**Breakfast Club March 7 2018**

MC Good morning, everyone.

Sorry to interrupt the wonderful networking that’s going on.

As usual, the Summer Foundation breakfasts are all about networking, having an opportunity to catch up with your peers and friends from the ABI community, but I’d like to welcome you this morning to the first of our 2018 breakfast series, and we’re starting off with something really interesting, which is great because I think that’s what we’re really trying to do at Summer Foundation is bring topics that help give us a real diversity of thinking and approaches in our clinical work.

So today is going to be a little bit interactive, so it’s a bit of a surprise for us all to walk in and have something a little bit different happening today, but I’m really going to hand you over to Bronwyn Moorhouse and Erica Mainprize who are presenting today and who are going to lead us through what’s happening.

The Summer Foundation has lined up a great set of four breakfasts throughout the year.

This is the first one, obviously, we’ve got another one in May which is focused on upper limbs and then another two, which I can’t remember the topics of, but there are still tickets available, so please encourage your friends and peers to continue to come along.

So without further ado, we have Erica Mainprize who’s an art therapist who’s been working with clients here at Royal Talbot and in the community and she’s going to share her creativity with clients and the way that she works with them and hopefully, inspire us with some creativity, and Bronwyn Moorhouse is a speech pathologist who’s been working with Erica on this project and worked in the area of ABI for a very long time.

Actually, that sounds really bad, doesn’t it?

People have said that it’s not a very long time, just a well experienced clinician and she’s been working here at the brain disorders program at Royal Talbot with very complex clients, so I’m going to hand over to you guys to talk us through what you’re going to do with us today. Thank you.

BM Okay, thank you very much, Margaret, and welcome, everyone and I don’t know how you guys are all feeling, I hope you’re awake.

For Erica and I, it’s a little bit early for our body clocks, but we’ll do our very best to keep you entertained.

Okay, so as Margaret said, our presentation is entitled Art as a Catalyst for Change in Acquired Injury.

So, I’ll just give you a little bit of an overview of what we’re going to talk about today.

To start off with, I’m going to talk about my journey as a traditional speech pathologist and my kind of awakening over the time that I’ve been working in the brain disorders program.

There are possibilities that our therapy offers that deals with severe problems following ABI and in terms of how I work with art therapists too, as a speech pathologist, and then I’m going to talk about some … it’s not working?

(other speaker) Don’t hit it, sorry, stand out to the side.

BM Then I’m going to talk about some preliminary research findings from some research that we’ve been doing.

Erica is then going to take us on a little bit of an artistic journey and explore our understanding of art, the therapeutic framework in which art therapy sits, which is a little bit different from where I come from originally, and she’s also going to talk about psychotherapeutic possibilities of art therapy in relation to people with ABI and particularly people with severe ABI, and she’s going to reflect on future possibilities.

So there are a number of challenges to working with people in the brain disorders program.

They nearly all have severe neuropsychological deficits.

They have issues with memory, with language and with executive function, nearly all of them, and this is combined. The reason that they’re in the brain disorders program is because it’s not at this point appropriate for them to be living in the community, so this is combined with really huge behavioural challenges that they have that might relate to an impulse control disorder that they have as a result of their ABI, but it might also be due to premorbid psychiatric issues.

That’s the case for quite a lot of people and trauma that might relate to their ABI or might predate the ABI.

So I think probably if we have a couple of people here who live on the brain disorders unit, they would describe themselves more as existing on the brain disorders unit rather than living a really full life. There are activities for all people on the unit.

Once a week, we have music therapy, we have horticultural therapy on our larger unit, the Wattle Protea Unit which is a 20-bed unit.

We also have an activities nurse who runs various kinds of morning groups and a range of other things, so there are things happening and some people, a reasonable number of people get to go off the unit with support workers, at least on the Royal Talbot grounds, and some people also go out in to the community, but having said all of that, a lot of the time, on BDU for people, it’s a really closed environment and some of the features of it are boredom, impoverished exchanges, social isolation, we have a big problem with mutually triggering behaviours for kind of a sort of hothouse effect and people do have really quite restricted choices.

So when I first started working in BDU, I’m thinking I had the very good fortune to come across the open studio that’s run, the art therapy open studio that’s run once a week by the creative therapies program at Royal Talbot, and the art therapists who’ve been involved in running that program, Sandra Hatton and Amanda Hansen have been really, really supportive of having now quite a large number of people who we’ve had living on BDU come to that program on a weekly basis.

So my initial thoughts regarding art therapy were, I wasn’t thinking about it too deeply at that point, I’d have to say, I was thinking it’d be something to do, something to make their week a bit fuller.

As a speech pathologist, I was thinking, I was thinking it’d be good, it’d be something for them to talk about, and I’d have to say that in the almost decade now that I’ve been supporting them to attend this program, it’s been so much more than that, and I’d just like to reflect on a few tings that I noticed quite early on in the open studio.

So I think you can see here that it’s a kind of an amazing atmosphere, it breeds many good things.

You can see here – if I can get this pointer to work – you can see people talking to one another.

You can see people who are busy doing actual real things and I think it’s just such a contrast to a lot of their life on BDU where they’re sitting, staring at four walls, or they might be watching the TV a lot of the time, so it’s a very different environment.

I’ve also noticed that some people, this is a young man who had an intellectual disability as well as an acquired brain injury, and I was just really overwhelmed by how he just really embraced colouring in mandalas.

He just loved doing it, it absorbed him and he concentrated really well and you can see there, he looks so proud, holding up his mandala and I also made a kind of a poster of all his mandalas as well, which he loved.

Other aspects we see in the art studio are people who are having real pleasure in what they’re doing and sometimes some playfulness as well in what’s happening in that space and it’s also something tangible that you can have an enjoyable conversation about, because a lot of the time, there aren’t a lot of things on BDU to talk about, and I also noticed this fellow here had had an acquired brain injury that had effected his memory very particularly and his executive function and his visual spacial skills were better.

He was a man premorbidly who’d worked in a sort of a visual technical field and you can see here, a lot of the time, he was just, he had a few initiation problems as well.

He was sitting around doing nothing and you can see here that he’s really sort of transported back to a real kind of technical discussion about what he’s going to do and he produced some really lovely artwork, and we also have people coming up to the studio who have very little verbal communication, but they’re still able to interact in sort of verbal and nonverbal ways combined around the artwork and it was also really good.

Here, it’s a bit hard to see, but this fellow’s working on some clay and he did quite a lot of clay work, but we were also able to give him some real choices.

We could put the clay out and we could put out some paints and paint brushes and stuff and on a particular day, we could say, which one would you like to work with, and he was actually able to make a real choice about what he would enjoy doing more, and I think also, I felt with a lot of our clients that there’s been a real sense of achievement.

Hika, who’s our lovely activities nurse, she’s been very supportive of the open studio program as well, and she, at various stages, has put a whole lot of people’s artwork up on the main noticeboard within BDU and people, they don’t always remember their artwork, but often, they would, they would recognise it or people would say, is this your artwork, and they would kind of be able to have a conversation and to feel proud and to feel that they were sort of more a little bit part of the unit with this sort of ownership of their work on the wall.

So another thing that I’ve found is really good with the open studio with artwork is I think as a speech pathologist, supporting people to have conversations because of course, a lot of our people have got really severe memory impairments, and it’s very hard to have, most of our conversations, they are about things that have happened recently and for them, they don’t have that opportunity or they have it to a limited degree and it can be really good to make up chat book pages for them with pictures of things that they’d been doing recently and it’s good to have their picture in there as well and to make a few statements about what’s happened, so later on, a support worker or someone else can look through it with them, there might be some questions that could be posed and it doesn’t have to just be those things.

It can be then a catalyst for a further conversation about the nature of the artwork or what they’d been painting that can allow them to have that feeling of a nice conversation, then particularly if they’re recognising the pictures of their artwork.

So another thing I’ve noticed about the open studio is that it’s been a bridge towards community participation.

So for many, it’s their very first tentative step off the unit and it’s been a space to kind of build tolerance of being in a new environment, and we might find, initially, people might just drop up and stay for a couple of minutes and have a look around and they might stay for five minutes and they night gradually build their confidence of being in another environment with people which is a really nice first step to moving out in to the community, and it also gives them, given that they can remember enough, something external to talk about where they can imagine themselves somewhere other than BDU in a different space where they’re having some success.

But unfortunately, some of our clients are not ready to attend the open studio.

They might not be ready to leave the unit at all because of their severe behavioural problems.

They might not respond to a verbal offer where I might say to them, would you like to come up to the art studio today? It’s really fun, you could use some clay to make a bowl, you could do a painting, you could do lots of different things, but they might not be able to visualise what that entails, or it might be that art doesn’t kind of fit their masculine self image, and it might also be, even though it’s not a noisy space, it’s a much busier space than on BDU and they might feel that they’re not able to cope with this busy new space.

So in 2013, I had the very great pleasure of meeting Erica Mainprize who at that stage was completing her advanced art therapy clinical practicum on BDU, and she had decided that on our Heath unit, which is a unit where people, if that’s the ten bed smaller unit where people have more severe behavioural problems and where there are higher staffing levels and it’s a more secure kind of double-locked environment, that on that unit, it would be good to pilot some on-unit art therapy groups, and she did this with nursing input and with allied health input and I was involved in those groups and really got a lot out of it, which I’ll talk about more, and it provided an opportunity for those who were not attending the open studio.

So the features of this weekly group were that Erica organised a different theme each week.

She tried very hard because there were varying skill levels to provide materials and strategies that would accommodate all of those skill levels, to maximise opportunities of choice, to be inviting people to participate, but not pressuring them, and to aim to support a feeling of safety.

So I thought those particular art therapy sessions on the unit were fantastic, and there were a few things that I noticed about that and the first one that Erica noticed as well and this was a young man with Huntington’s disease, quite advanced Huntington’s disease who had a lot of trouble tolerating proximity and he would spend a lot of time in his bedroom or in the activities room on his own and often, if staff needed to approach him, they would do it with a little bit of fear and trepidation and he really embraced the art therapy and he was out in the group area, he was sitting at a table with other people, he was really focused and enjoying what he was doing and he was able to tolerate proximity, even to share art materials with other people and it was just wonderful to see.

There were also a couple of clients who really de-escalated when discussing their artworks later on, so when Erica would ask permission, if people were happy to have an artwork that they’d made or that they’d made in combination with a staff member to put it on the wall, and we had one young man who was, he had a sort of a pattern of going up to the nurses’ station and kind of ranting and raving when he didn’t get exactly what he wanted right then, and I could see one day that he was starting to wind up in this fashion and I said to him, hey, is that a picture that you did with Erica on the wall, and he said, yeah, yeah.

He said, that’s about swimming. I really love going swimming. She painted that for me, he was just, he was really transported I think in to thinking of himself in another space where he felt happier and also thinking of how much he enjoyed doing the painting with Erica.

After that, he was able to kind of de-escalate and move away.

But there were also some clients who directed therapists.

There was one fellow with a very severe tremor and he said he wouldn’t be touching any of the art materials and I said, is it okay if I ever sit down with you and maybe you could give me some input in to what I’m doing, and he was initially a bit kind of stand-offish and after a while, he started saying things like, draw that line further up there, I don’t like that colour, move that over here, and at the end, he was really pleased with the artwork that had been produced, and I wrote on it, at the bottom, I wrote, drawn by Bronwyn, inspired by let’s call him Frankie, and he loved having that up on the wall and I think the other thing that he really liked about it, too, was that it was a bit of a role reversal.

He was so used to the staff telling him what to do and all of a sudden, he was able to give me some direction about what to do.

So in the pilot study, across those four weeks, there are ten beds on Heath, but there are only six people who were resident in Heath across those four weeks and you can see predominantly, TBI and one person with Huntington’s disease, most of them were at the more severe level of the spectrum in terms of neurocognitive impairment.

There were quite a few people with dysarthria and one person with really severely reduced initiation of verbal output as well and there were a couple of people who were having problems with language comprehension as well.

So we noticed all these lovely sort of nuanced things that were happening and we thought, is there some way that we could quantify what’s happened here that looks really nice on this unit, and we had got some help from Dr. Caroline Fisher who was the neuropsychologist on the unit at that stage and she said, I think you should do a medical record audit, and you should look for aggressive incidents, and we did this with reference to descriptions that were given on the overt aggression scale modified for neuro rehabilitation.

So what we did was we looked at three nursing shifts around the time of the art therapy.

We looked at the Thursday PM shift, when the art group took place, and then we looked at the two day time shifts the next day, Friday AM and Friday PM, and if it was documented according to the kind of definitions that are given, that someone had had an aggressive incident in a particular nursing shift, they got a score of one, and if they hadn’t, they got a score of zero.

So that meant that we had a possible twelve points that people would be getting, so we had four different sessions and in each session, we had three nursing shifts, and what we did then was we compared those shifts around the time of the art therapy with the four weeks prior when there hadn’t been anything happening on the unit, and you can se that’s the red bands here and you can see that people, a couple of people were getting some pretty high scores with an aggressive incident on nine out of a twelve possible nursing shifts, and what we noticed is that for all of them, except for participant six, there was a reduction in the number of aggressive incidents they were having around the time of the art therapy groups, and participant six was actually not present on the unit at the time.

The other five participated in the art therapy group, but participant six was actually going out at that point, and Caroline thought we should include him, anyway, because she felt that his behaviour may be influenced by the sort of change milieu on the unit.

But it’s interesting to note, he’s the one with the least aggressive behaviour, and it’s also interesting to note, so as a very small sample, but he was the only one whose number of aggressive incidents didn’t reduce.

So the pilot results left us wanting to find out more.

So we considered we didn’t want to just look at aggression, we wanted to actually track people’s participation because that can be a real issue for people actually getting them to focus and keep doing something and enjoying something.

We wanted to be able to reflect in a more systematic way some of that nuance change and we wanted to compare the art therapy with a more traditional group because what we had done in those instances is we’d compared it in the pilot with a time when nothing much was happening on the unit.

So we were thinking, well, traditional groups, a lot of them, a lot of groups who I’ve been involved with in Heath over the years are talking groups, and talking is a bit of a performance, isn’t it, really?

You have to be able to understand, you have to be able to attend to what’s being said, you have remember what’s being said, you have to find the right words, you have to interact in a socially appropriate way which is a big challenge for many people who are living on Heath, and also a big challenge for them is tolerating other group members’ behaviour in close proximity when you’re, they’re all talking to one another.

So at the end of 2015, myself and Erica and a small multidisciplinary team were lucky enough to be awarded a small, open medical research foundation grant to look at these things in a bit more detail as considering things I just discussed, and a very short time later, probably six or seven months, we received ethics approval in June 2016 and then the research took place on a weekly basis from July to December of that year.

So we had to think a little bit about our desire and we decided we would use a time series design again with sort of weekly data points.

So we started off with six sports discussion baseline groups because sport seemed to be something that a lot of people were interested in and it was at the time of the Olympics and stuff, so there was quite a lot happening with sport and I acted as the primary facilitator for those groups and Erica acted as my co facilitator, and then we had ten intervention art therapy groups where obviously, Erica was the primary facilitator and I acted as a co facilitator and then we also decided we would look at a return to baseline, so we had a further six sports discussion groups, and we also had, as well as ourselves, there were members of the nursing staff and some people had support workers, so there were quite a few other people in the room as well.

So like the pilot, the art therapy groups were themed, they accommodated different skill levels, then were non-pressured and encouraging to support a feeling of safety, but we also wanted to provide lots of opportunities for one-to-one assistance, and to maximise choice about whether to participate and also how to participate.

So the sports discussion groups were planned to maximise interest and I thought, as a good researcher, I couldn’t really write a below par discussion group and sport’s not my main sort of area of expertise, but luckily, I could rely very heavily on my young adult son who is an absolute sort of AFL and soccer nut and knows lots about … someone in the room who knows him.

Yes, so he would give me each week the good oil on what had happened and the goss and that kind of thing and then I would go and look it up on the Internet and I would get appropriate pictures and nice little snippets of things that had happened, and then we would sort of go from there, but this group did involve a lot of listening and I did make requests for verbal input from participants, but I did, as a good speech pathologist, try and be sensitive to how easy it was I thought for them to participate in that way.

Because everyone was sitting in a big group, there were more limited opportunities for one-to-one interaction and we ended each time with a multiple choice quiz where there would be a picture and a question and then three options and Erica and I would take that round to half the group each and we would try and get people to make a response and we just then, if people made an incorrect response, we didn’t really make much of that at all.

We praised the correct responses and we praised them for having a go as well and we used humour as well to encourage participation.

So we then thought, in terms of the analysis and that with it, we wanted a design that would allow for a empirical single-case design time series analysis, a group analysis, as I mentioned before, measures of participation as well as aggression and in terms of participation, what we did was that we had a couple of lovely research assistants, Kelly and Julie, who tracked each five minutes of where the people were present in the group area and also whether they were participating in the group activity.

So as well as that, I think I mentioned before that we wanted to have a chance to systematically look at those more nuanced things, the nuanced characteristics of what was going on, so we were very lucky to be able to get Professor Jacinta Douglas on board with us to help us with this and what she did was she organised to do semi-structured interviews with both myself and Erica at the end of each art therapy group and then, which was the main thing we were going to do but we decided then to do it for the sports discussion group, return to baseline groups as well because there were quite a few interesting things happening in those groups as well, and then those interviews were recorded and transcribed and then so far, we have this data for one person only, but Jacinta analysed this data using open and focused coding to reflect themes across the data.

So these are the characteristics of our research group.

We had nine people this time, we had more people, which was good, and you can see they had very wide and varying etiologies.

They were again more at the moderate to severe level of the neurocognitive impairment spectrum and there were again quite a few people with dysarthria of varying levels and we had one fellow who had really quite severe aphasia as well and we had a couple of people who had some problems with their comprehension and one whose comprehension was quite severely impaired and we’re going to talk about him a bit more.

So the results today, to start off with, we just, Erica and I have thought a little bit more about our informal observations about the research groups and we’d also then like to talk about that thematic analysis for that one participant and the time series participation data that’s been completed to date.

So, in terms of the sports discussion group, we did notice a lot of individual response differences.

We had one fellow who was really quite high level and articulate and he loved the sports discussion group.

It was an opportunity for him to take a leadership role with footy tipping and as well as that, he also took a leadership role in helping me to facilitate the group because of course, my knowledge was related to what I’d got off the Internet and nothing much beyond it and Erica knows even less about sport than I do, so when we would come to a spot where there was a bit of a problem, I’d say to him, look, I’d imagine you know something about this, could you fill us in on the details, and he was always up with the details and it was a really good experience for him.

I think people also enjoyed a tribal sense of belonging to the footy teams and they could rib me about barracking for Collingwood and they could rib Erica about pretending to barrack for Collingwood, but we did notice that the verbal abilities did affect the degree of participation and most people, in fact all in the return to baseline, were able to participate in the multiple choice quiz.

We did facilitate more positive interactions, but it wasn’t a feature entirely of that group.

We had one fellow in particular who was quite intrusive with his comments and he might yell out all of a sudden, what’s happening tomorrow? Do you want to hear what I’m doing tomorrow, or I think at one point in the return to baseline, he said something like, I don’t like doing this, when are we doing the art again, and the others didn’t like that, or most of the others.

There were a couple, there was a varying level of interest, there were two or three people who weren’t as into sport as the rest, but they didn’t like that, of course and they would tell him to shut up and that kind of thing, so it wasn’t, there were still a few instances of a lack of mutual tolerance.

So in terms of the art therapy group, it was a hive of activity was the first thing we noticed which was incongruous to how things are normally on that unit and that high level fellow I was talking about, he was initially thinking in the first couple of groups, this is not really for me, this is a little bit too low level, and he got really drawn into it and he really started having a lot of pleasure in things he was doing, and particularly in making gifts for his children.

There was more emphasis on one-to-one interactions with regular staff to assist with the art making process, and because of that, a few more staff were required, really, for the art therapy group, and we noticed kind of changed relationships with the clients as well.

It was a kind of a reducing of barriers.

Sometimes the client working with the regular staff member is a kind of a bit of a team to produce an artwork, or sometimes even when the regular staff were making their own artwork, to be kind of acting as peers next to one another, doing things together at the same time, and also the environment bore evidence of that pleasant experience because I said, as I said with the pilot group, Erica would ask people if it would be okay to put up some nice artwork on the unit, and people were nearly always okay with that, weren’t they, so we had lovely masks and collages and paintings and things decorating the unit to make it a brighter place that they could reflect back on that pleasant experience. There was, however, one participant whose engagement was minimal, and I think he fitted into that category of I think thinking, art was a bit too girly for him.

I’d have to say he didn’t engage all that much in the sports discussion group, but he did have a bit of a tribal feeling about the footy and quite a bit of pre morbid knowledge about his footy club, so sometimes we could get him to talk a bit about that in the sports discussion group.

So if we now just focus on this single case where we’ve got quite a lot of data that we can present, he had major issues with language and memory, he had a history of mental illness and trauma prior to his ABI.

His equilibrium was really easily upset, he felt sort of pressured in the group area and if someone asked him to talk in the group area, that was extra pressure for him and he had feelings of paranoia.

He didn’t participate as you’ll see in a minute in the next slide in any of the initial sports discussion groups and he had an amazing turn around when the art therapy groups were offered and he then, very interestingly, it seemed to build his confidence and he was able to participate in most of the sports, further sports discussion groups.

So you’ll see here, this white area here is the initial sports discussion groups, this is the art therapy in yellow and this is the return to baseline sport discussion groups, and you can see here that the blue is where the person participated and the purple is whether they were present in the group area, so you can see here that he had nothing at all happening in the initial sports discussion groups and this red arrow here is where I was trying to be a good researcher and thinking, I shouldn’t just be letting people go off in to their rooms, so I followed him down the corridor and I said, hey, would you like to talk about the footy, and I did not get a good response from him.

He was not happy with that at all, but then you can see that he then, there was a first tentative step for nearly 50% of the time on, even in the first art therapy group, he was present in the area and he completed this lovely collage, so 10% of the time, he spent actually working on the art and you can see after that, with the exception of one session down here where he didn’t come, that for all the others, he was present in the area and participating in the art making for most of the time and it’s really, really interesting, as I said, to note that he was able then to participate in quite a few of the sports discussion groups, and with this very last point here, point 22, he also had days where he just didn’t come out of his room and that was one of those days, so I think that didn’t actually have anything to do with the sports discussion.

It was more really that he was having a bad day, so we could actually say, in four out of a possible five sports discussion groups, he was then able to come out and participate in a very low key way in the group area.

So in terms of the overarching theme that came out of Jacinta’s analysis, she called it creating a smile, looking at the kinds of things Erica and I have said and if we just go back and look at his starting point in the group area, the kind of themes that came out of what we said was that he looked a bit depressed, that he had low energy levels, a lack of engagement and quite paranoid about one particular staff member.

So if we just look back there, that’s really here, that that’s where that kind of, where most of that information would’ve come from and the theme of creating a smile was reflected in the interplay between the constructs of creativity, pleasure and engagement and Jacinta noticed an increase in the growth of those constructs over time and other things that she pulled out were reduced anxiety and being more relaxed and I think it was Erica who said, I saw David smile. I haven’t seen that before, because most of the time, he was kind of, looked very frightened and sad and it was so lovely to see him smile.

So we’re still to examine the group participation and aggression data.

It’s taken us a very long time to extract all the aggression data from the medical record and we’ve almost finished that now and we’re still working on details of other single cases, probably David’s trajectory in terms of his participation between the two groups I think will probably be the most striking, but that’s got us thinking as well, is there more of a differential for those with really severe cognitive communication and mental health issues to be providing them with these kinds of non-talking groups and this is a theme that Erica is going to pick up on more in her part of the presentation. Thank you, Erica.

EM: Well, like a lot of people, I probably don’t find public speaking very easy.

Playing games is one thing, but public speaking is something else and when I’m writing something too present is kind of doubly difficult because you have to get the nub of the thing and it takes a lot of concentration and I suppose you could call it procrastination, but it feels like there’s always something getting in the way if you’re sitting down and doing that work, whether it’s somebody’s birthday or you’ve got a visitor from overseas or you’ve got a deadline, there’s just always stuff and it occurred to me when I was trying to write this that in a perverse way, that’s something to be really grateful for because for lots of our clients, the advent of a brain injury means that life just stops in its tracks and that everyday business that we take for granted just disappears.

The heading of this slide is taken from a 1991 article by a US neuropsychologist, Dr. George Prigatano, Disordered Mind, Wounded Soul, and the article discusses the serious impact of brain injury on mental health where we’re talking about the brain, of course, it’s often quite difficult to separate mental illness from organic damage.

Even so in a 2013 article, Simon Fleminger stated that, and I quote, “the neuropsychiatric sequel of traumatic brain injury outstrip neuro-physical sequel as a cause of disability”, and we know very well that in addition to physical disability, our clients often suffer a loss of identity and meaning in life, a sense of bewilderment, trauma that may not just be around the ABI, but can also be entwined with the circumstances that led up to their brain injury, depression and anxiety, and the difficulty of maintaining those vital connections with family when the family itself is dealing with an unresolved grief.

But in his article, Dr. Prigatano tells us that despite a great existential need, brain injured patients rarely receive psychotherapy because they’re not considered psychologically minded and this can be because they have cognitive issues including reduced or confused self awareness or difficulties with verbal comprehension or self expression.

His response to this was, and I quote again, “patients with marked cognitive defect deficits or patients who are unable to introspect and articulate their experiences need other ways to communicate about their disabilities”.

He also identified that rehabilitation culture was at odds with the language and culture of psychotherapy and this issue seems to linger, even though since the article was written, there have been significant advances in the understanding of how psychotherapy works in terms of brain structure and function.

Prigatano’s radical suggestion was to address matters of the human soul through the arts, including storytelling, drama, music, and visual art.

Why would this be useful?

Well, I’m going to hone in on visual art because that’s my field, but there is an overlap between what the different forms bring to the table.

To clarify what art might offer, let’s think for a moment about what art is. Perhaps this is a more of the middle of the night question than an early morning one, so apologies, but it’s an interesting one that’s kept our species pondering for a fair chunk of time.

I should probably apologise for this image, it’s a little bit uncomfortable and I was trying to create a visual paradox to express how the appearance and the uses of art have changed so hugely over the millennia that it’s actually incredibly difficult to boil the definition down to any single statement.

Anyway, looking to literal definitions, the word art derives from the Latin artem, which describes the application of learning in a skill.

The Romans of course felt this was a uniquely human activity, but it does seem that our much maligned sister species, the Neanderthals, were actually making cave drawings that predate the arrival of modern man by at least twenty thousand years, and to be honest, I never actually believed we were the only ones, but I do think that that reality check just confirms how deep rooted art making is in the genus homo and it suggests that it’s probably associated with higher brain function, in particular, the ability to conceptualise and to symbolise, as well perhaps as a associated awareness of ourselves as mortal beings that brings with it a need to make sense of a chaotic and indifferent universe and that’s the point where I’d like to offer a definition of art that arises from that more existential area of thought.

It comes from philosopher Arthur Danto who arrived at the phrase embodied meaning, which feels satisfying because it captures both the physical and the metaphysical aspects of art.

So how do these two definitions help us when we’re thinking about what art can offer to someone with a brain injury? Well, the Latin artem emphasises the doing.

Art is a rich activity that involves brain and usually, the eye and the hand. With reference to Danto’s phrase, embodied meaning, the art object itself can speak without the need for words.

I’d like to add a third general point, which is that even when expressing something difficult or distressing, creativity is intrinsically life affirming and self actualising and capable of inducing what Maslow called peak experiences and also the phenomenon high called flow and I’ve included this passage from *Summers of Discontent* by philosopher Roman Tallis because it so elegantly describes the experience of flow, and I’ll read the quote in full to give you a sense of the balance involved between structure and freedom.

These are the moments when the artist ceases to calculate, but feels freshly what it is like to be alive in that instant, enjoying a state of heightened awareness. At such times, he is utterly free and paradoxically constrained by his commitment to achieve his end. No one can tell him how to take the next step. At that stage, there are no guidelines. He’s at sea, the world is fluid, and the potential is endless, and you think it’s important to point out that the feeling of mastery that’s described here is not relative to the achievements of others, but to our own development, and this has an intrinsic value to people whose lives otherwise seem to be a continual challenge and frustration.

Okay, so how does art therapy differ from visual art per se? Well, as you may have gathered from Bron’s talk and my preamble about Dr. Prigatano’s ideas, art therapy exists at this curious interface between art and psychotherapy.

How is it like psychotherapy, conventional psychotherapy? Well, art also takes place in a safe space within rules of confidentiality and this extends to the artwork that’s produced in the session, which is regarded in the same way as medical notes.

Also, like any psychotherapist, an art therapist has ongoing clinical supervision, which provides a safety net and a quality control on their practice.

As in standard psychotherapy, a crucial aspect of art therapy is the witnessing relationship between the therapist and the client.

It’s more intense in individual therapy, but it’s still relevant in the group context, and building that relationship can be quite slow and challenging in brain injury.

For example, a client might not remember the therapist from one session to the next or their emotions might be very deregulated and as in conventional psychotherapy, the process in art therapy tends to be emergent rather than planned and the therapist is continually noticing changes in the client which in art therapy often are around behaviour with the art material and although I’m referring to traditional psychotherapy here as verbal psychotherapy, art therapy may in fact of course involve varying degrees of spoken exchange so that as in a conventional session, the therapist may reflect back to the client what they think they’re seeing or they will proffer a gentle challenge or sometimes of course, like any therapist, they’ll just be holding it in mind and speaking of psychotherapy, Donald Winnicott said that it takes place in the overlap of two areas of play, that of the patient and that of the therapist.

He felt that this space of play was where growth and change could occur and if that’s true of verbal psychotherapy, it’s especially true of art therapy with all its toys as we experienced just now and it’s interesting to note that anthropologists like Ellen Desnika have actually felt that art making is probably a variant of play itself with similar serious evolutionary purposes and when we talk about play, we can’t help but think of children and of the safe space we ideally see in early childhood development which perhaps takes on a new significance when working with people who have had some of their developmental learning just pepper shot out from under them by brain injury.

If someone appears to be unable to play, then like Winnicott, my aim is to find the circumstances and the materials, which make this possible for them.

So what’s going on inside the brain when we’re playing in art?

At the beginning of the talk, I asked you to play Scribble Chase and I’d like you to think about that experience for a moment now as we look at this slide which depicts something called expressive therapies continuum, a framework much loved by art therapists across all theoretical orientations, and it’s creator, Vija Lusebrink, never sure if I’m saying that right, she’s made a diagrammatical representation of the component functions that she saw in use when people were making art.

The layout is intended to refer to the bottom up arrangement of corresponding networks in the brain as well as their phylogenetic occurrence and the order of development in young humans.

The model is also intended to reflect information processing and functioning differences between the hemispheres, but of course, those theories about hemispheric specialisation are always under review and there are actually four interlocking continuums depicted here.

So on the primary level, we’ve got a continuum between kinesthetic and sensory functions and activity here generally doesn’t require words.

It’s rhythmic, tactile, sensual, the way that young infants experience the world. When you scribbled, you were working largely in the kinesthetic mode.

We then move up the developmental hierarchy to the perceptive effective continuum and this activity on this level begins probably at about age three, getting stronger later and form is beginning to come into pictures and there might also be quite raw emotional content.

It may or may not require words to explain what’s going on and when you were looking for forms in your scribble, you were working on this mode. In this mode, the perceptual mode, and then the third level, beginning at about age ten and continuing into adolescence, is the cognitive and symbolic processing level.

These functions become more important at that time and you can see it in adolescent drawings where they’re trying to nut out ideas and this, as we know is a complex brain function.

It involves planning, action and intuition and investigating an image produced on this level may well involve words such as the narrative you might’ve woven around your images in your scribble, but it can also be really powerful purely as a symbol if, for example, you just identified an image of significance and I forgot to ask if anyone had done that, but it might be a personal thing, anyway.

Finally, we have the central spine spiralling upwards towards infinity, and the creativity here can be something as simple as creating relaxation where there has been stress.

It’s actually bringing about something new, and in the diagram you see, it sits at the junction between all the continua, implying the potential for integration and whole brain engagement when we’re being creative.

Creativity can actually occur anywhere in the model, although as you might imagine, it’s less common where people are rigidly stuck at the extremes because that obstructs integration and it makes it less likely that something new is going to arise.

When this happens, the art therapist uses their knowledge of materials and processes to try and balance out the way the client is functioning and importantly, the model really suggests rather than prescribes because it’s about opening things up and maintaining fluidity and not about shutting then down with rules.

So now we have a little insight in to the way that art therapists work.

We can go back to the idea of the curious interface between art and psychotherapy and think about how art therapy differs from conventional psychotherapy.

So how does it differ?

Well, obviously, there’s art and we’ve discussed a bit how that can usefully take the stress off verbal competency, but it also eases the intensity of the therapeutic space in general because both parties have something else to look at, apart from each other, and that’s something else to look at is useful when there are problems with continuity and memory.

I’d also like to point out that conventional psychotherapy is involved with a dyadic relationship, whereas the presence of an art object makes for a triangular dynamic and that has implications for processes such as transference which can be embodied in the art object or enacts upon it.

Second, as we’ve indicated, this doesn’t all happen in your head.

The body is usually involved in some way in the making and that can be emphasised when it’s useful for either physical or psychological purposes.

Unlike regular psychotherapies, which tend to be topped down and word heavy, art therapy has the potential to activate and integrate all levels in both hemispheres of the brain which can be very useful to prompt or replace verbal communication because things don’t always have to be talked about to be processed.

Conversely, something we haven’t talked about directly is the potential of non-verbal modes to tap into implicit memory, which is usually inaccessible to voluntary retrieval, and then to bring it into the narrative context for further therapy to work, and also when thinking of trauma, art therapy offers rhythms and textures to bring somatic regulation.

These rhythms and textures combine, contribute to the relaxing effects of art making which can activate the parasympathetic nervous system, and again, we acknowledge the way that art therapy can adapt to the individual, which is especially important when working with such a divergent population and to illustrate the unique experience that unfolds with every new client, and to give you a sense of art therapy and action, I’d just like to present a snapshot of my experience with one client I had the honour of meeting at the Royal Talbot. Sam was in his mid fifties, he’d had a traumatic brain injury five years earlier. He had severe global cognitive impairment, fatigue, problems with balance and orientation, left side neglect and the inability to lay down memory.

He also had aggressive outbursts, particularly around personal care.

He was a big man, tall and strong who’d led a very spirited life, some of it overseas, but he was now highly dependent.

The aims of the treating team were to slowly prepare him for low dependence accommodation and this largely meant helping him to control his aggressive outbursts.

He had little sense of time passing or past, apart from the distant past before his accident for which his recall was good, and from one week to the next he couldn’t remember me, nor the work we’d been doing together.

So it was difficult to talk to him in terms of goals, but often, clients show you what they need from therapy, and with Sam, there was a wry bleakness in him that sought expression through the vehicle of the artwork.

When I first engaged with him in a lounge area, I saw that although he very quickly entered into creative dialogue, very quickly, it was difficult for him to orient himself to the work surface and I found myself being what art therapist Edith Kramer referred to as the third hand, and I drew this image as he described it, being a tank in the jungle, and he did paint these trees here and here, but it was really hard work for him and not easy for him to see what he was doing.

His brush strokes though were sensitive and deliberate and his metaphorical mind was definitely highly functional.

At first, I didn’t quite get the full weight of the symbolism, but over the following hours and days, it sunk in to me how immobilised this cumbersome blind vehicle would be by dense trees.

The tank in this jungle is broken still and stuck in a place where time seems nonexistent.

Both the tank and the jungle were metaphors that would recur in our later sessions and if the tank was Sam himself stopped up and tangled in creepers, he graciously acknowledged my presence in the jungle with him as a wild rose growing on a tree and he directed me in painting this.

For as long as the session lasted, we could share this space.

When we came into the art room proper, it was clear that the layout of Sam’s work space was crucial and our wonderful occupational therapist, Anna Brown, came in to a session with me to trouble shoot.

Sam was really drawn to painting and he liked to stand to do that, but he fatigued very easily, so we borrowed a bariatric stool and also an upright easel on a high table as he found it much easier to look ahead than to look down.

We’ve also angled the paints.

You can see they’re dripping a little bit over the pallet, but so that in as much as he could distinguish the colours, he had some idea of what he was using and he was particularly strong in greens and browns.

I’d also often hold the pallet so that it didn’t get lost in his blind spot, but I always kept it on his left to encourage him to overcome his neglect on that side.

Once Sam started painting, his strength in the sensory effective and symbolic modes of the ETC framework became even more apparent.

Sam’s sister shared some of our sessions and she told me that his sensitivity, his symbolic intelligence and his emotionality were typical before his accident, too.

In order to support and contain Sam’s emotive style, I provided smallish canvas boards, which gave him firm proprioceptive feedback, and to keep his expression unmuddied, I quietly made sure that the brushes and the colours stayed clean.

Apart from that, I made no attempt to shape Sam’s approach because his sensuous self-expression freighted with meaning felt entirely appropriate and necessary and I felt that my job was to bear witness, to give practical support and to offer emotional security in the safe space of the session.

I also refrained from offering any interpretation on what Sam created because I think that matter was expressed indirectly for good reason. Also, the meaning of his symbolism did feel fairly clear.

This painting is of a big tree, fallen in the jungle with the foliage grown over it.

Each week, when I approached Sam, I would reintroduce myself.

Each week, when he entered the activities room, he would look at the picture on the easel and he would say, who did that painting, and yet what I found amazing was that he would so quickly accept that it was his and then get back to work without further question and I know this is because his procedural memory was intact, but it was always very strange to witness and one week towards the end of our sessions, he entered the room and he said, did I do that painting, and I felt like some tiny but momentous shift had occurred.

Perhaps, I don’t know, the tangible traces of our previous work had given him just a momentary sense of the self in time.

The other thing I found quite curious was that he would read the same darkly humorous metaphors in to his work each week, which I think implied the symbolic integrity for him.

So in this painting, he repeatedly saw a train on fire and we often listened to monastic chanting while he was painting this one and the monks became involved as evil monks who had set the train on fire.

So as you can see, there’s a really playful atmosphere.

It’s hard to say exactly what impact our sessions had on Sam.

He didn’t stop having aggressive outbursts, although we did discover he could calm himself really quickly afterwards if he squeezed a slightly resistant light, dry form of clay, but I feel that just by partaking, despite his fatigue, despite his disorientation, he was indicating that it mattered to him to make this expression and really, that should be enough.

This is my own artwork and not long after I finished working with Sam, he became terminally ill and he died about three years ago. His sister reported being both heartbroken and relieved.

The emotional impact of working with our clients whose lives are tragically damaged is if possible, compounded when we lose them.

I know how important it is to keep healthy boundaries and maintain my own wellbeing, but of course, sadness seeps in to us all and as an art therapist, I’ve been taught to process this through my own artwork and being a fellow lover of jungles, I actually made this painting before working with Sam.

But shortly after Sam’s death, I just added a tank turret in there, in to the landscape as a memorial and this quote comes from an email I received from Sam’s sister at about the same time and it’s used with her permission.

“Art therapy was one of the shining moments for Sam and for me, a soft and gentle time away from the institutional environment where Sam could find more of himself,” and I’d like to hold on to that last phrase for a moment and think back to where we started with Dr. Prigatano’s suggestion that the arts might heal us by affirming a sense of self or even soul, and pragmatically, thinking now of the treating team, I would suggest that art therapy offers not just an alternative way of interacting with the client, but also another stream of information from which we can stay informed about the client’s progress and wellbeing.

Also, with its combination of doing and relating, it’s possible to entwine and reinforce speech, OT, and neuropsych goals within art therapy sessions, and as with Sam and his sister, it provided, it can provide a medium for meaningful interaction where family is re-establishing relationship post ABI.

I think as Bron has said, the reason that this research felt compelling was that the evidence base for art therapy is still emerging, especially in ABI, and as you might imagine, with the discipline that deals in nuance and symbolism, a big challenge is how to register its effects in a way that can be broadly recognised and Bron and I am in many ways at the beginning of this journey because the experience of running the group program as much as anything made us reconsider the questions we were asking and wonder whether they were the most revealing ones.

I think at this stage, we feel that really good qualitative approaches are probably more useful and randomised control trials for art therapy in ABI, but I do wonder if greater access to biometric measures might change the landscape in the future.

Of course, though, in the area of dual diagnosis, mental health and brain injury, ethical issues would arise with that.

I do feel that as a private therapist, in a public hospital and something of a lone ranger, I wouldn’t have embarked on this at all without Bron’s enthusiasm and support, she’s to blame and it’s my sense that particularly in the on-ward environment, cross discipline team work like this is crucial to moving forward.

But sadly, it’s probably uncommon also, precisely because of the fledgling evidence base for art therapy and ABI which discourages institutions from employing art therapists, so it’s a bit of a Catch 22.

The other big question on the horizon, of course, is the NDIS, and I guess I’m not the only one in the room to be struggling to understand the implications of this from my profession and for my clients.

I think what worries me at the moment is that although we all hope that people will be better off, there seems to be a lack of funding for less traditional therapies over the length of time that someone with an ABI might require intervention, and maybe that’s particularly fraught when the therapy in question has the word art attached because it tends to be misunderstood as a diversionary therapy, with the expectation then that care workers rather than trained therapists can be set up to facilitate it and that’s why despite my ambivalence about public speaking, I occasionally shed my overalls and I try to talk to other professionals such as yourselves about what I get up to with clients.

So in closing, I’d like to thank you for coming at this horrendous hour, not so horrendous now, but it was when we started.

I hope it’s been of some interest, and I’ll just leave you with a list of practice-based observations from the ABI art therapy literature as it stands, and open the floor up to questions. Thank you.

 (Applause):

MC Thank you both, Erica and Bronwyn.

That was such a lovely engaging presentation and really getting us to think outside our traditional little boundaries which I think is really important for us all to do, so thank you.

(Further applause):

**END OF TRANSCRIPT**