1977) states that art informs and simultaneously keeps certain conscious material at bay.

Further motivation that drawing is a form of positive feedback is that “art can give sustenance to the basic psychological need of proving one’s existence” (Csikszentmihalyi, 1977, p.100). The individual is part of the whole and cannot be looked at outside of context. Yet, Einstein maintains that an individual experiences feelings and thoughts as removed from the rest as “a kind of optical delusion of consciousness” (Vaughn, 1986, p.3). The therapist has to acknowledge the whole of the client. The bigger pattern should be seen, which incorporates the client and the therapist.

Adams (1992) recommended that a young boy whom he saw in therapy should create a story of his choice. This study will suggest that, rather than narrating a narrative, the client should draw a picture to give the therapist an indication of the problem. A narration might develop from the drawing. Woods (1991) believes that the story depicted in drawing could derive an aesthetic response, but the story does not have to be attractive to enjoy attention. It could even be horribly unattractive, as long as it enhances communication and conveys a story.

Labarca (1979) believes that the therapist should explore feelings about the colours and even the contents of the paintings by asking questions such as, What emotion did you try to convey in this picture?, or simply, tell me about the picture. All the descriptions that the client gives should be accepted. She also expresses the opinion that group drawing provides an excellent context for clients to reduce their inhibitions and to facilitate the art therapeutic process.

White (1989, p.6) says that “(w)e use stories in our thoughts and conversations about whom we and others are. These narrations not only constitute our descriptions of self and others but shape how we behave, interact and experience life”. The narrative approach

motivates the therapist to be active in participation in the therapeutic conversation. These “techniques” are an invitation for clients to be curious and imaginative about new possibilities and perspectives (Rogers, 1980).

This all seems wonderfully appropriate for psychotherapy with verbally inclined clients. However, the question is, what does the talking cure do with thoughts that are difficult to express verbally? What if expression leads to confusion and misunderstanding? Do these thoughts change meaning or are they locked away in despair? Thus, the typical apathetic way of being becomes the story.

Agell (1989) holds that an artist gains psychological distance from the artwork and may begin to see different meanings of which he or she was not aware. Another question is, Is art a way of externalising the problem? White (1989, p.6) is of the opinion that externalising conversation "frees persons to take a lighter, more effective and less stressed approach to deadly serious problems." In the process of objectification of the problem, feeling or describing the self through art carries the emphasis. Thus, I will continue to describe the narrative approach I have utilised in my interaction through art with people that have sustained a head injury.

CHAPTER 4

A SYSTEMIC MODEL OF DRAWING

Introduction

The focus of description in this chapter will be on a systemic model that incorporates the use of painting and drawing in therapy. I constructed a basic systemic model to make the incorporation of drawing and painting more accessible to the reader. The problematic process of drawing and painting is that it is frequently theoretically under-described. This chapter will strive to give structure to the therapeutic process.

The concepts of joining, enactment, representation, news of difference, and externalisation are primary in the use of the systemic paradigm, and form the main principles of the model. This dissertation will focus on the use of these concepts in therapy with neurologically impaired clients, with the focus on art as therapeutic intervention. The systemic model seems to have denied the use of art in the therapeutic context. The above-mentioned concepts will be incorporated to make drawing come alive in the systemic paradigm.

I do not believe that a therapist can have “conscious purpose”; I do not think that I have control over the therapeutic system; I can never predict the change that might occur (Bateson, 1972). I cannot have control over the drawings that the clients make nor can I control the change that might occur in the therapeutic context. I form part of the whole and can never claim to understand the “whole”. By drawing with clients I try to formulate an understanding of the whole of the system and of the ecology of relationships. The exclusive emphasis upon pragmatics and strategies often leads to “an ecological decontextualisation of therapy where one’s bag of tricks, cures, and problemsolving procedures are too easily disconnected from the more encompassing aesthetic patterns of ecology” (Keeney, 1983, p.9). Stated differently, a conscious purpose with its aim of achieving specific goals and changes cannot take into account whole ecological

contexts. Drawing is not a technique aimed at changing the client. It is merely a different way for me to perceive the client and for the client to perceive me and other relationships.

Bateson's (1979, p.100) words summarise my perspective: "I surrender to the belief that my knowing is a small part of a wider integrated knowing that knits the entire biosphere or creation."

Reality can never be described objectively. Each system has his or her own reality according to the distinctions made. The descriptions of the drawings that the therapist and clients make are never objective. It is not the therapist's role to question the client's construction of reality. Reality is co-constructed in the meanings that emerge while creating art and talking about it. A more playful flexible reality is opened, one that is more visible and tangible through the process of drawing it.

The chapter will constitute a description of the model. A model is

A representation that mirrors, duplicates, imitates or in some way illustrates a pattern of relationships observed in data or in nature...a model becomes a kind of mini-theory, a characterization of a process and, as such, its value and usefulness derive from the predictions one can make from it and its role in guiding and developing theory and research. (Reber, 1985, p. 447).

The first concept that forms the base of the model is that of "news of difference".

News of Difference

Bateson (1979) states that distinctions imply a relationship, a difference or change, to which the observer responds. The sensory and the mental system only operate with events that imply difference. The mind can only receive news of difference. In the therapeutic context new meanings are generated when new information becomes part of the interaction between the

therapist and the client (Keeney, 1983). “News of difference” (Bateson, 1972, p.20) is only meaningful if it fits within the relationship context. If the information fits within this context, is the therapeutic system enabled to perturb the meaning system in order for new meanings to be generated? New information has the capacity to perturb the system in order for new meanings to be generated. New meaningful information brings change to the therapeutic process that gives new meaning to the meaning of the problem and the tried solutions. Keeney (1983) calls the adding of new meaningful elements in the therapeutic process, the adding of meaningful noise. This new meaning can arise from the client or the therapist’s world or the one that they have created together.

A practical incorporation of the term “news of difference” can be seen in the following illustration. The therapist asked a client to describe the painting that he or she made. The description was vague and even unsure. The therapist then started to ask questions about the drawing. For instance, what was the story drawn here? How did it come about that the client used certain colours? How did certain blank spaces come about in the drawing? Different aspects of the drawing were addressed. A process of dialogue about the drawing then commenced. The client was given the opportunity to give different descriptions of the drawing. The vague description became more specific and different aspects of the drawing were co-constructed by the therapist and the client. The therapist even raised a different point of view, for instance, that the vague description of the client was symbolic of the vague and unsure way the client perceived life, although there were some aspects in the drawing where one could see certainty and structure. A dialogue followed around the meaning of these stable structures and how the client managed to hold on to these structures and ideas and symbols of stability. The reader should take into account that reality is only a construction. A dialogue about the map of a map broadened the perspective of the client and the therapist.

The term “objectivity in parentheses” as described by Maturana and Varela (1987), indicates that no objective reality exists. Multiple realities are the only reality available to us, as different people view reality differently. The therapist and the client do not view a drawing in the same manner. Objectivity is put in parentheses (Maturana & Varela, 1987): there is no objective way to view the drawing. A “multi verse” is then described as different ways of a described reality.

One statement is not more valid or true than the next and one description of the drawing is not more valid than the next. Each person who observes sees something different from the next and will punctuate a drawing in different ways.

Keeney (1983, p.24) says, "An observer observes by drawing distinctions." While observing, we create our own structure by which we live, understand and experience reality. According to constructivism, meaning and assumptions about reality are made from the internal structure of the nervous system. The therapist has to take responsibility for her observation of the drawing as the observation is made because of her internal structure. The dialogue between the therapist and the client about the drawing can only act as perturbation to the client and therapist.

Information or rather intervention does not determine how a system will behave. "Intervention as seen as a trigger and a bag of skills or expertise has no relevance" (Dell, 1985, p.9). The therapist needs to take the position of participant and is allowed to "co-drift" with the system, rather than taking the position of a change agent. The therapist is part of the observed drawing. The drawing acts as consensual domain between the therapist and the client and as a symbolic structure where the structure of the therapist and the structure of the client overlaps.

A goal of treatment is to assist clients with the problems that brought them to therapy, even if the problem is head injury. A broader perception enables clients to change dysfunctional patterns of behaviour. The concept of reframing has been with family therapists from the early years of the family therapy movement. Penn and Frankfurt (1994) have explored the reasons why a reframe is often enough to shift a client's perception. They state that, in therapy, a person's inner monologue is involved with another positive voice, that of the therapist. The monologue evolves into an internal dialogue which changes the dialogue that the person has with other individuals.

Riley (1990) says that art therapy offers great opportunities for reframing. The artwork is seen as a way of communicating and is, by its very nature, capable of being reframed. A physical reframing is possible by, for instance, filling in or talking about blank spaces in the artwork or repositioning certain elements in the artwork. Altering the physical frame itself is a powerful

metaphor and can open the doors to a change in pattern and/or meaning. Social constructionism describes the concept of meaning and the process of developing meaning from a different perspective to constructivism.

Social constructionism focuses on social interpretation. Meaning is not inherent to the system, but forms a part of the movement of stories that flow between interactions among people (Hoffman, 1990). In these interactions people create meanings that correspond and resonate. “The combination of diverse pieces of information defines an approach of great power to what Bateson calls ‘the pattern that connects’” (Bateson, 1979, p.77). When the client and the therapist or two systems interact, each individual punctuates the flow of the interaction. When the views of both individuals about the drawing are combined in a sequential fashion, a sense of the whole of the system will emerge. One might be able to discern the pattern that connects (Keeney, 1983). When the client’s and the therapist’s views and perceptions about the drawing are combined, we formulate and construct a sense of the whole drawing.

To see a relationship requires what Bateson (1979, p.79) refers to as “double description”. Double description is often used as a linguistic tool to direct us to a higher order description. Bateson maintains that the simultaneous combination of two interacting sides of a distinction will give a glimpse of the whole relationship.

My question remains, if language is not readily available to those in interaction, can a different language be used to give higher descriptions? The answer is therefore “yes”. Language is not only the words that come out of our mouths, but is also the way we are, the way we draw, the way we play. Bateson (1979, p.23) claims that context is “a pattern through time ... without context, words and actions have no meaning at all”. Meaning is in the context and is woven into the contents of the context. The meaning of the context is drastically changed as the drawing alters the meaning of the therapeutic context. The therapist and client explore the meaning of the drawing together. The role of expert alternates between them as each perspective or description is true and valid.

Social constructionists also place the focus on social interpretation and the inter-subjective influence of language, family and culture. Social constructionists posit an evolving set of meanings that emerge unendingly from the interactions between people. These meanings are not skull-bound and may not exist inside what we think of as an individual "mind". Hoffman (1990) explains that it is helpful to think of problems as stories that people have agreed to tell themselves in interaction with others. A client described his drawing as what he would be doing after he had been medically boarded. He would be fishing and lazing around. The therapist asked him if he felt like the fish on the hook that he drew. The client tearfully admitted that he felt very disempowered and left out of the decision to be medically boarded. They generated a conversation around what he could do to feel more in control of his life. In this interaction, the therapist and client co-created meanings that corresponded. Reality was in dialogue.

These meanings frequently evolve and are in a process of change; the development of concepts is in a process that develops socially (Hoffman, 1990). The focus is on the interpersonal correspondence in the generating of meaning. The relationship between therapist and client is the most important meaning-generating system; together the meaning of the drawing can be questioned and explored.

In therapy, a cybernetic system is created where the therapist and client are part of a process of co-evolution and co-construction (Keeney, 1983). Meanings are formed in interaction. Bateson's (1979) description of co-evolution is that two systems in interaction make changes in one another according to certain recursive principles. Co-construction can be spoken of, where the creation of meaning takes place within different feedback systems that connect systems to one another. The different descriptions that the client and therapist give of the drawing make the process of change more active as recursion enhances change. The client is enabled to think differently about the description of the drawing that is also a description of the self.

Meaning changes with context. The construction of meaning is a constant changing, creative, and dynamic process (Anderson & Goolishain, 1988). There is never a termination point when constructing meaning. The client will constantly change his or her perception of the drawing. Even now when I look back at the paintings that I have made, I see some different aspects of the

painting to which I attach different meanings. News of difference (Bateson 1972) is only useful when it fits into the relationship context.

I will never know how the act of drawing in therapy has changed the patterns in the rest of the client's life. All I have to work with is the drawing and the change in the relationship that took place within this context. Art can be used as meaningful noise that gives rise to new meanings in the therapeutic process. The new meanings constructed are not external from the therapeutic relationship, but flow from it and are part of it.

However, I do not think that news of difference would be heard if joining had not taken place between client and therapist.

Joining

There is a tendency for living things to join up, establish linkages, live inside each other, return to earlier arrangements, get along whenever possible. This is the way of the world.

Lewis Thomas

Art in therapy is a very practical and often misunderstood way to join or blend with the therapeutic system. The therapist can draw with the client or be the participant observer of the creative process. Neurologically-impaired clients often feel excluded and easily take on the passive patient role. By drawing with them, the therapist is prepared to meet them on a person-to-person level that is not always the interactional style that most people adopt towards a person with neuropsychological damage.

Maturana's (1975) constructivistic theory does not exclude the role that interaction plays in the forming of perceptions. Systems are always in interaction with each other. In the recursive processes of interaction, structural changes constantly take place which are called structural coupling. Structural coupling takes place when two or more systems coordinate in their interaction towards each other, which facilitates structural changes. A consensual domain is a domain in which there is correspondence between observations, if the structures allow it. The

structural makeup of the systems allows the correspondence between systems' shared meanings. To understand how structures work, I found it important to use Minuchin's (1974) structural way of entering the therapeutic context.

Minuchin (1974) describes joining as the method that the therapist uses to create a therapeutic system and to position the self as its leader. Joining is described as the actions of the therapist aimed at relating to the system. Accommodation and joining refer to the same process. Joining incorporates the therapist's adjustments of the self to accept the system's organisation and style. The strength of the transactional patterns must be experienced. This implies a certain sensitivity to the pain, pleasure and interactions within the system. The therapist participates in the exploration of certain themes. Minuchin further states that the therapist has to follow the system's path of communication and discover which paths are open, blocked or partly open.

In working with neurologically-impaired clients I encountered many paths which were closed or partly closed. Subsequently I had to search for a different way to address these partly opened paths. Minuchin (1974) further states that the joining process can never be a one-sided process. Just as the therapist accommodates to join with the system, the system must also accommodate to join with the therapist. A context has to be found in which accommodation takes place. Drawing contributes to this context. The therapist and client establish a partnership with a common goal and two systems join for a specific purpose and for a certain time. The therapist is usually termed the leader/healer of this therapeutic system. This puts the therapist under tremendous strain as this role requires the therapist to join with the system.

The question is, what is joining in this context? Minuchin and Fishman (1981) maintain that joining is more of an attitude than a technique and that it is in this atmosphere of joining that all therapeutic transactions occur. Joining gives the message that the therapist understands the client's system and that cooperation takes place. The client receives a sense of comfort and understanding. Joining offers protection and security in order for the client's system to explore alternatives, to accept news of difference and to change, as previously explained. Joining is the essential element that keeps the therapeutic system together. The process of joining is often difficult to explain as it is a way of being rather than a technique. The therapist punctuates the

common ground between the therapist and the client's system. Certain self-segments that resonate with the client's system are made overt or are activated. The therapist will accommodate the client's system but the inverse should also be possible.

The primary joining factor between therapist and client is the therapeutic relationship. The interaction between the therapist and client determines the type of emotions, perceptions and ideas that are co-created. Lincoln and Guba (1985, p. 105) call "mutual shaping" the process by which both therapist and client's meaning systems are subjected to change in the co-creation of conversation.

There is a second-order cybernetic perspective that can also be interpreted as the therapist having no control over the joining process. A therapist merges as part of a system and aims to create a context of change with her role as participating leader. The reasoning behind this is that a system is too complex for a therapist to claim to be able to predict the process. A vertical hierarchy emerges where the client and therapist join in an even, cooperative relationship where sharing takes place. The therapist assumes the role of leader. The therapist gives the client the choice of media with which to create, be it paints, pastels, clay, or pencils. The client chooses the most appropriate creative medium. The therapist creates the context for creating and the client joins with the therapist in this effort. Both the therapist and the client take responsibility for the therapeutic endeavour. Mutual influencing is the order of the day. The ultimate joining technique, to my mind, is one of oneness and sharing. Assuming the role of expert is not necessary for the therapist as that role is already ascribed to the therapeutic context. There is always some form of hierarchy in therapy, thus punctuating and emphasising it is not necessary. The therapeutic relationship ought to become isomorphic to those relationships outside the therapeutic context.

Minuchin (1974) states that the therapist gains information experientially through joining with the client's system. She hears the client's experience of reality, yet the self is never taken out of the observation. The therapist can experience that the client does not make a space in his drawing or in his description of the drawing for other individuals. The therapist is in touch with how the client relates to her. Joining is the use of the therapist's personality and experience that

resonates with the client-system's personality and experiences. The drawing acts as joining structure or context and gives the therapist certain experiential information about the client.

The act of drawing makes the common denominators more evident, and the therapist makes the segments of the self more evident by drawing with the client. It is not just a question of supporting the client, but sometimes self-disclosing to the client. The use of the self is the most powerful tool in the changing process. To facilitate the use of this powerful tool, the therapist must be aware of the resources that are available to the therapist or of resources that are part of the therapist's repertoire. A practical illustration of joining that takes place between client and therapist is when the therapist draws with the client. The white paper in front of the therapist fills the therapist with uncertainty just as she assumes it fills the client with ambivalence. Together they enter a space of uncertainty and, by that togetherness. The expert role and the patient role are taken away.

Joining is a natural process that Minuchin and Fishman (1981) describe as occurring beneath the surface in the normal processes of relating to people. The above-mentioned authors mention different positions of closeness that are part of the joining process. A useful tool of affiliation is conformation. The therapist searches for something positive to describe in the client's description. The therapist recognises areas of pain, problems, loss, and misunderstanding. By responding to the drawings that clients, make and by acknowledging their expressions, a form of joining can clearly be seen. The act of confirming the positive aspect of a drawing or description defines the therapist as a source of self-esteem for the client. Confirmation is not an act of interpretation as the client is already aware of that which the therapist is saying. This act of confirming is an acknowledgement of the client's expression.

The term "accommodation" is used when the therapist has to make adjustments or adaptations to the self to join with a client system (Minuchin, 1974). Joining implies blending with the client's system. Minuchin (1974, p. 125) refers to "maintenance as the accommodation technique of providing planned support of the client structure as the therapist sees and interprets it". This technique often implies active confirmations of the client's system. I am often involved in supporting the individual's strength and potential and enhancing the individual's position in the

client's system. I often praise the competence that a client shows in his drawings or self expressions. By using these different techniques, Minuchin describes accommodation and restructuring as being intertwined. Accommodation incorporates the humanity and artistry of the therapeutic encounter. It should be kept in mind that joining is not really a confrontational or challenging mode of action. By drawing with the client the therapist creates a joining operation. Themes are highlighted, clients improvise and participate while drawing and expressing their realities.

Minuchin and Fishman (1981) emphasise that the therapist should constantly search for ways to enhance positive ways of looking at the client's system, while, at the same time, looking for ways to reach for goal-attaining methods. They describe the therapist as a source of support and containment and the leader and facilitator of change. As participant observer, the therapist is caught up in the rules and boundaries of the system. The therapist has to abide by the rules of participation as she is part of the therapeutic system. The rules and boundaries about drawing are clear. The therapist has to use extreme caution in commenting on a client's drawing. Respect for the client's capacity to self-express should always be kept in mind. Structuring the sessions so that the clients know what to expect from the session is important, and the clients can learn to understand their responsibilities and abilities within this context. The sessions become almost ritualistic in a sense. A note of caution should be sounded: choose appropriate material that fits with the client and the context. The act of drawing should never be imposed on the clients. It has to fit with their structure to be a therapeutic experience and not just another extension of their life story as incompetent patient.

Minuchin and Fishman (1981) describe the median position as the active participation of the therapist, who all the while maintains the role of the neutral listener. The therapist acts as facilitator of the client's story. The technique described here is called "tracking." The use of tracking is to follow softly to redirect or explore new ways of description or behaviour. The process and the content should be taken into account during the therapeutic process of tracking. The danger of this technique is that the therapist may fall into the trap of looking at content rather than focusing on the process that is taking place. The therapist engages with the client on the same level. In my work with neurologically-impaired clients, remembering not to use intellectual

language and interpretations was important. It might have satisfied my needs, but the connection between therapist and client would have been lost. I very often had to speak in concrete terms to be understood.

The position that the therapist takes is an oscillation between the role of expert and participant. Contrary to Minuchin and Fishman's (1981) description of the disengaged position of the therapist, I maintain that the therapist takes on the role that is an oscillation between the role of expert and participant. The therapist has to be aware of his or her strengths and weaknesses. I believe that the static expert position disengages the client's system from the therapeutic system. Joining with neurologically-impaired clients is difficult because of the difference in cognition that includes language, expression, and even sometimes cultural identity. The frustration and helplessness that I have encountered in working with these clients was not beneficial for the therapeutic system. In my despair I have looked for qualities or experiences that we could share. I have found these qualities in drawing and painting with these clients. Minuchin and Fishman (1981) maintain that joining is not separated from the process of changing a system, and that it is not confined to a section of therapy. A therapist joins sporadically during a session and series of sessions. The therapist is part of the system; consequently she cannot observe and probe from the outside, and joining is always essential. The therapist must let herself be pulled and tossed about by the system to experience the pattern and, to my mind, the drawing experience (Minuchin & Fishman, 1981).

Dunne (1993) describes how the therapist and client meet and how creativity arises out of this meeting. This space where the client and therapist meet is described as the "transitional space" and is enhanced and created by the medium of art. Winnicott (in Horner, 1984) wrote that this so-called "space", enables the client and therapist to meet and interact in a context of safety and healing. To my mind, art creates a context where expression enhances the process of change. Maturana and Varela (1987, p.135) describe the context of change in these words: "The solution, like all solutions to apparent contradictions, lies in moving away from the opposition and clarifying the nature of the question, to enhance a broader context."

Enactment

When neurological impairment occurs, the transference of information is frequently made very difficult. The quality of the information is threatened. The client is isolated and does not know how to express the self. On an interactional level, these clients often disappear as they themselves are confused about what has happened to them and who they are. Minuchin and Fishman (1981) describe “enactment” as a technique in which the therapist asks the client system to manifest or “dance” in the therapist’s presence. The therapist is given the opportunity to observe the client’s verbal and nonverbal transactions. Art as creative medium almost makes the therapeutic process a creative process. Meanings are creatively co-constructed. Enactment also implies that energy is used in the process. Art enhances this energetic state. This makes the process more mobile and flexible. Haley (1963) describes psychotherapy as a mixture between play and dead seriousness. The act of drawing highlights the recursiveness between play and seriousness. The act of drawing and even deciding what to draw is a serious and often difficult procedure. Yet drawing has a playful, almost silly side to it and makes the process enjoyable and light. This interplay between seriousness and playfulness is isomorphic of life outside the therapeutic context. The recursiveness also makes way for news of difference in that the mobility between the two states shows the client that life is flexible and flowing. The client reaches for the pencil, crayon or paintbrush. With this movement, the client actively participates in the therapeutic process. The theme is changed from a passive to an active state.

By allowing the clients to draw their life stories, the intensity of their experiences is manifested and the significant aspects of, for instance, their interactional transactions appear. Information that is usually not readily available is gathered. The client’s life unfolds in front of the therapist through the drawing. Enactment asks that the therapist engages in the therapeutic process and facilitates fast engagements between the client’s system and the therapist. Reality that the client presents is viewed in a different light; it also concretises the narration that the client displays.

Minuchin and Fishman (1981) state that cultural and other boundaries are surpassed with the use of concrete language and metaphors, drawn from the systems’ transactions. The act of

drawing or painting also allows the therapist to focus on certain aspects without being bombarded with information. The therapist can merely describe or ask questions around the use of colour or space or the absence of other figures in the painting or drawing.

When one is a systemically inclined thinker, communication and information form an integral part of descriptions. Becvar and Becvar (1996) name three principles that should be kept in mind when discussing enactment, namely:

1. One cannot not behave;
2. One cannot not communicate;
3. The meaning of certain behaviour is merely a personal truth for the person describing the behaviour. When these principles are examined, it can be said that even clients with neurological impairment are doing something for doing nothing is also doing something. The drawings that the clients make, however insignificant this might seem, are always a way to communicate and to express the reality of the client.

Haley (1963) emphasises that we are always in a struggle over the definition of the relationship with someone else. In expression, the individual is suggesting what type of relationship he or she has with the other person. Even when individuals do not speak, they qualify the other person's behaviour. One cannot fail to qualify a message. Any message, however meaningless it might seem, influences and commands the interchange between individuals. Two people in dialogue are always working out what kind of relationship they have. In my interaction with the clients in the neurological rehabilitation ward, I frequently found that I was involved in static complementary relationships. A complementary relationship is one where two people exchange different types of behaviour, for example, one gives and the other receives. Haley even states that one person is in a "superior" position and the other in a "secondary" position. Activity and energy marked the position that I held, whereas the clients in the rehabilitation ward seemed passive and apathetic. I was not satisfied, as constant shifts between a symmetrical and complementary relationship mark healthy relationship types. A symmetrical relationship is one where two people exhibit the same type of behaviour. By using art in therapy, aspects of these two relationships types manifested. By drawing together and asking one another questions about the drawings, a

symmetrical relationship evolved. This symmetrical relationship is described as “sameness”. Both systems are active and have the same task to fulfill. The complementary relationship manifested when I gave the client a choice between art mediums and took leadership as to the structuring of the therapeutic context. I was allowed to comment and lead the way into the generating of new meanings by means of the client’s drawing. One could see a dance or an oscillation between the symmetrical and complementary relationship manifesting in the therapeutic context. The social process between the therapist and client is the focus of the discourse.

Concepts such as emotion, motives, self-concept, perceptions, and observations are products of social processes and discourse and are not situated in the interior world of the skull. The enactment of these concepts manifests in therapy when creative drawing is part of the process. The focus is on the relationship, not the knowledge. The client is given the responsibility of restructuring the therapeutic discourse. Certain emotions and the above-mentioned concepts are enacted in this restructuring. The therapist will ask the client to tell her more about the picture. The client might be emotionally filled or merely talk about his motivation for creating the picture. The meaning that the client attaches to the drawing can only be manifested in the discourse between client and therapist. Knowledge is formed in interaction between people in what Gergen (1985, p.271) calls “communal basis of knowledge”. He says that knowledge is not something that we keep somewhere in our heads, but that it is something that people do together.

Representation

Representation is defined as “a thing that stands for, takes the place of, symbolizes or represents another thing” (Reber, 1985, p.638). The description of representation in this chapter implies that the drawing that the client creates is a representation of a part of the meaning that the client ascribes to the context.

Warren (1993) thinks artistic and creative activities can help the individual to overcome or adapt to a specific disability. In therapy, becoming aware of their creative potential and their need to make their mark is important for clients. Individuals, whose rights to function as full

members of society have been denied because of an accident or another reason, claim this right again, through art. This expression of the self is unique and is an affirmation of the self. There are numerous reports of individuals, previously seen as useless and incapacitated, who began to take charge of their lives and role in society. This is not an appeal to use art as technique in therapy but merely an emphasis on the right of the client to be given the space in therapy to self-express. Art is merely a method for self-expression and a way of engaging the client in therapy. Art is a medium that allows individuals to express the self in a space/context where creativity is enhanced. Persons who have some form of disability have very few opportunities to realise their own potential.

This can encourage individuals to do something because they want to and not just because someone else decides it is good for them. The arts can motivate in a way possibly no other force can. It is only through making a mark that no one else could make, that we express the individual spark in our own humanity. (Warren, 1993, p.4)

An investment in the self takes place while drawing. When this is done, the individual grows in self-appreciation and self-esteem (Warren, 1993). The making of drawings about the self gives the client the chance to explore different self-descriptions. The client can describe how it came about that he always just draws himself, and why other individuals seem absent from his painting or drawings. The multiple descriptions and facets of the self are exhibited. These different descriptions can be described as voices of description. The client carries these different voices outside the session into relationships and the self-concept. Penn and Frankfurt (1994) explain that different voices for different contexts can together request change and transformation of the meaning of experiences. Openness to new experiences and different voices are consequently encouraged.

Some different voices and expressions can be ugly, angry, and even unsettling. The essence is that they are real. The authenticity of the experience is the most important aspect of drawing, and of therapy too, for that matter. The reawakening of the self in relationship with others might be the goal of my therapeutic endeavours. The act of drawing in a group often gives a chance for other group members to engage in each other's drawings. On a basic level they get to know each

other better, they acknowledge each other's description, and a dialogue is formed around the different descriptions. As the individual creates, participation takes place in what is created. This participation enhances change. The constructivist term to describe this change is "co-drift". "The creative power of the self results in literally a self created by the self" (Master, 1991, p.450). The creative power lies in the client creating a drawing or painting and a certain meaning being attached to it. When this painting or drawing is described, it stimulates the client to make different distinctions and descriptions, so that a different meaning is attached to the artwork. It is a constant and evolving process of self-referentiality. The creative power is growing and feeds back into the self. Therapy becomes an active process of feedback and participation.

As the clients in the neurological rehabilitation ward become both participants and spectators through the recursive act of drawing, the art objects may become objects of "meditation". Penn and Frankfurt (1994) use writing in the creation of participant texts. I use drawing and painting as a medium for creating a participant text. By bringing the drawing into the session, it defines the therapist as witness and participant. The drawing is "a tangible object as well as a process, serves as an artifact of the relationship between the client and the therapist ...it embodies the voices of the therapist as well as the client's many voices" (Penn & Frankfurt, 1994, p.219).

The art that the client creates acts as a form of news of difference by which new information is obtained. The process of developing a perception and processing information from information derived from the environment, forms part of the essential internalised maps and structures of a person and it is "an ongoing process interrupted only by the death of the system" (Ruben, 1983, p. 138). The individual thus behaves according to her or his observation and observes according to his or her behaviour. The drawing basically speaks to the therapist and the client; they communicate about what they saw in the painting. In this manner they derive different perceptions about the drawing that are a manifestation of their constructions of reality.

Narration and Unique Outcomes

The act of drawing gives the client a chance to draw a segment of his life story. Humans are by nature story tellers; we attach meaning to certain stories and live by these stories. The

narrative movement subscribes to the opinion that people live according to the most dominant stories of their lives (White & Epston, 1990). These stories include the meaning that people give to their lives and determine how they are in interaction with other people: "... to make sense of our lives and to express ourselves, experience must be 'storied' and it is this storying that determines the meaning ascribed to experience" (White & Epston, 1990, p. 10). Themes of loss and longing have mostly coloured the life stories that the clients in the neuro-rehabilitation ward convey. According to Foucault (in White & Epston, 1990), the knowledge that we have about ourselves, and the way we see it, has a certain power over us. People internalise this knowledge in order for behaviour to manifest according to this knowledge. People will believe that all they are, are the labels attached to them. In the cases I am describing, the label is mostly "neurologically impaired". The knowledge of being neurologically impaired is linked recursively to behaviour and meaning. Thus, the client will either act impaired or deny any communication that subscribes to this assumption. The narrations about the self are trapped in the negative discourse that dominates their lives. The clients give negative descriptions of the pictures that they have drawn. These perceptions should be treated with respect. Yet, because of the entrapment that these descriptions enhance, giving alternative descriptions of the drawings is necessary.

The post-modernist argument is that the ideas and meanings that people attach to certain events and problems contribute to their behaviour. White and Epston (1990, p.3) say that "it is the meaning that members attribute to events that determine their behaviour". Organisation takes place around these meanings. Thus, if we as therapists can create a context in which new meanings are generated, new behaviour will emerge. From being the participant observer I found that neurologically-impaired clients have trouble expressing the self; the problems that they have are often related to interaction with others. If they experience that they can relate to others, and that others can understand them, the meaning of the communication problem changes in order for their behaviour to change recursively.

A client described one of his drawings in the following scenario. He was standing and talking to a few children as he felt that adults rarely understood him. He drew himself without a face and in a blue greyish colour. The client could express that he felt misunderstood and treated like a

child. The rest of the group acknowledged that they often felt the same way. The therapist commented that it seemed as if the group understood each other and that she understood what he said. The fact that he drew himself without a face made it clear that people did not understand him, since he did not really manifest. The group discussed why it was that they understood him and came to the conclusion that it was because he showed them how he felt. In the group he had a face.

The therapeutic context created by therapist and client determines what types of meanings are generated. The client's perspective was that he was isolated and misunderstood. His ideas around the problem steered his behaviour to entrapment within the different meanings generated within the interactions. The meaning that the client ascribed to the painting became his life story of being misunderstood and unable to communicate with adults. Anderson and Goolishian (1988) believe that therapy is about saying the unsaid and broadening ideas. New themes and narrations develop through dialogue in the therapeutic group. The therapeutic context gives the client a chance to deconstruct the problem-centred stories and to live a different story. Experiencing a different pattern within the group was possible for the client after he had said the unsaid. Penn and Frankfurt (1994) infer that interaction moves back and forth from conversations with the self to conversations with others. A move from monologue to dialogue occurs. The client could use this experience in other contexts and interactions. This monologue-dialogue becomes the new narration. The focus in this case was on more hopeful narrations to discover other meanings.

In therapy, interaction is a way of perceiving the story that is dominant in the client's life (White & Epston, 1990). Therapeutic interaction is a context in which the stories are played out, shared and exchanged. The neurologically-impaired patient will take on the role of the "non-communicator, the non-connector" and play out the story of not playing out the story, which is impossible. When I realised that this was the story, I could introduce a new way of playing out a different story. Hoffman (1990, p. 11) says: "In therapy we listen to a story and then we collaborate with the persons we are seeing to invent other stories or other meanings for the stories that are told". Keeney (1983) states that therapy is a context during which stories are shared and exchanged. Alternative ways of connecting are found or co-created. Conversations take place around the stories which form a feedback loop, which in some way forms new stories. A shared

reality is constructed which generates conversations around the constructed reality. The conversation around the client's experience of being misunderstood was a way of constructing a different story with a different meaning. The group heard and understood him because there he had a face. The meaning is that he manifested and shared his perception with the group.

The group members gave different descriptions of how they saw the client's picture. This is a manifestation of the different voices and descriptions that the client's drawing could have. Maturana and Varela's (1987, p.32) "multi verse" can clearly be seen as describing the different descriptions of reality. These stories or different descriptions of the client's drawing are always in relationship to others and relate to relationships and co-constructed realities. Both the therapist and the client have stories that are in relationship to one another. New meanings and ideas are added to the therapist's and client's stories and descriptions of the drawings.

The relative influence of the problem requires the client to select facts that are not homogenous to the dominant experiences of the problem (White, 1989). The client can, for instance, draw how he experienced himself before the accident and how he views himself after the accident. The influence of the client on the problem, which might be the losses suffered, is described, as well as the changes of perception that the client has developed through time. The neurologically-impaired patient might describe how the damage to his or her body impaired him or her and how change took place regarding adjusting to the impairment. The effects of the problem or the impairment on his or her life can include the effects on emotional state, and family, social, and work relationships. White (1991) emphasises the effect on how such clients view themselves and their relationships. One client described himself as being outgoing and likeable before the accident. He described himself as aggressive and frustrated after the motor vehicle accident. He drew himself small and passive, whereas the drawing of himself before the accident was one of a confident man. A conversation about the effects of the accident on the current drawing of himself took place. White calls these conversations "externalising conversations", since alternative ways of description begin to emerge. The use of art facilitates the imagination to construct different ways of describing the view of the self. The client begins to realise that certain aspects of the old self are still there, as in for instance, his relationship with his parent or wife. Still, the damage surely threatens these relationships. However the interactional passivity is seen

as something outside the client, something that the client can change and control.

The concept of unique outcomes is the focus of the narrative movement. Unique outcomes are times or experiences where the problem or the dominant life story did not overshadow the rest of the client's experience: "I have referred to these aspects of lived experience that fall outside the dominant story as 'unique outcomes'" (White & Epston, 1990, p.15). Normally the focus in therapy falls upon the losses suffered as mentioned in chapter 2. The challenge is to look for positive aspects that refer to the problem. New ideas are then sought around the positive aspects to deconstruct the problem. The unique outcomes thus pertain to situations or experiences when the client did not succumb to the demands of the problem and achieved a sense of control and dominance over the problem. An example is where a client repeatedly drew himself alone. I asked him how it came about that he perceived himself as so isolated. The conversation shifted to him being adopted and how he always felt alone. I pondered over the question whether he was always alone. He started to tell me about his wife and how he liked to do things for her. I commented that it did not seem as if his drawings of being lonely always manifest in his descriptions and even in therapy. I did not experience him as an isolated, disconnected man.

A technique that White and Epston (1990, p.4) frequently use is externalisation: "externalisation of the problem is a mechanism for assisting family members to separate from 'problem saturated' descriptions of their lives and relationships". A distance is created between the problem and the life of the client. This enhances the ability to objectify the problems that clients experience as oppressive. The relationship between the problem and the client is often described in an attempt to punctuate the decisiveness that the client has over the problem. The problem becomes a separate entity and does not become part of the client's dominant life story. The losses or isolation that the clients in the neurological rehabilitation ward frequently suffer becomes part of their dominant life story. These losses claim much of the client's spontaneity. The externalisation of problems helps the clients to "separate from the dominant stories that have been shaping their lives and relationships" (White, 1989, p.7). This attempt to separate the client from the problem is often a playful process. The use of art is also a playful process that leads to externalising of the problem. The therapeutic relationship offers the client a space in which to play with a new perception of the problem. The client maps or draws how the losses have

influenced his life. Merely by drawing the influences of the problem, a separation is punctuated between the client and the problem.

In therapy, both the therapist and client enter a therapeutic conversation or encounter about the drawing, without a set game plan or script. Within the therapeutic relationship, a new narration or description about the drawing is created. Neither party knows which way the conversation will turn. There is no strategy. The therapist takes the responsibility of keeping the conversation flowing and exploring new meanings around certain descriptions. If one sees the drawing as a common denominator, one could say that the drawing perturbs the therapist to create new explorations around descriptions. After the therapist has been perturbed, the therapist perturbs the client. The client is in control of what is said about the drawing, thus taking control of the content. The therapist takes responsibility for describing the therapeutic process. A context is created for change, and the process is not controlled but facilitated.

In this chapter, I have tried to illustrate some principles and ways of thought that underlie my way of working and subsequently the use of art in therapy. I have shown how art can be part of a therapeutic process where new meanings are generated and alternative stories are narrated. These stories could not have been described if art as a joining act was not used. The enactment and representation of the self are linked to drawing and the description of the story that the client symbolically shows the therapist. This drawing is seen as an invitation to enter into dialogue with the client to co-construct new meanings through news of difference. Art changes the therapeutic context in that the client actively participates in the enactment of the life story. This new context creates new ways of creating different meanings. I perceive my role as a therapist as assisting the client to bring forth new realities and as opening a space for the client to consider new possibilities. This space is enhanced by drawing and languaging about the drawing or painting. The relationship between therapist and client also changes in this new context where mutual story telling by means of expressing the self through artwork becomes possible. Art makes the narration that is brought forward more complex, which induces a richer description of meanings. Art can be seen as meaningful noise added as news of difference to the therapeutic process. A feedback loop is enhanced by this news of difference during which change is co-constructed in the interaction between therapist and client.

Art gives the therapist and client an opportunity to look at the problem through a different lens. Art as such has no real meaning, but when it is incorporated in the dialogue between the therapist and the client, it acquires meaning. This multi verse that is co-created gives the opportunity to access different meanings and ideas.

Joining is enhanced by art as the therapist gives of the self to the client. This process connects the client and therapist in a social constructional process where meanings are generated. Unique outcomes are explored by means of art. The expression of the self is in itself a unique outcome in that it breaks the pattern of not expressing the self, which is frequently a phenomenon found among people who are neurologically impaired. Through art, the client is expressing and dialoguing about the expression to the therapist. This unique outcome often leads to the generating of new meaning. Thus, the client forms new narrations that can result in a new life story. This approach is not symptom-oriented as the neurologically-impaired patient does not exhibit any real psychological symptom other than loss as discussed in chapter 2.

CHAPTER 5

THE THERAPEUTIC PROCESS: CASE STUDIES

Introduction

This chapter will focus on the therapeutic processes that the therapist and the clients co-constructed. The processes will be illustrated by means of drawings made during therapeutic sessions, sections of dialogue between the client and therapist, and process commentary. The use of art and drawing is primarily used in the therapeutic process although it is not the main “ingredient”; the main ingredients are participation and the construction of meanings. My aim is to construct a circular description of the therapeutic process. I will write this chapter with the model in mind that I described in chapter 4. Three case illustrations will convey the dynamics around the process of creating art with clients.

The use of drawing in therapy has many virtues. A prominent virtue is that it connects the therapist and the clients on an emotional level. Professionals often negate the emotional aspects of these clients as their neurological damage often prevents any emotional connection. By adding drawing to the therapeutic context, the context will change as news of difference will become part of the existing context. Together the client and therapist can explore new avenues with the pictures that the clients draw acting as tour guides.

Mr M

I began seeing Mr M in the summer of 1997, when as an intern psychologist I was appointed to the neurological rehabilitation ward. The final session with Mr M is used to illustrate the use of art in therapy. We used a temporal component to construct how Mr M experienced his life

story. (Please refer to chapter 2 to gain sufficient knowledge about his background.) The first two therapy sessions we had consisted mainly of testing and neurological-psychological assessment.

Forming a therapeutic relationship with him was difficult. His aggressiveness developed into anxiety and disqualification of any relationship. He was always making jokes about what he said. His participation was not bound and I had difficulty understanding what he was trying to express. He was still under the impression that the hospital would soon send him home and that any mention of problems would prolong his stay in the rehabilitation ward. He reacted with uncertainty towards what the occupational therapists and physiotherapists expected of him during the therapy sessions. It seemed to me that he did not take ownership of these sessions. He took on the role of the passive brain-damaged victim who was just following orders and wishing that these sessions would end as soon as they had begun. It seemed to me that Mr M did not want to address his problems. It would have been a therapeutic mistake to force him to speak about the losses he had suffered. These losses would put him in the position of the eternal patient in therapy. We started to focus on his life experiences and not on the problems that brought him to therapy. Thus we sought no problem definition in the first few sessions after assessment was done.

Mr M's interactional style was to dismiss any discussion that could describe him as having suffered loss or change. He almost denied any form of change to his own life and described that all he wanted was to return to his home and work environment. I felt quite dismissed and did not know how to react to his interactional appeal since it seemed that he denied our therapeutic relationship. The rest of the therapeutic team described him as uncooperative and sporadically aggressive. His wife was afraid of him and a marital problem seemed inevitable. I had the idea that Mr. M's aggression was a manifestation of his anxiety and fear of being in a situation or context where others did not understand him. He could also not understand what had happened to him. Mr M was not the person that he used to be and he was in a context where he was different. People treated him differently and his only way of handling the situation was to be aggressive and dismissive. I was at my wit's end as Mr M had manifested certain ways of hiding his vulnerability. Jokes and passivity were the main mechanisms he used to deny the trauma he had suffered.

I realised that I had to acknowledge that Mr M was not ready to expose himself so blatantly by admitting that he had a problem. The relationship developed as we started to draw together, as he told me that he had liked to draw before the accident. This was a joining technique if ever I had seen one! The act of drawing would change the therapeutic context and news of difference could become part of the existing context. A co-creative therapeutic process was about to commence. I did not feel as if I was manipulating the process, as Mr M was quite keen to draw again. This connects to Keeney's (1983) idea that the therapist can never have control or "conscious purpose" over the therapeutic process. The therapist must be sensitive towards the client's needs and abilities. I, as therapist, could not force my needs upon the client and subsequently became part of an unpredictable process of exploration and joining. Mr M could through drawing with me, "dance" in my presence, something which has its roots in the concept of enactment. I must admit I was relieved when Mr M acknowledged that he would be keen to draw with me. Our mutual partiality for drawing initiated the process to co-drift in a process of drawing and engaging in dialogue about the drawings. I did not know what would happen in this new process of which we were part. While Mr M was drawing, I asked him what he would like me to do. He commented that I should also draw or create something. I decided to paint and to try in that manner to comment on what he was drawing. As described in the conceptualisation of the model, the client's inner monologue, as portrayed through his drawings, is put in interaction with the description that I gave. I gave the description in order to generate new meanings.

Sketch 1 (1 Appendix 1)

Mr M described himself in the picture he drew as always clean, punctual, obedient, and a good listener. He was always friendly towards other people. His reaction to the question: "What was not always good?" was that he did not like to read and that he did not talk softly. He was always laughing and had the habit of hiding his true feelings, especially his feelings of anger. He described his marriage as very good and said had had obedient children and a wife. He liked other people and aimed at helping the less fortunate. He was a big man on the inside but small from the outside. Mr M was good at his work. He took pleasure in sports, soccer and cricket. He also liked to play with his children and to cook food for his family. He was easily angered and was always searching for the truth. Many people cared for this man.

A context was created where representation could take place as described in the model in chapter 4. I gave Mr M the chance to describe the type of man that he was. He therefore could actively participate in the co-construction of the self. He explained what his duties as a warden were and why he chose to join Correctional Services. The process between Mr M and I changed as I did not treat him as someone with a deficiency of some sort. We laughed together at the stories that he told. For the first time, I realised that I did not have a sense of urgency in the therapy session with Mr M. I realised that I was not taking sole responsibility for the therapeutic process and I could calmly co-drift. This self-referentiality was very important as my own beliefs about what therapy should consist of became known. The tension between Mr M and me was released in a creative process where we talked about his experiences and views of the context and persons that he knew.

The next sketch that Mr M drew was about his experience of himself after the motor vehicle accident. The content of the sketch is different as it depicts a drawing of himself after the accident, where he is in the hospital. This picture shows that he could comment on and describe the losses that he had experienced. In brief, Mr M clearly acknowledged that he had experienced change and loss. Through his paintings, I caught a glimpse of his reality.

Sketch 2 (Appendix 2)

Mr M was involved in a car accident. He was taken to the hospital. He hurt his head and body badly. At least he was still alive and could walk. Mr M lost his car. He received a cranial fracture and had to drink tablets. His wife came to visit him, but he was still alone. He was quiet and often hid. He pondered on his problems. He was worried about his wife and children as there was not a man at home to protect them. The one child was sick with longing for her father. She did not sleep. Mr M hurt his brain but would recover. He was not such a big man as he always had been. He could not think properly and he could not remember things. He felt sorry for himself. He had lost so many things: blood, the car, his wife and children, his marriage, and his job. People treated him the same as they treated his father who had had a stroke many years back.

Here Mr M showed his dissatisfaction at being labelled. He did not experience that he was simply a patient. The knowledge of being neurologically impaired affected his behaviour. He saw

that people treated him as if he were disabled. Through the drawing, I gave Mr M a chance to escape the negative discourse that dominated his life. I saw him in a different way as he also saw me differently. The dialogue concerning this sketch was more emotionally laden. Mr M did not describe himself as happy. This changed the therapeutic process and relationship. Here Mr M acknowledged that he needed support and that he still had to go through a process of healing. The wounds to his head and shoulder were made a bright red that acted as a further form of acknowledgement that he was truly hurt. I reflected that the intensity of the colour was symbolic of the emotional intensity with which he experienced the trauma of the accident. The intensity of his description touched me. I think that he probably could not describe his pain other than through colour. I became aware of his vulnerability and loss. The silence between us lasted in order for us to absorb the emotional impact that this drawing had. I commented that this drawing was different as this man was not afraid to hide his true feelings of pain and loss behind jokes.

In comparing Sketches 1 and 2, the present Mr M was clearly not as friendly as the old Mr M. The present Mr M was still as easily angered and still did not like reading, liked working, and saw it as a blessing to be able to work. Both of them still laughed a lot. Both persons wanted the same things, namely a happy family. The present Mr M longed to be the old one again. Yet he knew that it could never be because he had encountered an experience that led him to reevaluate his life. His priorities lay with his wife and children now. Mr M described the second drawing in these words: "He had seen something big". He was now more quiet and thought about future plans and beautiful things.

The final sketch described Mr M's view of how the future will look. There was a sense of control in this picture, he had certain plans and views that he expressed.

Sketch 3 (Appendix 3)

The future of Mr M was described in this drawing. His thoughts centred around his wife and children. This man would be close to them. He would always be thankful and happy. This man was obedient. He planned to buy a new car. He would also get a firearm to protect his family as they lived in a dangerous area. This was an even bigger man than he ever had been. He had learnt from the traumatic experience that he had survived, and he had the strength to take charge of his life.

The head that Mr M drew on the third figure was disproportionately large. The focus of his attention might have been on intellectual power as the head is the primary organ of intellectual functioning. The drawing of the gun worried me as it might have been an indication of Mr M's aggression. I had to remember that it was not my role to question Mr M's reality and the meaning that he attached to the gun. All I could do was to talk about the gun. We co-constructed the reframe that the gun was symbolic of Mr M's renewed strength that he had found.

The three sketches depict how Mr M attributed meaning to his experience. In dialogue about the drawings, he could express the meaning that he attached to the accident and the losses he had suffered. While Mr M was making his drawings, I painted how I experienced Mr M's drawings. I gave honest feedback as to my impressions of Mr M's drawings. Self-referentiality played a major role in the therapeutic process, as I included myself in the descriptions that I gave of Mr M's drawings. Mr M and I were partners in this therapeutic context. I joined with him in a humane way by also drawing with him, without the expert position. I had found a positive way of looking at Mr M. One can see the drawing that I made as a meta-comment on Mr M's drawings.

The conversation did not involve the problems that Mr M was experiencing. The dialogue was around how Mr M experienced himself in three stages and how I experienced what he was drawing and saying. Mapping of the problem took place within the three sketches that he made. Mr M drew me a description of himself. The drawings were the story of his life. I understood his story and he could express himself.

Throughout the therapeutic process, confirmation was used as a tool of affiliation. I constantly praised Mr M for the effort he put into the drawings. I described Mr M's effort to draw, very positively. The act of confirming the positive aspects of Mr M's drawings defined me as source of self-esteem for Mr M and was a joining technique. I acknowledged Mr M's self-expression and risk-taking behaviour.

Out of my drawing (which is the fourth drawing, Appendix 4) that was feedback on his expression, we formed new words to describe our descriptions, thus new meanings were co-constructed. The story that I painted was in relationship with the stories that Mr M drew. In the

dialogue about the four drawings, new ideas and meanings were added to the stories. This process of self-referentiality played an important role in the therapeutic process. I connected myself to the description of growth and change that was the meta-comment on Mr M's drawings. Thus, there is a pattern that connects in the drawings where both of us described change and growth. Mr M participated in this context by organising his experience of his life and the traumatic event that formed part of his life story. A story about Mr M's story emerged in the therapeutic process and through the picture I was drawing. The drawings that Mr M made created a context in which he told his story. This is a depiction of Mr M's struggle to let people, specifically the therapist, get closer to him. It seems as if Mr M could express his feelings of pain, hope and despair through the medium of drawing and talking about the drawings.

Mr M moved away from a problem-saturated description of his life. The third drawing was full of positive descriptions. The problem became a separate entity of Mr M's life story. The drawing shows that Mr M allowed different descriptions to form part of his life story. He described himself as changing and learning from the accident that changed his life and his perceptions about life, which is a manifestation of news of difference.

The process of drawing and painting was a playful and creative process, which made the externalising of the problem description easier. The therapeutic process was lightened by rather focusing on change and not darkened by placing the focus on loss. The drawings gave us an opportunity to tell stories and finally to merge our stories. I saw Keeney's (1990) idea that therapy is a context during which stories are shared and exchanged come alive.

Mr J

Mr J was in the final stages of rehabilitation. (See chapter 2 for background information.) The first drawing that he made was a picture that he had copied from a cartoon. He was not ready to communicate anything about himself or express what his thoughts were. Nevertheless, as already mentioned, there is no such thing as no communication. He described that the picture is a painting of his experience at the rehabilitation ward where he had to learn about things he lost after the motor vehicle accident. The picture was about Snoopy and a chick with their noses in books. I saw that this picture was a manifestation of Mr J's passivity in therapy and in the ward.

The drawing was first drawn in pencil and then painted, which might be a manifestation of his caution in entering a therapeutic relationship. He was afraid to expose himself interactionally. I, on the other hand, was energised and active, almost on Mr J's behalf. I created my painting with much conviction and energy. This interaction was a manifestation of a complementary relationship, where the one part of the system is active and the other passive.

Mr J, at the time of the drawing, was quiet in the therapeutic groups and seemed to ignore the rest of the therapists. His passivity bothered the rest of the therapeutic team as he showed no progress. He manifested with feelings of depression and sending him home was considered as he was taking up space at rehabilitation that a more active patient could occupy. Putting Mr J on antidepressant medication was also considered. Mr J's wife and daughter indicated that he was passive at home and did not seem to care about anything. A conscious attempt to change Mr J's attitude did not seem to meet with success.

It should be kept in mind that Mr J had sustained extensive brain injury, yet his attitude towards the people in the rehabilitation ward constantly negated any closeness. He admitted the passive patient role as part of his self-description. In therapy we spoke about all the things that he had lost and his uncertainty about his own future. He said that he disliked being treated like a child by everyone who came in contact with him, even the people with whom he worked. I saw the comments that Mr J made as a positive manifestation of his ability to still take control of his life. I realised that I could not observe and probe from the outside; joining was necessary. I needed to experience what Mr J was communicating to me.

Mr J acknowledged that they had not yet told him the extent of the damage as everybody thought that he could not handle the knowledge. I interpreted this statement as his willingness to take responsibility again and explained to him what had happened to him during the accident. I explained what the nature of his injuries were and how some of his cognitive functions would be affected. Mr J fell silent for a while and then said that he did not know that the damage was so extensive. He said, after a while, that the knowledge of the damage at least gave him an understanding of what had happened to him and why he felt so totally out of control. Mr J's memory was the function that was the worst impaired.

My impression was that the information that I gave him shocked Mr J. I felt ill at ease with my decision to share the information with him. It was almost as if I had wanted to protect him from the harsh reality. Yet his appeal to me was to explain and guide him in the process in which he was involved. I realised that I could not take the responsibility of bearing his burden by keeping it away from him, as it was already affecting his whole life. At least now he knew what he was up against. Maybe now he could participate actively in the healing process, since he had ownership of the problem. Mr J could ascribe a different meaning to and reframe the narration of his life as explained in chapter 4.

Painting 1 (Appendix 5)

The painting that followed depicted his house. Mr J jokingly commented that there was a problem in this picture, namely that, although his house was supposed to be deserted as his wife was at work and he was elsewhere, there was smoke coming out of the chimney. I commented that there might be a stranger in the house. Mr J stared at the picture and said, "Yes, like a burglar.. I again commented that the burglar might be an imposter - someone that Mr J or his wife did not know. Mr J smiled and said, "Yes, but who?" I said that this person might be the Mr J after the accident, the person who has little use of his memory and is often lost. Mr J began to look very sad and said that he had lost so many things. Mr J seemed to connect with my last description of his picture. He told me about his lost role at work; he was the "memory" of the team he worked in and his cognitive ability that distinguished him from the team was gone now. His good friends had disappeared since his strange behaviour manifested. He felt isolated. He told me of incidents where he sometimes did not know his wife and that he lost himself. He was amazed at the things that he allegedly did, according to his wife; of all this he had no memory. This new person was taking over his life and he felt like a helpless onlooker. In the dialogue about this drawing I saw a different aspect of Mr J. He was able to give me a monologue about his reality. His monologue then became involved with my more positive voice.

My question to him was, what had he gained? He answered that he had become much more humane. He cared about people and their feelings. Pre-morbidly he only looked out for himself; now he constantly worried about his family members - he was more approachable and liked to be in a space of closeness and connection. The group members confirmed that Mr J made them feel

at home in the ward. A new reality was generated as different ways of looking at reality were explored.

Mr J's need to be in a space of closeness and connection can be seen in the painting that he made. The house has a clear fence painted around it. This might be a manifestation of his need for security and structure. This need was taken into consideration in future sessions. The sessions were always at the same time and in the same context; he would always sit in the same seat. The structuring of the sessions is very important as this gives the client a sense of comfortable control over the session.

I expanded Mr J's description of the imposter. This is a good example of double description. Mr J and I combined our descriptions to obtain a sense of the whole picture. In interaction we created meanings that corresponded. The problem was that, for a very long period, Mr J's dominant life story was that of soldier and team builder. Now, without his consent, the accident changed his life story to that of patient. In interaction with others, he accepted this new life story but the implication was that he was left without control over his own life. The drawings gave Mr J the opportunity to comment on the changes that he had experienced, which in a way gave him a sense of control. The dominant life story was again in the process of transition. I took the responsibility of keeping the conversation flowing and of exploring meanings around "the imposter". The leadership role of the therapist can clearly be seen as a joining effort. Mr J experienced a sense of understanding and comfort. The joining offered Mr J the security to explore alternative ways of describing the drawing. I accepted Mr J's organisation and style to join with his system.

Painting 2 (Appendix 6)

This painting shows the same picture of the house but with trees overshadowing the house. I interpreted this as a sign of change and development. Mr J confirmed that he was changing. He was on a type of growth journey and he had to get used to himself from the start, but he was hopeful. I commented on the progress these pictures showed me, whereupon Mr J commented on a more cynical note that he sometimes felt as if there was no progress but rather decline. I explained that progress and change are not always positive. Mr J smiled and said that these

pictures told me a lot about what had happened to him.

I asked how his relationships had changed, if at all. Mr J explained that he was not a pleasant person anymore and that he had few friends left as he was often in a bad mood. Mr J also described his mood as constantly depressed. He felt that people focused too much on the accident. His normal reaction when talking about the accident was to withdraw as he could not remember the accident. He did not feel that all conversations should centre around the accident. He was prepared to learn different ways of memorising difficult information and to learn to get used to his new life. All he asked was for other people to let him try on his own. I interpreted this as meaning that Mr J would have liked more responsibilities and I suggested that we ask the ward personnel to act on this request. When Mr J found his own voice, he took charge of his own story. He was not satisfied with subscribing to the passive patient role that liberated him from all responsibilities. Mr J's interactional style changed as he became aware of change.

During the weeks that followed, Mr J developed the leadership qualities that he had had before the accident. Mr J amazed the other therapists with the initiative that he took. He organised the ward activities and resumed the position of coordinator. Soon, comparing him with the passive, apathetic patient that had come into the ward a few months previously was very difficult. I became involved in supporting Mr J's strength and potential. I described the "unique outcomes" (White & Epston, 1990, p.15) that he showed me through his drawings. His position in the ward system was enhanced, which contributed to the positive aspects that he saw in himself. The other therapists and ward personnel praised his efforts in the ward, which enhanced the unique outcome. Mr J expressed his needs through the art medium; he claimed his right to be treated in a humane way. His paintings punctuated his individuality. These paintings were unique and acted as an affirmation of Mr J's ability to take control of his own life, even if it is a different life to the one he was used to.

During one of the last sessions, Mr J could show his emotions. He could show me his pain and turmoil. His ability to express himself verbally was an indication of his movement towards taking control of his life and allowing others to come close to him. The main theme that I could identify is that Mr J took control of his own life. He commented on those aspects that did not suit him and he soon created a worthwhile life for himself in the ward.

His wife commented that he made jokes and did some work in and around the house. He was taking control of his environment where he was previously just the victim of an accident. In some respects he was totally different from how he was before the accident; he was more docile and did not get as angry anymore. He felt more like a husband to her than ever before because he was at home and seemed more in touch with the aspects of her life.

Painting 3 (Appendix 7)

Mr J made this painting shortly after he had heard that he would be medically boarded. He was in dismay over the loss of the working context. He felt that his purpose in life would be taken away as he lived for his work. Mr J made the painting of a fish and explained that fishing would be his main activity to pass the time. I commented that Mr J might feel like the fish on the hook that he painted. This seemed to fit in with the way that Mr J felt and he commented on how out of control he felt. He described that he had always been at the helm of his own life and that people now decided on his behalf. He did not know what the meaning of his life was going to be without his work. This, as already explained in the model, is an example of how a conversation could be generated and meanings that correspond could be co-created.

The drawing made the emotional component of Mr J more obvious to himself and to me. The painting enhanced the emotional intensity of the therapeutic process. Mr J seemed very sad but soon communicated his feelings of loss towards his wife and, in fact to anybody that would listen.

He described himself as an elephant, huge and clumsy. Very soon his family knew what Mr J was going through because it seemed as if he had mastered the technique of eliciting support from them. They discharged Mr J shortly afterwards.

There is no right or wrong way to describe the paintings that Mr J made, as objectivity is put in parentheses (Maturana, 1975). My descriptions of the fish on the hook are not the only descriptions of the truth and are merely different ways of looking at reality. They are merely different punctuations. It became clear through Mr J's drawings that pain and misunderstanding that were part of his life. Mr J made me aware of these areas of pain, loss and problems through

the drawings. Joining also implies that the therapist must be sensitive to the pain, pleasure and interactions within the system. I was involved in these processes with Mr J through the drawings that he made. The paintings made overt certain elements of myself that resonated with Mr J. We shared the experience of pain and the meeting of our two systems. I gained information about Mr J in an experiential manner, through joining. He gave me a description of his reality in interaction with me.

Of course, one has to realise that Mr J's picture, did not tell it all. A reductionistic approach implies that the characteristics such as colour, space and detail are required to understand the drawings. Yet in a typical Batesonian voice, it must be kept in mind that the whole is more than the sum of the parts. This leaves me asking if a reductionistic approach is meaningless. The answer seems to differ from individual to individual. The creator's explanation of the picture structures the understanding of the picture. Thus, I have to rely on the client's description of the picture rather than making my own interpretation. Mr J's description of the fish led me to comment on the fish, rather than, for instance, the sea or the use of colour.

Mr J risked a lot to expose himself emotionally to me, but through the drawings he could see that I would understand him without ridicule or evaluation. A context of safety was co-constructed through the drawings that we made and risked showing each other. Mr J's life and emotional states unfolded in front of me through the drawings that he made. We created a type of ritual, much like the ancient rituals of healing. The therapeutic sessions always had the same drawing process and structure. The only difference is that the content would change which also changed the dialogue and process.

Drawing brought unity between Mr J and me. One could see how Mr J developed from a passive patient to an active participant in the therapeutic process. The change can clearly be seen if one compares the copied Snoopy painting with the last painting of a fish on a hook. The relationship between us also changed from a static complementary relationship to an oscillating relationship, characterised by an interplay between a symmetrical and complementary relationship.

Mr T

Mr T made a series of sketches that we discussed in a final session. (Please refer to chapter 2 for background information about Mr T.) He was eager to participate but was unfortunately not in contact with what had happened to him. He was under the impression that his stay at the rehabilitation ward would be of short duration. I had the assumption that he was not aware of the extent of the neurological damage that he had suffered. In the sessions after drawing, I would refer to the drawings that Mr T had previously made. He could remember the drawings and details as he could organise the conversation we had about them into a structured visual form. This is a benefit of working with visual stories; they are easily remembered and give the client a sense of accomplishment, which as, described in chapter 4, is a joining technique.

Muriel: Hoe ek dit sien is dat jy sedert Mei van hierdie jaar hier by ons was, hoe was jou belewing gewees van alles wat met jou gebeur het?

Mr T: Vir my was dit aan die begin baie vreemd gewees seker omdat ek nie gewoon was aan die militêre opset nie, maar ek het dit vinnig aanvaar en ek dink ek het goed aangegaan.

At the onset of his stay Mr T did not believe that participating in the rehabilitation program was important for him. His comments were an indication that he finally did adapt and participate in the program. The context where he at first found himself did not fit with his structure, as he was not a member of the Defence Force. He found a consensual domain in the ward with the other patients - this he described as adaptation. Their consensual domain could have been that they had loss and struggle in common.

Muriel: En met betrekking tot wat met jou gebeur het, hoe het jy sin daaruit gemaak? Hoe het dit jou lewe verander of eerder beïnvloed?

Here I structured the question to describe a context of change. I gave Mr T the opportunity of telling me about the change in his life story after the accident, and then describing the change of change.

Mr T: Ek glo dit het my rustiger gemaak, ek was dit glad nie. Ek was baie besig en gejaagd ek wou altyd aangaan ek wou vorentoe gaan voortbeur. Ek het op mense getrap solank ek vooruit gaan.

Muriel: Jy het baie hard gewerk.

Mr T: Ek dink ek het te hard gewerk. Dit is iets wat ek aan gewoonde weer moet raak. Ek is nou baie rustig. Op hierdie stadium wil ek net voortgaan met my lewe. Daarmee bedoel ek nie dat ek wil voortjaag met my lewe nie ek wil net rustig op my eie rustige pas aangaan.

Mr T described that he needed to feel in control of his own life. He wanted to set the pace for recovery.

Muriel: En met betrekking tot jou huwelik, waar dit nou 'n nuwe wending toon? Wat is jou gevoelens daaroor?

Mr T: Ek is seergemaak daardeur maar dit is maar deur myself, ek neem verantwoordelikheid. A (sy vrou) het lank terug gesê dat wat ek ookal besluit, is my besluit, toe sê ek dan moet ons maar skei.

Muriel: Hoe het jy dit so gesien?

Mr T: Daar is nie eintlik vooruitgang nie, dit gaan nie gered word nie. Die seuntjie sal wel daar bly en hy sal altyd daar bly, hy is al wat ek het in elk geval en ek sal hom probeer ophemel so ver ek kan. Maar sover die huwelik aangaan sien ek nie 'n nuwe kans om voort te gaan nie. Ek sal die beste probeer maak van 'n slegte saak.

Mr T and his wife had serious marital problems before the accident. They were on the brink of divorce and the accident merely prolonged the divorce procedure.

Muriel: Die manier hoe ons mekaar leer ken het was ook vir my 'n nuwe ondervinding. Die terapeutiese proses was anders as die manier hoe ek gewoonlik in terapie is. Ek het min met jou gepraat, ons het meer saam geteken. Hoe was dit vir jou?

Mr T: Die teken aksie was vir my goed, ek wens ek kon myself in 'n teken rigting in dwing, want dit sou vir my 'n nuwe, ander perspektief gee oor my lewe. Deur te teken kan jy jouself uitbeeld. Dis 'n abstrakte ding, jy moet dink wat jy doen, waar met praat is dit anders. Teken laat jou toe om te wys wat jy gedink het.

Here the client gave a meta-comment on the process of drawing. He described the different way in which he perceived his life. He saw something different and was exposed to news of difference. In his words he saw how he thought and arrived at certain descriptions. The drawings made the client's inner monologue evident and resulted in a dialogue between the client and myself. The use of art in therapy fitted with Mr T's structure (Maturana, 1975). He lectured in mechanical drawings and was used to drawing; thus I made the assumption that he would find the activity resonant with his structure. Mr T seemed to enjoy painting and drawing; it was something that he was good at and he could enjoy a sense of achievement. It was a different way for Mr T to communicate.

Muriel: Watter ander perspektief het jy dan gekry met betrekking tot jouself? Kom ons kyk na al die prente wat jy gevef het, dis amper 'n hele gallery!

Mr T: Ja dis 'n hele paar.

Muriel: Wat het jy daarvan gedink toe ek saam met julle gevef het?

Mr T: Nee wat, ek het gedink dis hoe dit hoort, dis hoe mens dit doen. Dit was meer aanvaarbaar.

Muriel: So dit het vir jou iets anders beteken wat dink jy?

Mr T: Ek het gevoel die terapeut doen moeite met ons, jy't ons soos studente laat voel.

Muriel: Het dit vir jou gevoel asof ek steeds die terapeut is of iets anders?

Mr T: Nee, dit het vir my gevoel asof jy een van die pasiente is basies, maar nie altyd nie net as jy saam met ons teken was jy deel van ons. Dieselfde tog anderste.

The therapist does not stand independent from the artist but joins the artist as a responsible participant in the co-construction of realities. Thus, meaning is co-constructed in conversation and hopefully other options and possibilities will emerge as happened in this case. The therapist

also did not take on the expert position as this would have brought distance between the client and the therapist. I saw my role as therapist on a cooperative level, and I co-drifted with Mr T as I was part of the whole therapeutic system. The act of drawing with Mr T gave me the opportunity to make segments of myself more evident. I believe that the use of the self in therapy is the most powerful therapeutic tool in the process of change. Through drawing with Mr T, I also changed as I became more in touch with my own traumatic events or rather the way I storied them.

All I did was to create a context in which different meanings were generated about the drawings and paintings without controlling it. I took the role of leader in the structuring of the sessions. I could see how our constructions changed as we were exposed to news of difference. The therapist related to the system in a joining attempt by drawing with the clients. In Mr T's stay in the hospital which continued for more than four months, it seems that he described the relationship between us as meaningful. This relationship in which he acknowledged his pain has become a unique outcome for Mr T.

Muriel: Kom ons kyk 'n bietjie na die prente. Myne laat my soms 'n bietjie skaam voel.

Mr T: Ag toemaar myne ook.

Mr T accommodated my uneasiness with showing my paintings. Minuchin (1974) calls joining and accommodation the same process. Joining is never one-sided. Just as I accommodated to join with Mr T, Mr T also accommodated to join with me. We established a partnership between us where we gave each other support and reassurance.

Muriel: Kom ons kyk na die heel eerste prent (Figure 1, Appendix 8). As jy daarop terugkyk en jy kyk na wat jy geskep het, dit was net toe jy in die hospitaal ingekom het, wat het jy gesien in jou prent?

Mr T: Die taak was om iets te teken wat van jouself iets sê. Ja, dis reg, ek het maar gedink aan die huis, dit was tog maar waarvoor ek gewerk het. Ek het baie gespandeer aan die huis, ek het maar gedink aan die fisiese seermaak om nie by die huis te wees nie.

The client gave a description of the meaning that he ascribes to the drawing. The therapist's question is a perturbation for the client that contains news of difference. Mutual shaping took place as both the therapist and client are subjected to change in the co-creation of conversation.

Muriel: Dink jy, jy was besig om afskeid te neem van die huis?

Mr T: Ja ek dink so, soos laas naweek toe staan ek daar in die tuin en ek kyk na die dak en ek kyk so en beseft dat ek die gras geplant het met my eie hande. Ek onthou hoe die water onder deur die boom deurgeloopt het. My vrou sê toe vir my wat doen jy, toe sê ek, ek neem nou afskeid. Dit sal nou seker een van die laaste kere wees wat ek daar sal kom en dis vir my baie moeilik om afskeid te neem van die huis. Baie van dit was wat ek gedoen het.

Confirmation of Mr T's loss was not an act of interpretation but an act of joining as discussed in the model, as Mr T was already aware of his loss. This was more an acknowledgement of his expression. It seemed as if there was a sense of responsibility which emerged as Mr T described the picture. My assumption was that Mr T had become the expert in his own treatment and in the handling of his own future. Another assumption that became clear is that people are capable of change by behaving and thinking differently. Mr T had never shared his feeling of loss and melancholia when thinking about the divorce and leaving his house. He always kept his feelings vague and at a distance. The picture, it seems, set the stage for an emotional conversation around the divorce and his leaving his family.

Muriel: Onthou jy dat ons ook gefokus het op die gedeelte wat jy niks geteken het nie, nou dat jy daarna kyk wat beteken dit vir jou?

Mr T: Dit is my lewe vorentoe en daar is basies niks om my nie. Ek sê nie niks nie, niks wat my pla nie, niks waarvoor ek omgee nie. Baie min mense en so. Dit is soos ek miskien die wit gedeelte kan interpreteer.

Muriel: Ek kan ook onthou dat ons gesê het dat jy baie vry is en dat dit 'n nuwe blaadjie is wat jy begin.

Mr T: Ja... ek kon seker die bure se muur geteken het maar dit het nie vir my sin gemaak nie.

An important question that needed to be answered was, whether the client and the therapist could attain a sense of the drawing, as this was the main motivation for using the act of drawing. It seems that Mr T could attach a certain meaning to the painting that he had made. In retrospect, we had a dialogue on the meaning of the blank space. The discussion around the blank space generated a reframe of the previous reframe. This is a manifestation of the movement and change in ideas that the drawing could elicit. Therapy is about broadening ideas. In this example we addressed a new theme, namely that of the future. Mr T described his alienation and uncertainty about the future. This was an “unique outcome” as Mr T previously had not revealed his uncertainty.

Muriel: Ek kan ook onthou dat ons gesê het dat die pad dalk simbolies is van die motor ongeluk, en dat die ongeluk 'n skeiding in jou lewe veroorsaak het in terme van wie jy is en dat dit baie dinge uitmekaar getrek het.

Mr T: Dis reg so.

Muriel: Hoe beleef jy dinge nou? Het die ongeluk baie dinge uitmekaar uitgetrek?

Mr T: Dit het my nie uitmekaar uitgetrek nie, maar dit het basies nege maande van my lewe weggevat. Maar ek het darem ander mense deur hierdie proses ontmoet en so aan.

Muriel: So jy het iets daaruit gekry, dis baie braaf.

Mr T: Ja op 'n stadium toe ek daar in die hospitaal gelê het, kort na die ongeluk, wou ek net opstaan en werk toe gaan. Dit was die doel in my lewe. Toe is ek huistoe gestuur vir drie maande en toe is ek hier opgeneem. Ek het basies al toe maar begin afskeid neem van my ou lewe. Ek sê vir A dat dinge nie dieselfde is nie, so dis seker met die wete dat my lewe basies begin skeur het, uitmekaar uit raak. Dit is nou omtrent die regte tyd vir my om dit weer aanmekaar te sit. Ek het nou op die kant niks geteken nie want daar was niks nie, ek het nie geweet wat wag nie, die toekoms was maar duister.

Muriel: Het jy nou meer van 'n idee?

Mr T: Okay, ek sal in 'n woonstel wees en ek gaan terug werk toe. In my woonstel sal daar min wees, ek sal nie kreppeer by die huis nie, ek sal goedjies bymekaar kry.

Muriel: So jy het 'n plan?

Mr T: Die plan is daar, ek moet dit net tot uitvoer bring.

Mr T's competence was praised and could be seen as an act of joining. The therapist facilitated new content by using the drawing. The blank space provided a new theme. Mr T looked at himself differently; the meaning that he attached to the blank space had changed. He had gained new ideas about what had happened to him. He first had to face the fact that his life had changed and then he could move on to taking control of his life and decisions. He planned to move to his own flat and to slowly gather new symbols for his new life. Through drawing a different way developed for Mr T to perceive his life and even the therapist. The drawing also gave me an opportunity to perceive Mr T in a different way.

Muriel: Hierdie tweede, prent kan kan jy onthou waarom dit was?

Mr T: Ja ek moes iets teken wat deur my gedagtes gaan.

Muriel: En dit was dat jy terug gaan werk toe. Weereens het jy hier 'n groot stuk oop gelos.

Mr T: Ja ek kon die klas langsaan geteken het maar dis nou hoe dit is.

Muriel: Wat is nou anders, watter ander perspektiewe het jy gekry as jy na die prent kyk?

Mr T: Wel hoe dit is, is dat ek een van die dae weer terug gaan na die kollege en ek gaan die naambord sien.

Muriel: Wat beteken dit vir jou?

Mr T: Dit beteken vir my dit is waar my toekoms is, dit is waar ek my lewe weer optel. Ek kan weer vooruitgaan.

Muriel: As jy na hierdie prent kyk, kry jy 'n idee wat jy van die toekoms wil hê?

Figure 2 (Appendix 9)

Mr T: Ja, ek gaan steeds in 'n klaskamer funksioneer miskien nie nou dadelik nie dit hang maar af.

Muriel: Maak die idee dat jy terug gaan jou nie skrikkerig nie?

- Mr T: Ja dit maak my angstig. Ek is half verbouereerd ek weet nie wat om te verwag nie. Daar het baie verwickelinge plaasgevind. Ek weet daar is 'n paar dinge wat verander het, ek weet ek gaan terug maar ek weet nie of ek my ou klas gaan terug kry nie. Dit is tog my standvastigheid dis iets waaraan ek kan vashou alles is daar my kabinette, leërs en so. Mense het my leërs gebruik. Ek het nie eers my eie klassleutels nie, dis alles gesteel na die ongeluk.
- Muriel: Wat gaan anders wees as jy teruggaan, watter boodskap aan jouself lees jy uit die prent?
- Mr T: Wel die feit dat ek die tekenklas geteken het met leë stoeltjies. Daar is niemand wat daarop sit nie, beteken vir my dat ek alleen daar gaan wees daar gaan nie ander mense wees nie veral nie die eerste ruk nie. Ek sal alles weer moet opbou. Daar is op die bord geskryf maar dit beteken niks nie dit was miskien die vorige ou gewees.
- Muriel: Miskien is dit jy wat dit voor die ongeluk geskryf het.
- Mr T: Dis baie moontlik... ja maar daar was iemand anders in my klas toe ek weg was het hy die klas afgelos en daar was skoonmakers.
- Muriel: Wat van op simboliese vlak.
- Mr T: Dis regtig soos 'n handtekening, ek het baie gewerk op daai bord.

It seems that Mr T was in a constant process of making sense of himself and his experiences. Any knowledge that he might have had was a result of the process of making sense of the experience. The artwork that Mr T created was not the truth but rather the perceptions of an experience, or an experience that he was about to have. His description of the drawing seemed to imply themes of disconnection and loss of support. The paintings gave me a clue as to what Mr T wanted in the therapeutic relationship.

The meaning that Mr T attributed to the drawing had changed from the first description that he gave. The first description did not focus on the new challenge that lay before him. He described through the painting that there was something that he just had to reclaim. The description that he gave now, gave the impression that he saw his going back to work as a new challenge. This description showed the apprehension that he felt in going back to work, which was more congruent than the way he first described the painting. This is an indication that the

construction of meaning is a constantly changing process. There is never a point of termination when it comes to attributing meaning. The constructions that Mr T made could change and evolve. It seemed that in this description, he acknowledged his fears of going back to work.

Figure 3 (Appendix 10)

- Muriel: En hier het ons jou laaste prent wat kan jy maak daaruit?
- Mr T: Die chaos een. Dit is hoe ek my lewe sien met die dag en nag wat geskei is, die groter gedeelte van my lewe bestaan basies in die nag. Ek het gery, ek het die bus gery en goed. Ek was omtrent nooit by die huis gewees nie maar ek het myself kleiner in die dag geteken omdat ek eintlik maar 'n klein werkjie gedoen het in vergelyking met die nag. So dis dit.
- Muriel: Mr T 'n ding wat ons al voorheen oor gepraat het is dat dit lyk of dit 'n baie alleen skets is.
- Mr T: Ja, dis die geval. Daar is nie mense saam met my op die skets nie omdat ek myself maar sien as 'n alleen mens op hierdie stadium. Tog hou ek baie van mense ek kan baie goed luister en ondersteun maar in my hart is ek maar alleen. So dis hoekom ek die skets geteken het. Ek het nog altyd alleen gestaan. Ek het vooruitsigte dat daar ander mense ook daar sal verskyn of ek sal hulle daar sit.
- Muriel: Lyk my daar is plek in die prent
- Mr T: Ja, daar is plek, daar is gras en 'n boom en alles, maar ek is alleen. Ek sou eendag wou deel wat ek doen met iemand.

Interactionally, Mr T kept a distance between himself and other people by defining himself in such a manner that a systemic organisation was maintained that was characterised by alienation. I suspected that this process of isolating himself took place in Mr T's interpersonal relationships, especially after the accident. Yet there was a longing for closeness and the therapeutic relationship was a manifestation of Mr T's ability to let other people get closer to him.

By drawing with Mr T, I gained certain experiential information about him. This conversation illustrates how the therapeutic problem or theme could be drawn out and discussed. The drawing brought these emotions of loss and loneliness to the surface. These emotions were his and he was

in a context of safety because he controlled the descriptions of the drawing. The drawings that Mr T made set the emotional boundaries. The aspect that caught my attention was that these pictures were laden with emotional expression although Mr T did not acknowledge these expressions until I carefully touched upon them. It was almost as if he needed another voice to bring these aspects to the surface. Yet, Mr T owned these emotions and the descriptions of the drawings. He was given the space to differ from me and to elaborate on certain themes that fitted with his structure.

Mr T supported the meanings that I attached to his drawings. The interpretation could be given that he incorporated these meanings into his own meaning-system. Mr T's inner monologue was involved with my monologue which evolved into an internal dialogue. The relationship between the client and therapist is always important as it sets the creative and safe context.

The next drawing is the product of the process where we drew each other. We were amazed at the perceptions we had of each other. Mr T described how he had learnt to let someone get close to him on a meta-level. My hope is that letting other people get close to him will be possible. The unique outcome could be expanded to other relationships.

Muriel: As ek na jou laaste prent kyk waar ons mekaar geteken het, het jy die idee gekry dat die alleenheid tot 'n mate gebreek word? Ons moes regtig na mekaar kyk ek moes jou in ag neem en jy moes my in ag neem.

Mr T: Nee dis goed so. Met die ander sketse kry ek die idee dat ek baie tot myself gekeer was en my situasies. Maar hierdie was anderste, ek moes vir jou teken.

Muriel: Wat het dit vir jou beteken?

Mr T: Ek het basies daaruit geleer dat ek nie net aan myself kan dink nie. Ek moet aan ander ook dink wat belangrik is want ek het in my tyd hierso maar die hele tyd na myself gekyk en myself geteken. Ek wou die hele tyd my eie probleme oplos. Ek het niemand in ag geneem nie. A was wel daar en my susters maar ek het net aan myself gedink en dis hoe vër ek gegaan het.

Muriel: Ek kry die idee dat daardie tekening bewys dat jy wel kan "connect" met ander.

Mr T: Ja, ek het die naweek wat verby is vir A gesê ons moet gesels oor 'n paar dinge en ek het dit so rustig as moontlik benader. Ek het vir haar gesê dat al is ons nou geskei en alles. Dat sy my moet kontak as sy iets gedoen wil hê, want sy is ...afhanklik. Sy's nie ek wat soortvan onafhanklik is nie.

Muriel: Hoe bedoel jy, jy is meer onafhanklik?

Mr T: Ek kan my eie ding doen, ek kan self aangaan. Byvoorbeeld die naweek wou sy 'n elektrisiën laat kom om die wasmasjien reg te maak. Toe sê ek vir haar wag so bietjie. Toe trek ek my overall aan en maak die ding reg, terwyl sy kan dit nie self doen nie. Toe sê ek vir haar as ons uitmekaar uit is sal ek nog steeds vir haar goed regmaak. Sy sê toe nee maar baie dankie, sy het dit nie verwag nie. Toe sê ek ja kyk hoe surprise ek jou nou. Ja nee sy's baie afhanklik sy hou dan daarvan om dat ander van haar afhanklik is. Soos sy het byvoorbeeld altyd vir my toebroodjies gepak en ek sal seker sukkel sonder dit. Dit is haar manier van dankie sê.

Muriel: So ek kry die idee jy begin om die behoeftes van ander mense raak te sien

Mr T: Dis reg ja.

The model describes the concept of unique outcomes. Here Mr T's isolation did not overshadow his interaction with his wife. As I looked at, or rather tried to make sense of, Mr T's pictures I realised that his carefully constructed pictures, devoid of human figures became more unified and social. I could relate the concept of social interaction to his paintings. The feedback that I gave Mr T was that I understood his picture and that he was not as alienated as he thought he was. This is a manifestation of a unique outcome in an experiential way. The meaning of the therapeutic relationship changed interactionally. The therapeutic relationship can be described as a unique outcome as Mr T acknowledged his pain and isolation. The meaning of this relationship was incorporated into Mr T's meaning system. The therapeutic relationship became isomorphic to Mr T's relationships outside the therapeutic context. This can be seen in the way that he described his different interactional appeal towards his wife. He was honest with himself and therefore is now sometimes able to enter a relationship with other people.

Mr T's interactional appeal had changed from our first encounter. He did not have that

denying, even defeating, self-righteous manner about him that generated distance. He did not try to hide his vulnerability and isolation. The drawings were a manifestation of Mr T's loneliness and isolation. The drawings and the words he used to describe them formed a new work of art. This work of art was in an ever-changing process as Mr T and I described it at different times. Mr T described how he had to take other people into consideration with this final drawing. Afterwards he told a story of how he had started to consider other people. The problem in the previous painting might have been the isolation that he felt. In this painting the isolation was broken to a great extent. This picture was not homogeneous with the other picture. Mr T described a change in perception in his description of how he did odd jobs for his wife. This fact did not fit with the dominant experience of isolation. He gave alternative descriptions of his interactional style. Slowly he was breaking down the wall that stood between him and other people. The manifestation of this theme is seen in his drawings.

Muriel: Mr T, ek dink deur die afgelope paar maande met die tekeninge het ek 'n idee gekry van wie jy is, en dankie dat jy toegelaat het dat ek so naby aan jou kon kom.

Mr T: Ja dit is baie snaaks om ander mense naby aan my toe te laat, dit was vir my 'n voorreg. Ek was vir amper vier maande hier dis nogals lank maar ek sou steeds weer met jou wil kom gesels.

Muriel: Ja, ek is ook maar nuuskierig oor wat met jou gebeur? Jy gaan nou weer in 'n nuwe omgewing in met nuwe uitdagings en soms het mens ondersteuning nodig wat dit aanbetref. Wat sê jou vrou?

Mr T: Nee sy's heel verlig oordat ek terug gaan werk toe, sy was onseker oor wat van my gaan word.

I explained to Mr T that his brain had suffered diffuse damage. I used a sketch to aid me in the explanation of the microscopic damage. I had to keep in mind that information does not determine how a human system will behave. Human systems only respond to their own perturbations. I had to find a way of perturbing Mr T so that the information I gave him might be meaningful and integrated into his system. I used the context that he described namely, the college, as an example of what he might expect in the "outside world".

- Muriel:** Nog 'n ding wat ek jou op moet voorberei is dat as 'n mens se brein seergekry het dan hanteer 'n mens nie spanning baie goed nie want vreemde situasies maak dinge te onvoorspelbaar. Daarom vra ek dat jy jousef monitor en dat jy baie rus inkry. Dis baie normaal om 'n bietjie gestres te word.
- Mr T** Ja, dis wat die breinshirurg ook vir my gesê het.
- Muriel:** Jy kan ook verwag dat ander mense jou dalk anders mag hanteer as waaraan jy gewoond is, veral as hulle weet van die ongeluk. As jy ontevrede is oor die manier wat hulle jou hanteer gaan jy iets sê?
- Mr T:** Ja, ek is heeltemal kalm daaroor, die program het my baie gehelp. Ek weet ek moet nie bekommerd wees oor hoe mense my hanteer nie. Almal by die kollege sien uit na my koms hulle gaan vir my 'n partytjie hou en als. En daar gaan vrae wees oor die kollega wat saam met my in die kar was. Hy's mos dood en ek's nog nie seker wat ek gaan sê nie. Maar ek sou nou graag wou voorberei op die vrae. Hulle gaan almal vra wat het gebeur, al wat ek kan sê is ek weet nie ek het 'n breinbesering opgedoen en ek was in 'n koma. Daarna gaan die mense my seker pla, op my check. Eintlik het ek nie 'n problem daarmee nie. Ek sal maar die rustigheid vanself wees.

Here the client is prepared for discharge. It was amazing to see how the client acknowledged the needs of other people. He described himself in relationship to them and could foresee the implications of his going back to work. He was in touch with the changes in interpersonal relationships that had taken place. He had thought about what his reaction would be to the invasive questions and different interactional appeals that his colleagues would confront him with.

He was clear about his goals, values and future plans. He was not the dependent expressionless patient. In this conversation, we tried to structure the event of Mr T's return to work. This co-construction would make the transition from a predictable context in the ward less traumatic for Mr T. Mr T would only react to the perturbation from me if his structure allowed it. Therapeutic advice denied Mr T's autonomy; all that I could hope for was to trigger Mr T into considering the stress of the workplace.

The act of drawing ignores language boundaries and somehow the client seemed more confident because of this. His comments indicated the ability to give a meta-comment on the process. It seemed that Mr T found his own voice or way of expressing and within this process he took charge of his own life. It seemed as if he were ready to enter a new phase of life, which he knew could not be the same as in the past. Integration took place with the past, present and future.

Conclusion

In each of the three case studies the inner turmoil with which the client is struggling, was portrayed. This blatant cry for help, could not be denied or ignored as it touched me in relationship to them. These clients needed a form of self-expression that would not provoke performance anxiety. Their state of dependency surely contributed to the poor construction of the self. Through art there was an exceptional opportunity to co-construct a different concept of the self.

In the therapeutic process, drawing and painting were integral parts of the new constructions made. Drawing and painting were implemented in different ways as the clients were seen as individuals and not as a homogeneous group. Each painting differed and each process although coloured with similarities, was different. I could not predict the outcome of the drawings or the meanings that they would have. Conscious purpose did not have a chance to be portrayed in the therapeutic process.

Drawing was used in therapy to help the clients and me to connect on a different level. This connection can often be seen as a unique outcome, as these clients are often cut off from any meaningful relationships. This positive experience often leads to the construction and extension of new meanings that deconstruct the negative discourse that often dominates the narrative of these clients. These negative experiences of the self in relationships can now take on a new meaning as a positive relationship is formed with the therapist. We defined this relationship around the drawings that we made together.

The drawings gave the clients the structure and safety to explore their life stories. The drawings gave the clients a chance to describe the conflicts and aspects of their lives that were unaddressed. The drawings said the unsaid. I sometimes verbalised the unsaid and co-construction then took place with the clients. Self-referentiality played an important role in the therapeutic process. The descriptions that I gave were more of an indication of my own assumptions rather than the paintings. I had to use caution in describing and I had to take responsibility for my descriptions.

Clients with neurological damage somehow lose the ability to self-express. The loss of the ability to express the self verbally contributes to this phenomena. Through drawing this obstacle is overcome as the clients express and comment about their lives through a different medium. Drawing gave me as therapist and as “co-student” the chance to know the client and to move closer than I would have if a verbal mode of communication was the only one available. Activity is so often absent in people who have sustained traumatic brain injury. Drawing as an active mode of behaviour elicits a certain activity where movement and change become part of the therapeutic process. Creativity characterised the descriptions of the therapeutic processes of all three cases. The act of drawing broadened the perspective of the client and the therapist as the theme or rather the culture of the sessions was one of risk and containment. In essence I believe that the act of drawing seduces the client into a participative role. The case examples are illustrations of how these clients could find alternative meanings in dialogue. These meanings manifested in the relationships that they had with other people outside the therapeutic context.

The model described in chapter 4 was implemented in the descriptions of the cases. Every case had elements of joining, enactment, representation, news of difference, and externalisation.

CHAPTER 6

META-COMMENTS AND INTEGRATION

The introduction, chapter 1, describes the research process where I attempted to motivate my reasons for choosing this theme and to explore what I aim to achieve in the study. Chapter 2 gives a broad exploration of the losses and disruption that clients experience when submitted to neuropsychological damage. I give a structural description to equip the reader with basic knowledge about the impact of trauma on the brain, and the implications for functioning. I focus on the different systems and contexts that change when one member is submitted to neuropsychological dysfunction. I introduce the clients' stories to the reader to give a personal description of the impact of trauma on the lives of the people in the case studies. Chapter 3 describes the use of art in therapy. The development of art is traced to put it in context with the use in therapy. I describe the use and meaning of art through a systemic lens, as a systemic therapist concentrates more on the context and the relationship in therapy than the diagnostic value of the client's art. The motivation is expressed for the use of art in therapy as it shifts the client and therapist into a different way of communicating and relating to the problem definition. In chapter 4, I focus on the description of a systemic model that incorporates the concepts of joining, enactment, representation, news of difference, and externalising. I give a theoretical discussion of these concepts to give the reader a framework of my descriptions in the case studies of the following chapter. I describe how these concepts fit into the use of art in therapy.

Chapter 5 illustrates the research process by means of three different case studies. Theoretical constructs are chosen that fit with the descriptions of the process. The researcher's reality is thus described by means of the concepts in systemic language. I attempt to show the reader how the clients and I generated different meanings around the drawings that we made in therapy, upon which we formulated meanings about the meanings. The term co-construction is in essence the aim of the use of art in the therapeutic context. Co-construction cannot take place without the therapeutic relationship which is based on participation and joining. The researcher is part of the

therapeutic process and does not claim objectivity in the therapeutic process. The study concludes with a meta-description on the research process in this chapter.

The goal of this chapter is to trace the process that the project followed. I will use meta-descriptions of the research process to elicit more questions and to indicate the deficiencies in the study. As part of the observed system I will comment on how the project touched me and how it influenced my way of thinking about therapy and the way I think of myself as part of a therapeutic team.

Many rehabilitation programs focus on evaluation, creative activities, social skills training, and memory training (Busittil, 1990). The goal of any rehabilitation program is for the patient to develop an adaptable identity in which he or she can build up a productive and optimal functioning life. The role of the psychologist is to assess the client's cognitive functioning and to enhance the functioning. The goal in therapy as I perceive it is to be in a cybernetic feedback process where the patient can evolve and change to adapt to all the changes that have set in. This feedback loop is endangered if language as feedback medium is inhibited. Therapy relates to adaptation and self-expression. In therapy we create a space and a therapeutic relationship is established that might be isomorphic of life outside. The client must experience that he or she is part of that relationship. When the client experiences connection and understanding in the therapeutic relationship, he or she may enter other relationships. The therapeutic relationship is described as a unique outcome that is not part of the normal pattern. The meaning attributed to this relationship gives the client an opportunity to integrate this relationship into the constructions that the client and therapist make. Other relationships become part of the unique outcome pattern.

This study attempts to show the use of drawing in therapy with clients and how it can enhance the therapeutic process. Clients with neurological damage can often not remember the previous therapeutic sessions. By referring to the drawings that the clients make, this obstacle is overcome. We seek the pattern that connects through talking about the drawings that we make.

Since recovery from brain damage tends to run a certain course over time, assessing the true contribution of art and other therapies is very difficult. The clients always show change because

the brain tends to find other “pathways” to recover certain functions lost. However, I think it is safe to say that the drawings and paintings that the clients and I made inspired us to communicate beyond language, as language emphasises only one side of any interaction. The more senses we used in the therapeutic process when drawing and painting, and the more sources of information we used, the better the information that we communicated was organised.

Drawing and painting gave us the opportunity to express ourselves. Most of the clients that I saw in the neurological rehabilitation ward were not able to talk about themselves and their new contexts and relationships. With the aid of the pictures, we could communicate and address certain relationships. Through drawing and painting during the therapeutic process, we could co-construct change.

A trusting relationship between the clients and the therapist is of crucial importance. The drawings seem to stimulate the clients to speak about their feelings and loss. The therapy sessions were mainly a quiet time where inner monologues could “surface” and become involved in dialogue with the therapist. The neurologically-impaired client’s life story has been dramatically changed and the client needs to find the mobility to move around between the descriptions of different life stories. Drawing seems to offer that activity and mobility. As the therapist, I no longer feel cut off from the client’s world. I can engage with and understand the frustration and fears of my clients. Through drawing and painting I have found new ways to challenge the limited images I had of my clients. Through my own paintings, I explored new perceptions and in relationship with my clients, we created circular descriptions of these images. My role is to be the active and creative participant observer in the dialogue between the clients and myself. The key to this experience is respect. We have to be respectful of each other’s unique expressions and descriptions. The process of drawing in therapy develops into a triangular relationship between the therapist, the client, and the image.

The drawings and paintings give the clients the opportunity to see themselves as competent and courageous and able to accept themselves as changed. Such a view of the self as competent and active leads the clients to a new behaviour pattern of control and responsibility for the self and the relationships of which it forms a part.

The ideas of social constructionism play an important role in the description of the drawings. The meanings that we generate around the descriptions of the paintings are discussed and evolve into other conversations and other meanings. These meanings can change. In retrospect, the clients and I could see how change had occurred. The clients use the drawings as pinnacles of the meanings that they attributed to their life stories. Together we talked about these drawings in an attempt to exchange news of difference.

“News of difference” can be generated around the paintings and drawings that were made by the clients. The therapist can comment on the paintings, by introducing a different perception. The clients frequently give the therapist very concrete descriptions of their paintings. The therapist then uses these descriptions to describe a different aspect, sometimes on an emotional level, of the drawing or painting.

Art making may be regarded as a potentially complex process. A person who is having trouble in self-expressing is exposed through art to a new way of expression. A channel is used that was not previously used. The client is invited to move with the therapist. We create a different context. Co-participation takes place. The act of drawing also externalises (White & Epston, 1989) the description that the clients give. We create distance between the client and the problem description. This makes the description of the description more flexible. We attach a playful element to the therapeutic process. One can see the playful element in the way Mr M can map his life story without being overwhelmed by the implications of the motor vehicle accident.

The research process develops according to the feedback that the clients give about the process. The feedback is then used to develop the therapeutic process. As part of the therapeutic and research process, I cannot predict the process. I have to co-drift with the system.

Art has always been a hobby of mine but I never thought that it would become part of the way I relate in therapy. It was out of pure desperation that I incorporated something that I was comfortable with, to connect with patients that do not connect. The problem that I faced was that these clients did not talk to me. They denied the interactional appeal that the therapeutic context gave. Art seems to connect the therapist and the client. Art spontaneously becomes part of the

therapeutic process, without planning or “conscious purpose” (Keeney, 1983). The act of drawing and painting corresponds with the structures of the clients and the therapist. In the presented case studies, it seems as if the use of art in therapy perturbed the clients in order for them to make certain structural changes (Maturana, 1975) on interpersonal levels.

The research process illustrates how a process develops over a period. The patterns are evolving and constantly changing. Most clients with neurological damage want the therapist to take the position as leader. The therapist takes this position as a way to join with the client and to structure the sessions to enhance participation. Gradually the process changes so that the clients take responsibility for the process in co-construction with the therapist. No leaders are punctuated in the process of creating art.

The therapist facilitates the dialogue between her and the client so that together they can generate news of difference. Keeney (1983, p.4) says “therapists can play an active part in the reconstruction of a client’s world experience”. I do not pretend to know or to lead the whole, but I do challenge the reality in order to co-construct a new world experience. My thoughts are that drawing may challenge the client’s constructed world of loss into a world of expression.

Drawing and painting dramatically transforms the therapist/client’s relationship and it promotes independence in thought and behaviour. The relationship between the therapist and the clients changes when drawing and painting are introduced. The therapeutic relationship becomes more familiar and relaxed. The therapist does not feel as if she is carrying the therapeutic process, in other words, I no longer feel as if I am taking sole responsibility for change and dialogue. My interactional style changes. I am no longer the assessor, the expert that has to give advice and structure the rehabilitation context. I no longer feel the need to perform and to save the client from the losses that have been suffered. By drawing together we create a context of safety and sharing rather than that of passivity and expertise. Now my concept of therapy has changed in order for me to describe it as a meeting of systems in an intense and safe context where the systems are allowed to manifest in an emotional and relationship-bound manner. It is the therapist’s role and responsibility to negotiate with the client to co-create this context. Whether the context is co-created through art or not, is up to the therapeutic system.

Different levels of description are used in the research process. Keeney (1983) describes this as “different levels of complexity”. The client and therapist make the drawings or paintings. The client and therapist describe these works of art in dialogue. We describe the descriptions in later sessions. I describe these descriptions by means of process notes and comments that I make in later sessions. Maturana (1975) calls these different levels of descriptions a “multi verse”. Different meanings are generated by means of the different descriptions. The client and therapist often integrate these different descriptions into the construction of the self and into the therapeutic relationship. The drawings act as a feedback technique on the different levels of the therapeutic relationship.

As I look at the clients in the case study, I realise that these men had to undergo an epistemological change. Keeney (1983) describes this as the deepest order of change as a change takes place in the way clients experience the world. They also change the way they are in the world. They rediscover their own uniqueness.

The research process has certain deficiencies and areas that need more attention. I have written the study in such a manner that the practical implication of drawing in therapy is often not emphasised. This suggests that the study frequently loses its focus. I convey ideas in a roundabout manner. Drawing and painting are visual activities. Thus, I find it difficult to convey the therapeutic process through words. The therapeutic experience has not been totally described through the words that I use. In future a video clip might be more useful in the conveying of the atmosphere and connection that takes place between the clients and me.

In retrospect, it seems as if the different chapters on the implications of neuropsychological damage and art do not meet; they are not as well integrated as expected. It seems as if the theory overshadows the practical use of art with the clients in the case study. Using the case study as basis for the study would have been more useful than a theoretical punctuation and emphasis.

An area that did not receive much attention is the content or sub-components of the art works. With this I mean the brush strokes, the different colours and how the colours changed, the use of space and medium. In further studies, these aspects should receive attention as they generate a richer, concrete description of the art works.

As the therapist, I am included in the descriptions that I give. As I painted and drew with the clients, one would expect more focus on the self as therapist and how the process perturbed me. I think that further studies should incorporate this aspect as this subject is too big to be touched on in this study.

A further idea that needs more research is the involvement of the family system in the therapeutic process where drawing and painting is part of the process. As a systemic therapist, I acknowledge that any change in a part of a system affects the whole system. Yet the physical participation of the family in the therapeutic process will naturally incorporate a different therapeutic process.

I do not think that the aim of the study is to convince the reader to incorporate art in therapy. The aim is to convey the idea that creativity is essential in therapy, despite the nature of the client system. The study makes it clear that the use of art, in the context of therapy with clients with neuropsychological damage, makes the therapeutic process more active and open to new meanings. I cannot use art in therapy to change the client as then I would use “conscious purpose” as part of the therapeutic intervention.

The clients and I are in a process of play. Play is essential for the therapeutic process for it is only then that we can truly become creative. As I look back at all the art we created I realise that we have an undeniable record of the therapeutic processes.

The question arises, how is this study different from the many other studies focusing on art? The answer is that this study is done from a systemic perspective. The art works are never used as diagnostic tools but rather as a way to generate different meanings. This study is done with the premise that the circular relationship within the broader context receives the focus rather than lineal descriptions.

By describing the therapeutic process, I have to include myself and how the study perturbed my assumptions about therapy. I realise that therapy and the inclusion of drawing and painting with the clients change my expert position to that of participant. This new role relieves me of

much tension and responsibility, to such an extent that I am revitalised after therapy rather than drained and exhausted. I realise that perturbation of the client can only take place if the perturbation fits with the structure of the client (Maturana, 1975). The perturbation enhances change in both the therapist and the client.

I have always thought that art should be part of the therapeutic context as I have received news of difference through describing the art that I have created. I also receive a sense of recognition and comfort by expressing myself in this manner. The study has given me the opportunity to convey this idea without forcing it upon others. I realise that expression is important to me and that I frequently battle to express myself through words as it is sometimes used as another mask to hide behind. Through art the true essence of the system receives a space to manifest. The final product is important but even more important is the relationship between the artist, the art work, and the therapist. I realise that I have shifted from calling the people in the therapeutic context patients, then clients, and now artists, which is an indication of how art gives me the chance to view the artists/clients in a different manner.

None of the statements that I make in this study can be equated with a final truth. They are merely inventions of the writer. The realities created by these ideas are constructions imposed on the phenomenon of drawing in therapy. I can only take responsibility for my own distinctions and the way I experience the act of creating in therapy. I derive considerable satisfaction from experiencing clients' move from positions of desperation and isolation back into the context of communication, sharing and hope. The finished product never heals the underlying lack or loss; the relationship and dialogue that develop from the creation only create a space for change and connection. The understanding we have or the context that the art is received in determines the meaning that we ascribe to an event or in this case the drawing or painting. The context gives the meaning not the artwork itself.

Finally, I come to the conclusion that art in therapy creates a context of change and participation. The creations of a metaphorical gallery create the climate for change and even a glimpse of the whole. The use of art structures the therapeutic process so that the client and therapist can become part of the whole.

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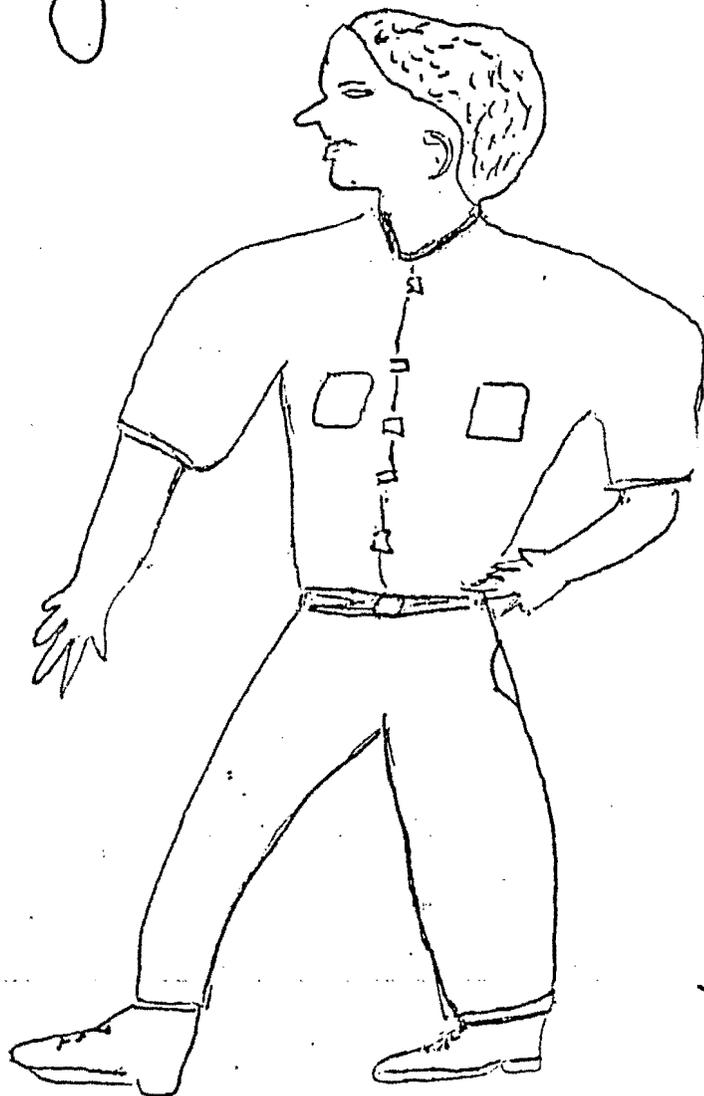
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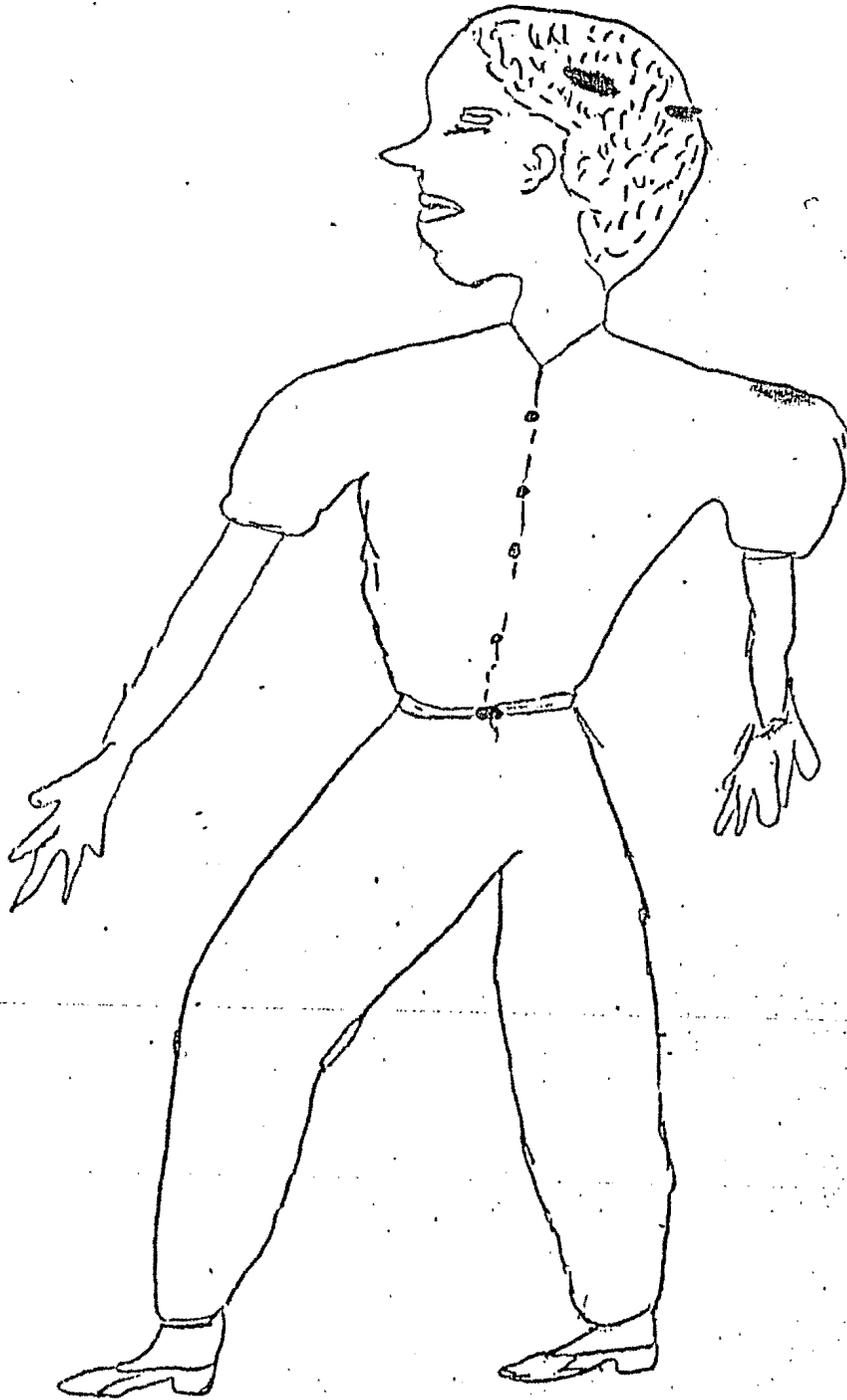
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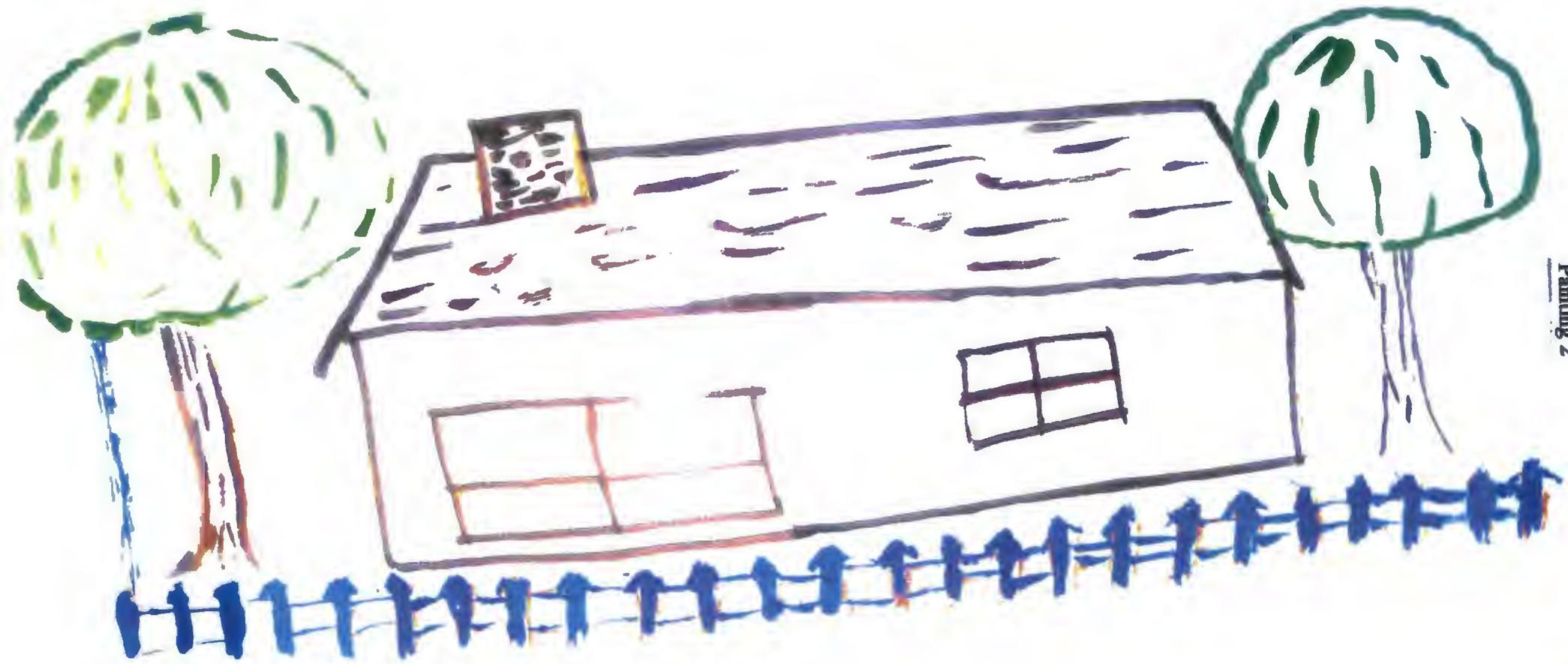




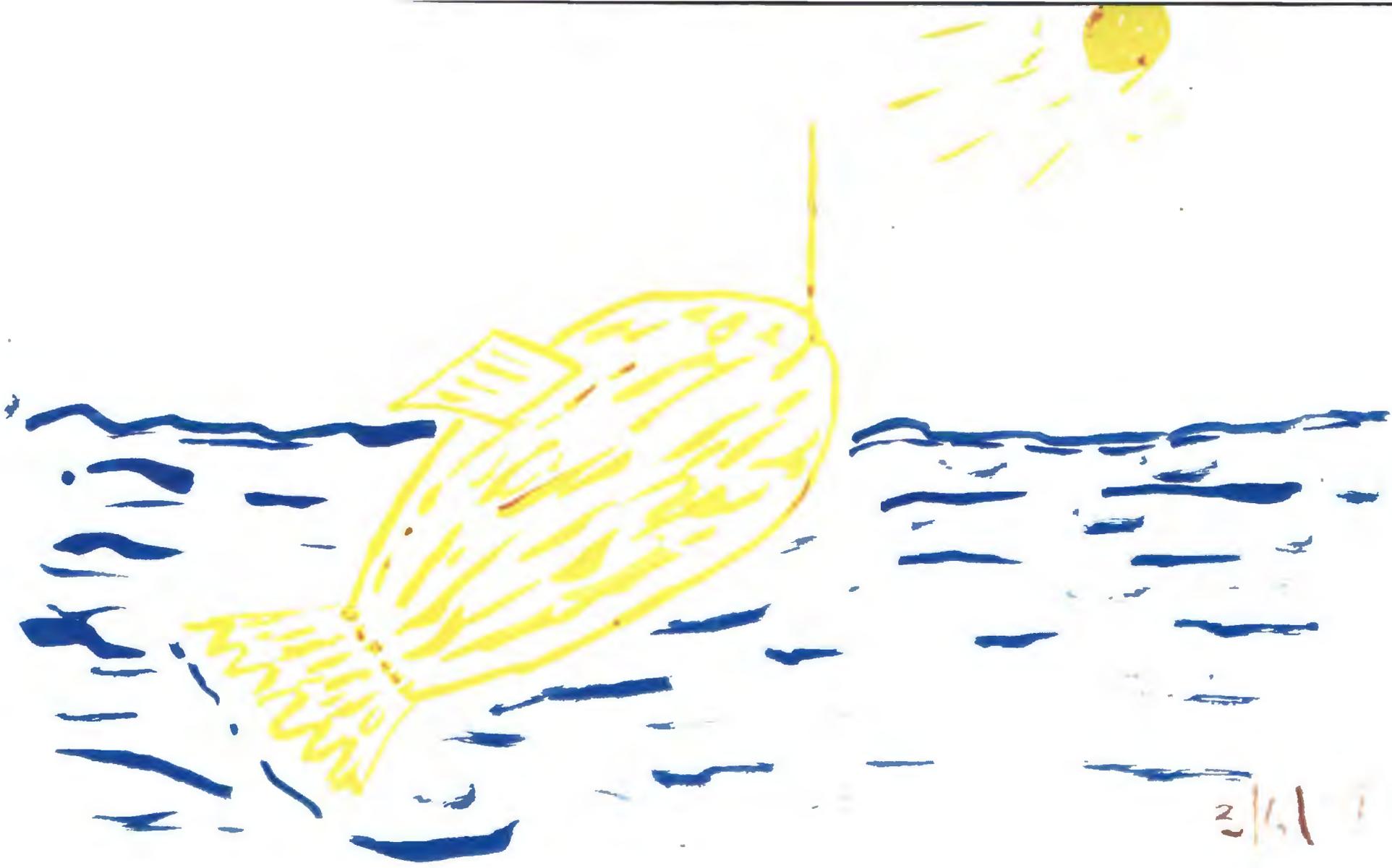
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Appendix 4

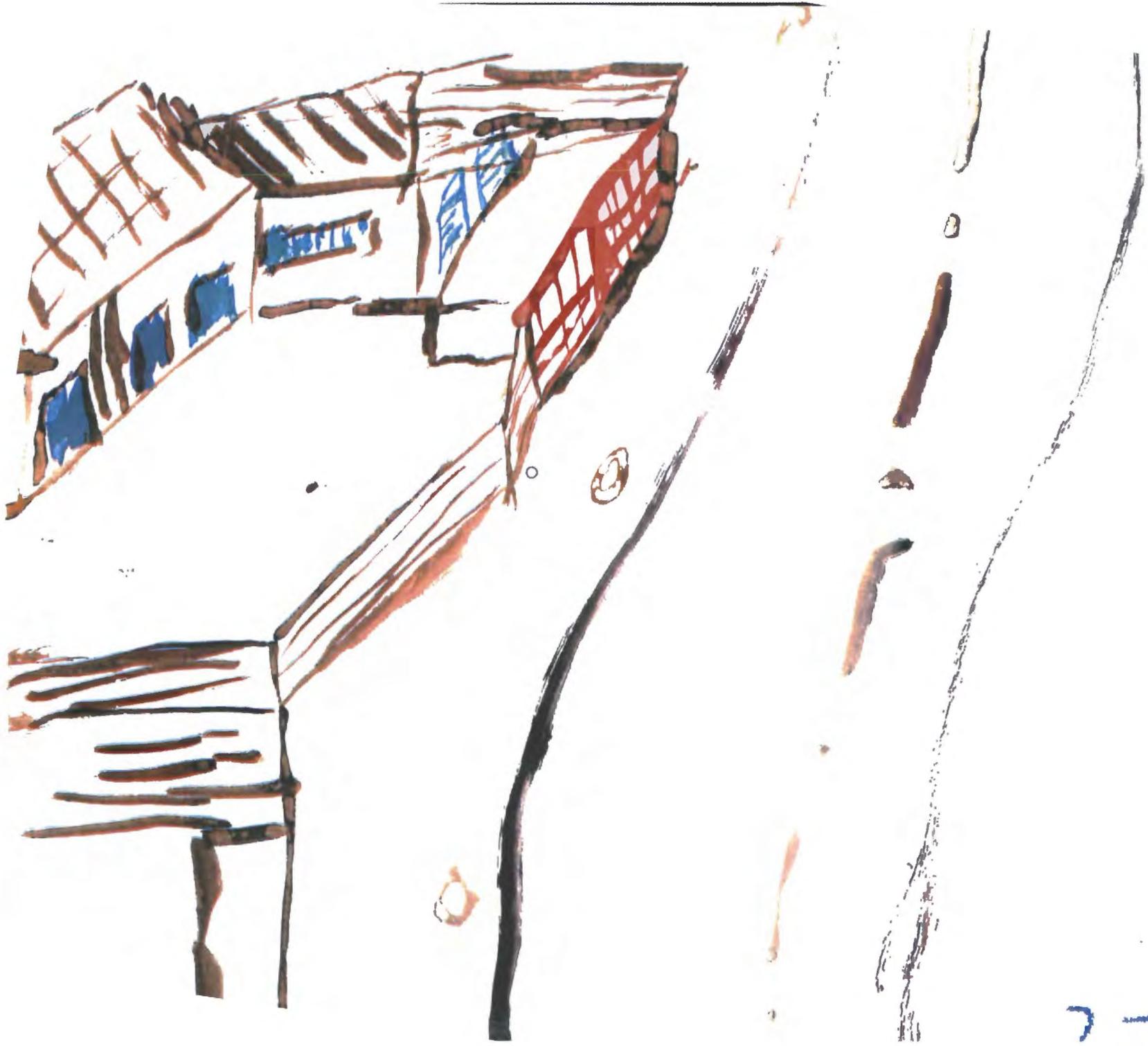




Painting 2



Painting 3



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Figure 1



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Figure 2

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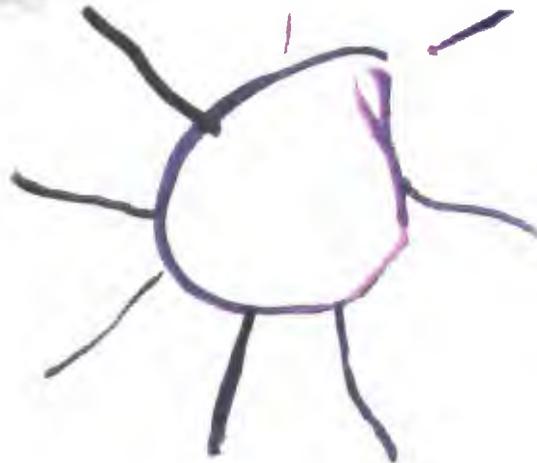


Figure 3

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