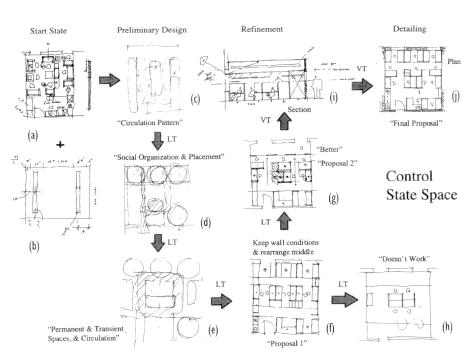
tence is placed together with t seem appropriate. It seems ign ability as a form of intel-

telligence' in the case studies ood designers have a way of oss different levels of detail, sical principles. Rather than their intelligence to the wider ons that resolve conflicts and em framing, of gathering and patterns from the data that t possible solution concepts. The interaction with represently to shift easily and rapidly thought, between doing and thinking not only in their twork.

cicularly, and tragically, highneurological damage in the
es was reported by cognitive
studied an architect who had
mour in his right prefrontal
s associated with high-level
n had practised successfully
is post-attack design ability
t with similar education and
imple task of re-designing a
tehes that the two subjects
h began by making a survey
re. The healthy control subs, beginning with abstracted
en developing proposals and



8.1 The sequence of sketches made by the healthy control subject.

refining the preferred one. The neurological patient produced three separate, basic and incomplete proposals, finishing with a 'final proposal' that was still inadequate and incomplete.

The differences in the thinking processes of the two subjects become clear in graphs of the amount of time each devoted to different cognitive activities, as revealed by their 'think aloud' comments made during the experiments. These are shown in Figure 8.3. The control subject focused initially on 'problem structuring', with periodical returns to this. He then moved to 'preliminary design' and on to 'refinement' and 'detailing'. The graph of the control subject clearly shows a controlled but complex pattern of activities, with overlap and quick transitions between activities. In contrast, the patient