

**Commentary on *The Art of Communication Through Drawing:*  
***The Case of "Mr. R," a Young Man Professing Misanthropy***  
***While Longing for Connection With Others*****

**Discontinuous Change Facilitated by Emotional Expression Through  
Drawing and the Accurate Verbal Responsiveness of the Therapist**

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**ABSTRACT**

Murase's (2015) case study of Mr. R meticulously examined the process of psychotherapy with a severely disturbed male client who received a variety of diagnoses such as personality disorder, schizoaffective disorder, and nonspecific psychotic disorder. His condition was drastically improved through interaction with the therapist using the medium of drawing. The severity of his condition was shocking enough for me as a psychiatrist in private practice to carefully examine the differences and similarities with the assessment and intervention that I usually practice as a behavior therapist. This case study took the form of a "narrative case study," in which there were no quantitative outcome measurements used; however, there were more similarities than differences with single case experimental design in behavior therapy. Intervention in this case was carried out through communication enabled by drawing. It can be inferred that central to this process were emotional expression through drawing and the accurate verbal responsiveness of the therapist. As the intervention progressed, there emerged discontinuous change in the client without his making conscious efforts to do. I examine the mechanism behind this next. Murase's intervention seems to be directed at the client's living and its context itself, while setting the initial condition and constraining condition that determine the new emerging context. This is in sharp contrast to behavior therapy that directs its intervention to facilitate continuous change in a set of behaviors selected by the assessment using functional analysis. In this case study, the initial condition consists of the assessment expressed as "first take the pulse of the situation before you, then apply the method that best conforms to it (p.109)," which enabled two constraining conditions: the framework for self-expression in the form of drawing, and honest attitude and responsiveness with no evasiveness or shakiness. These are core facilitative determinants of this therapy. Finally, I conclude my commentary by discussing how case studies can provide models and guidance for future generations of therapists and therapy researchers.

*Key words:* personality disorders; drawing; responsiveness with accurate verbalization; discontinuous change; the succession of intervention techniques

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## 1. INTRODUCTION

Having been given the invaluable opportunity to read Dr. Murase's (2015) case study of Mr. R, I reflected on my own clinical attitude and felt a strong sense of responsibility for passing on culture. My clinical career is as a psychiatrist in private practice, and I am also a behavioral therapist. My orientation is quite different from that of Dr. Murase and I have never used drawing in my therapy. The fact that she nonetheless appointed me as a commentator for her case study seems to represent her desire that I relate to this client as a person and comment in my own words. Although the client went through a vivid and poignant change process and made significant improvement, it was a psychotherapy case conducted 45 years ago. She accumulated many years of clinical experience in that time span that also added to this case study. Therefore, I will also mobilize all of my own experience and discuss as openly as possible my thoughts and feelings triggered by this article.

## 2. CASE STUDY METHOD

First, the method in this case study allows readers to understand the change process and related factors by presenting the drawings that the client made between sessions and by describing session processes based on the process notes taken after every session. In terms of actual verbal exchanges between the therapist and the client, Dr Murase reported specific statements made by the client and also by his parents, as well as her responses to them. The therapist's internal thoughts and feelings in making these comments were presented separately. According to Iwakabe (2015), this case study takes the form of a "narrative case study." In addition, the article by Dr. Murase now and again notes the fact that there were no quantitative outcome measurements used.

I would like to examine the differences and similarities between her case study and single case experimental design in behavioral therapy. My conclusion, which I state in advance, is that there are more similarities than differences in their basic principles. There are two central features of case studies in behavioral therapy: One is a direct measurement of the behavior that is the target of intervention and the treatment outcome. The other is to repeat the measurement until the trend in changes in the target behavior becomes clearly delineated between the pre-intervention period forming a baseline and the intervention period. In the current behavioral therapies, including Acceptance and Commitment Therapy, "internal events," including thoughts, emotions, memory, and bodily sensations, are considered measurable and thus objects of measurement as private events and verbal behavior. (Hayes, 2012).

Along these lines, the therapist's narrative content and verbal behaviors in Dr. Murase's case study are recognized as targets of measurement and intervention as they too can be regarded as similar to the verbal behavior of the client and his family members in addition to explicit external behaviors of the client.

Regarding the second point, which is the taking of multiple measurements at both a base line period and the intervention period, Dr. Murase described:

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Mr. R ..... had quit school permanently from middle school on. Mr. R spent all his days at home, frequently exhibiting violent and destructive behavior. He had a history of repeated hospitalizations. Upon entering the hospital Mr. R's behavior would change abruptly, becoming uncharacteristically calm and quiet, whereupon he'd be granted discharge. Immediately upon returning home he would once more become emotionally labile and violent. Mr. R had passed through 10 different outpatient facilities. Unable to form even one stable relationship with a psychologist, Mr. R would soon terminate therapy (p. 83).

This description can be interpreted as a behavioral trend in the base line period. In addition, it is sufficiently understandable from what Dr. Murase reported that after therapy started the therapeutic relationship was maintained, violent behaviors decreased, and pro-social behaviors increased. Therefore, the behavioral trend in the intervention period is adequately indicated. In sum, we can judge that the two central features of behavioral therapy are attained in Dr. Murase's case study.

Searching for the differences between Dr. Murase's case study and behavioral therapy case studies, on the other hand, I find that neither the target behavior for intervention nor the outcome measurement is clearly specified in Dr. Murase's study. Therefore, the functional relationship (causal relationship) between intervention and behavioral change cannot be estimated. The difference is perhaps due to the different goals of these types of case studies. However, the difference may be so negligible that if a behavioral therapist analyzed the data of this case study in relation to the goal of case studies in behavioral therapy, he or she would probably conclude that the intervention was effective.

It seems that the above similarity is related to Dr. Murase's principle of responsiveness, that is, "In the beginning, don't approach matters in terms of theory or methodology; first take the pulse of the situation before you, then apply the method that best conforms to it" (Murase, 2015, p.109). In other words, it is the larger principle of starting from facts that enables communication with professionals of other disciplines.

### **3. DRAWING AND COMMUNICATION**

The features that particularly stood out in this case were the severity of Mr. R's condition, which invited a variety of diagnoses from personality disorder, schizoaffective disorder, nonspecific psychotic disorder, and so on, and that this condition was drastically improved through interaction with the therapist using the medium of drawing. This stimulates my curiosity to speculate what therapeutic factors were operative. What was clearly identifiable from the description of the therapeutic process was that the client continued to draw and that the therapist in return used "words that remind you yourself of a sense of reality and the feeling of being present; use the words that you find when you dig deeply inside yourself " (p.109).

Dr. Murase described the therapeutic role of drawing thusly:

Drawing can be used effectively as communication; ...the reality is that there are also situations in which thoughts and feelings that are otherwise difficult to communicate

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through words can be expressed through drawings, and sometimes those drawings can serve as an opening for a communication that is otherwise cut off; ... [and] drawing has played an invaluable role as a communication channel in my clinical work (p. 82).

Based on these statements, we can regard drawing as a tool or channel so that "a connection can occur even when one might otherwise be apt to consider it difficult to establish communication with a particular client" (p. 85).

In order for drawing to be effective in therapeutic situations, Dr. Murase suggests that two things are needed. First is "the therapist being open to and perceptive of the experiential world of the client; being open to and perceptive of the thoughts, sensations, and visceral feelings that the therapist feels in response to the client's communication" (p. 85). The second is the therapist using his or her feelings to respond to the client in words that are "individualized, unique, uncomplicated, and clear (p. 85)." This is the process of receiving the meaning of drawing and reflecting back what the therapist understood and constitutes the necessary conditions that effects communication. It is necessary to examine further why effecting communication works therapeutically.

Dr. Murase explains this by saying, "the fundamental basis of art therapy demands that the therapist maintain a stance of treating the client first and foremost as a person, regardless of how they may seem" (p. 84). She continues:

The given factors prevailing when we're born are neither equitable nor fair. It is of crucial importance that we remain mindful of this injustice within the clinical space regardless of how the client might initially appear to us, and that from the outset we unconditionally accept the client's existential inevitability. The sense of relief felt by the client when their existence is accepted and affirmed is precisely what encourages them to seek reconciliation with that injustice. ...

By mobilizing one's knowledge and experience in the moment, and by trying to exercise one's imagination and richly expand upon those impressions, it is then possible to focus on the underlying potential and resilience expressed in the drawings (p. 85).

In other words, by effecting open and expansive communication, Dr. Murase claims that client's unrealized inner potential begins to blossom. However, there is no further explanation about the mechanism of how this potential emerges.

#### **4. EXPRESSION AND RESPONSIVENESS**

Here I would like to examine how drawing and the communication effected by drawing brought about client change by tracing the facts that were reported in this case study. First, what caught my attention was that many of Mr. R's drawings were quite poignant, and they changed dramatically over the course of therapy.

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The first drawing (Figure 2) was The “Hitler and Munch’s ‘The Scream’”. The portrait of Hitler was imbued with intense aggression and hostility presented with exposed teeth ready to bite and numerous eyeballs on which veins run prominently in all directions. They conjure a feeling of strong trepidation and also a fear of the gaze of others. It seems that the drawing presses the therapist with the question, “Aren’t you scared? Are you not disgusted?”

The next drawing of Stalin (Figure 3) followed by the Tulip (Figure 4) that transforms into a human face included portrayals of Stalin and a student member of a revolutionary group seemed imbued with destructive wishes. However something new emerged: the client depicted the ominous and cryptic tulip with a human face, about which he explained that he allowed "his pencil free reign, but he didn’t understand himself how what he meant to have been a tulip had transformed into a human face. He said that he himself found it strange" (p. 93).

These drawings seem to differently express Mr. R’s pre-treatment condition. How did Dr. Murase respond to them? One aspect of her response was not to evade or wince but to “receive with care the message communicated by this drawing of Mr. R, without being held captive to any previously held framework or posture" (p. 108), allowing her to directly grasp the difficulty that Mr. R felt at the time and also to understand Mr. R’s view of his parents. The other aspect of her response was to reflect back what she received. She reflected back her understanding of the current difficulty that Mr. R was experiencing in an honest and genuine manner. She intentionally did not bring up the topic related to his parents, being mindful of the potential confusion that might have brought, and instead directed her attention to the obscured tenderness by commenting that the drawing of Hitler was almost “cute” and that the drawing of Stalin seemed “compassionate.”

A major change occurs in the fourth drawing (Figure 5). Dr Murase labeled it “Encountering a new eye”, about which Mr. R commented, “It’s really strange. Without any intention on my part my hand just moved around the page until this was what it had drawn . . . all the other stuff that’s in the broken, cracking foreground scene—I can see that that one has a totally different look in it to any I’ve had in my world so far" (p. 97).

However, in the next sequence of drawings, a theme that Dr. Murase described as “Fear of Transformation” emerged: in the fifth drawing (Figure 6), Mr. R drew a portrait of Machiavelli, of Goebbels in the sixth drawing (Figure 7), and of Nietzsche in the seventh drawing (Figure 8). In the drawing of Nietzsche, Mr. R. drew “a new eye,” which he recounted as, “This is such a strange picture. It’s like it was drawn with eyes that are totally different than the ones I have in this world" (p. 97).

How did the therapist respond to the fourth to seventh drawings? In the fourth drawing, she “quietly listened” because as she writes, “I also get the impression that if we stopped here those changes would be fairly superficial; R’s experiences of loss and his loneliness are so deeply ingrained that I had a foreboding sense that rather than following an upward progression of transformation, we would soon be facing the difficulties of the next level" (p. 97). This anticipation was confirmed when Mr. R. provoked her with exaggerated and pretended destructive and anarchistic arguments with the drawing of Machiavelli. Once again, Dr. Murase

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is consistent in not deflecting but instead listening carefully and also carefully repeating her thoughts.

Later, a major change occurred in the situation surrounding the therapy. This was initially triggered by R's mother's second consultation. R and his family were invited for dinner at Dr. Murase's house, which led R and his parents to agree to openly talk about their feelings about their past and the future. This experience had a major impact on R's parents as well. His father made it a daily routine to take a walk with R before he went to work. R started to help out his mother, who had strong compulsive symptoms. He also stated in therapy that he started to think that he needed to study more conventional academic subjects than the making of poisonous gas. These changes appeared to show that he was stepping out of "the world of ideas and violence into the reality of daily life" (p. 98), as if dawn arrived after a long drawn out night.

However, it was not yet easy for R to accept and cope with the reality at the time: there still was a major cleft between the positive attitude driven to confront the activities of daily life seen in his statements during sessions and the antagonistic attitude that he expressed toward the outside world, including the therapist, in the letter he sent her by express post. This state of incongruence continued for a while. The last two drawings were created during a short break in therapy due to the absence of Dr Murase when she returned briefly to her parents' home.

The eighth drawing (Figure 9) portrays a drawing of Marx alongside "five politicians from the Soviet Community Party" (p. 102). Here R asked an intriguing question: "Haven't you ever imagined being a soldier in the regular army, advancing toward the front lines?" (p. 103). Dr. Murase responded that no, she had never thought of that before. Then, "seemingly out of nowhere" he asked her "what sorts of words I thought truly reach a person's heart" (p. 103). From these exchanges, we can learn that Dr Murase's genuine, unflinching and truthful attitude and responses had a major impact. This is evidenced by R's statement at the end that, "My father says that it's a waste that you're a woman since you'd make a great army officer. I think so too" (p. 105).

Presenting her with the ninth drawing (Figure 10), R smiled as he said that she probably knew the reason why this would be the last drawing that he'd be bringing. He drew a large picture of Mori Ogai in the middle of the bottom of a picture featuring Hegel and Clausewitz at the top. Dr Murase said softly, "It's desirable for a person to combine intellectual reason and active power—perhaps even the use sometimes of forceful, active power—in order to lead a balanced existence. That's my guess." Mr. R nodded gleefully" (p. 103-104). She concluded the description of the course of therapy by concluding that, "Now he was capable of communicating how he thought and felt in a nuanced, expressive way, without going through the drawing detail by detail (p.104)."

## 5. WHAT IS NECESSARY FOR CHANGE

So what aspects of drawing and the communication effected by the medium of drawing can we conclude contributed to client change? The main feature of this case study is that a major

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change occurred in the drawings and in R, who drew them, by the therapist having him engage in drawing and in the communication through drawing “without conscious effort.” It started as a discontinuous change within the world of drawing as an encounter with new eyes. Later, it came through during a dinner with Dr Murase’s family, which constituted a discontinuous change in the therapeutic relationship, which then led to another discontinuous change in which R moved from the world of abstract ideas to that of the external reality. Finally, a major change in the family life cycle occurred when R and his parents left Tokyo and moved to a rural setting. Therefore, it is crucial that we understand what role drawing and the communication through drawing played in enabling these major discontinuous changes.

In order to highlight the features of the above change, I would like to make a comparison with interventions in behavioral therapy. In behavioral therapy, the intervention goal is to change habitual behavior that is conceptualized as the sequence of stimulus-behavior-consequence that occurs under a specific context (environmental conditions and internal conditions). The assessment method that is employed in this process is functional analysis that focuses on the functional relationship, which is the causal relationship between a specific behavior that occurs in a specific condition and a desirable (or undesirable) consequence immediately following that behavior. Behavioral therapy targets continuous change in the target behavior so that a particular behavior gradually increases (or decreases), as it is repeatedly accompanied by the same desirable (or undesirable) consequences (Kumano, 2012). In other words, functional analysis is effective in problem solving in a calm period of life, that is one with stable equilibrium, when a major discontinuous change does not occur. In such a period, our mind and body can be regarded as forming a closed system, enabling an effective control by a rigorous causal relationship.

However, life also involves periods accompanying discontinuous change, a turning point or a critical juncture. Moreover, overcoming chronic psychiatric disorders requires discontinuous change in the individual and his or her family. This is widely recognized in various psychotherapy approaches. In psychoanalysis, a theory of psychosexual development by Freud traces a discontinuous developmental process. Erikson proposed a theory of psychosocial development that describes the gradual lifespan developmental process of identity. The goal of psychotherapy based on this theory is to help clients overcome challenges specific to a particular life developmental stage and change personality (Okonogi, Iwasaki, Hashimoto, & Minagawa, 1985). In addition, in family therapy two routes of change are pointed out: one is to return to the previous state of homeostasis and the other is to arrive at a new state of homeostasis. The former is called morphostasis and the latter is morphogenesis (Hoffman, 1981).

In recent years, behavioral therapy has also changed to include not only first order continuous change (chief complaints) but also second order change (including context) as therapeutic goals. For example, in ACT a method called “value clarification” is employed to elucidate a new context (Hayes, 2004).

In a period of life transitions, our body-mind becomes an open system with a drastic increase of energy and information coming in and out of it. It is therefore impossible to assess or control the system based on a causality relationship. What then becomes necessary is control through changing context, which includes bounding conditions (constraints) indicating the range

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of activities and an initial condition indicating the direction for potential new change. Prigogine, who received a Nobel Prize for Chemistry, conceived of a dissipative structures theory: when an order is generated according to the initial condition and constraints. An example is that when water is heated in two receptacles of different shapes, two structurally different convections will occur, each reflecting the structural characteristics of the receptacles; this provides a basis of understanding discontinuous change in an open thermodynamic system (Shimizu, 1990). The conceptual equivalent of this in psychotherapy is what is referred to as treatment structure. The nature of change aimed at by therapies that manipulate treatment structures is fundamentally different from that aimed for by therapies that manipulate causality.

It can be argued that in Dr. Murase's therapy, therefore, the initial condition is her assessment: "First take the pulse of the situation before you, then apply the method that best conforms to it" (p. 109). The structure that enabled self-expression in drawing and the solid constraints created by Murase's genuineness and consistency in her responsiveness that never wavered in any situation—these were the determining facilitative factors.

Sandbox therapy, which belongs to the same category of art therapy, also assumes that double frames—the frame of the sandbox and the therapist who protects the ethos of therapy—facilitate change (Kawai & Nakamura, 1993). Likewise in Mr. R's case, the structure of the drawing exercise and the responsiveness of Dr. Murase provided a firm constraint that withstands dramatic change. In addition, it is by the enormous energy that was invested by both the client and the therapist that a variety of non-continuous changes were evoked, such as "encountering a new eye" (p. 96) and "Communication and the Family Circle" (p. 100).

## 6. THE ROLE OF CASE STUDY RESEARCH

Finally, I would like to conclude with a discussion of the role of case study research. Okumura (2015), who was a long time student of Dr. Murase, wrote in a section about case studies in the introduction of her edited book, *Supervision*, the following: "In reality, it is important to regard a case in case study not as information about a particular client but as information about the interaction between a particular client and a particular therapist" (p.11). Supported by this statement, I feel confident that we can learn how Dr. Murase relates to her clients from reading this case study.

However, in a discussion called "Case Study as a Clinical Method," Dr. Murase (Murase, Morioka, & Iwakabe, 2013) said, "The life of a person begins and ends with the person. Even if a clinician masters his or her clinical skills and uses them at his or her will, it is no more than a set of skills that he or she acquired within him or herself. Others cannot graft their clinical skills onto those of their master (p.18)." When I read this statement, I realize with a sense of despondency that it not so easy. Dr. Murase continued, "The core entity of a clinician who executes a clinical action is a 'person' whose life starts from being a baby. There is no other way than building our skills over time in the course of our life" (2013, p.18).



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When we refer back to the case description, we find something very powerful had occurred. After almost 40 years had passed since Dr. Murase met him, R's sister attended her lecture with her young adult son. The son told Dr. Murase that he wanted to join a helping profession after completing his graduate degree. The collaborative work between Dr. Murase and Mr. R was passed down to this young man in an impressive way after 40 years. Although coming from a totally different theoretical orientation, after reading this case study what I feel is a curious sense of generativity in Dr. Murase handing down a tradition to the next generation.

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