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ART THERAPY IN STROKE REHABILITATION: A MODEL OF SHORT-TERM GROUP TREATMENT

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Introduction

In 1991, art therapy (AT) was incorporated in the stroke-rehabilitation program of the Loewenstein Hospital located in Raanana, Israel (Gonen, Ring, Stern, & Soroker, 1992). From the very beginning the staff felt the need to develop a structured model of AT for the subacute stroke patients undergoing intensive rehabilitation. A prerequisite from such a model would be the creation of a form complementary to the conventional treatment modalities already being applied in the rehabilitation program, and a consideration to such constraints as mean hospitalization time and restricted number of qualified AT clinicians versus a large number of patients in need. We also believed that the structured model to be developed should include means for assessing its efficiency with respect to its declared objectives. In this paper we describe the Loewenstein model of AT for stroke patients, and the means developed for evaluating the role of AT as a part of a rehabilitation program.

The Loewenstein Model of Art Therapy in Stroke Rehabilitation

Objectives

The AT program was structured to fulfill the following objectives:

1. To increase the patient's awareness of the changes that occur after brain injury and their implications in terms of impairments, disabilities and handicaps.
2. To help the establishment of an adequate emotional response to the above consequences of stroke, dealing with mourning, depression and anxiety on one hand, and with motivation for rehabilitation on the other hand.
3. To improve the patient's interpersonal relations, by assisting him/her to pass from a commonly occurring state of extreme introversion, soon after the onset of stroke, to a state of greater interest in the immediate and extended environment.
4. To help recognize new alternatives and opportunities for recreational activity.

Target Population

Adult stroke patients with focal lesions causing variant motor, cognitive, language and emotional deficiencies comprised the target population. Patients would be at least partially independent in activities of daily living, and in a stable clinical and metabolic state, enabling them to leave the ward for short periods of time in order to participate in the AT activity (usually 2 or more weeks following the onset of stroke upon admission to the program).

Setting

Therapy was provided by two qualified AT clinicians to a closed group composed of six to eight hospitalized male and female patients, heterogeneous

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with respect to lesion parameters, impairment type and disability level. There were two sessions per week, 1.5 hours each, for a period of 10 weeks. The program was divided into seven successive phases as explained below.

Therapeutic Modalities

To actualize the set objectives, our model of AT for stroke patients employed the following principles:

1. The use of art language in therapy—by means of pictorial projection and other artistic modes, stroke patients were encouraged to deal with newly changed contents of their inner world and to better communicate on troubling issues with others (many of the basic elements that constitute the essence of art therapy are commonly accessible and may be applied naturally with disabled persons in the rehabilitation milieu). In our model we used mainly the following elements of the language of art: Imagination, which although applied in the context of a structured model of therapy was unconstrained by formal logic, social rules or cultural conventions; symbolic representation and imagery, which constitute a definition or redefinition of known, existing phenomena; metaphors, which enable a dynamic adaptation of symbols and images, whereby patients, can deal with painful or frightening consequences of the stroke that they would normally be inclined to deny or suppress; and finally, guided fantasy was used to raise in patients a sensory-like experience of both the factual, real world of hospital life, paralysis and uncertain future and, simultaneously, the sometimes glorified world of "how I was" and sometimes illusory world of "how I would like to be" (Feldman, 1967; Pickett, 1991).
2. The psychotherapeutic process—within the model of AT for stroke patients, we made use of psychotherapeutic tools, mainly to assist patients in coming to terms verbally with their losses. These tools include introspection, sharing, mirroring, feedback, encouragement of emotional expression, ventilation, sublimation, etc. These modes were used in accordance with our understanding of the covert and overt processes of interpersonal dynamics within a group of recently handicapped individuals. It was thought that an enhancement of insight could be obtained once patients underwent the process of sharing and mirroring.
3. Experiences and exercises—patients' self-expression was encouraged through active participation in structured exercises involving the experiencing of space, time, materiality, color, shape, condensation and organization of materials and elements.
4. Group interaction—our short-term model (10 weeks) followed a guided dynamic approach. It emerged out of need to develop an effective mode of treatment within given setup constraints (limited hospitalization period, mixed population with respect to impairment type and disability level, many patients in need versus few qualified art therapists) (Bernard & MacKenzie, 1994; Yalom, 1985).
5. Application of AT principles and methods in the treatment program—the emphasis in our model was on the internal process the patient undergoes in the AT group experience. The personal meanings attached to the product were considered to be more interesting and important than its artistic value (Lusebring, 1990; Rubin, 1984). The art objects produced by the patients were usually simple, as determined by the simple materials used and the "exercise" nature of the work. A "here and now" attitude in the treatment session enabled the art work to serve as a kind of "transitional object" and, the session itself as a "transitional space." Elements such as symbolism, pictorial and verbal metaphor, concretization and imagery were all used with an emphasis on concordance between the somewhat implicit nature of artistic expression and the verbal expression, explicitly indicating the patient's insight and concern (McNiff, 1992; Roukes, 1982). The patient's personalized usage of the language of art was expressed in the style, color and material selected by him or her in the different exercises, by the mode of page filling, of combining different materials, repetitive use of certain patterns and finally, by the verbal commentary on made products.

Stages of the Treatment Program

The program was divided to seven phases, each aimed to create the appropriate conditions—in terms of patients' trust, understanding and motivation—for deepening the therapeutic process in the subsequent phase.