The Power of Art Therapy and The Mind of Dementia

By

Calla Hodgkinson

A Thesis Submitted to the
Graduate Faculty in Partial Fulfillment
of the Requirements for The Degree of
M.A. in Art Therapy

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The Power of Art therapy and The Mind of Dementia

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Abstract

This paper explores the multiple dimensions of the disease dementia. It is also an exploration of how art therapy is useful and beneficial in treating the psychological and psychosocial needs of people living with one form of dementia or another. An overview of how dementia affects the brain, primarily focusing on Alzheimer’s disease, vascular dementia, and dementia with Lewy bodies, the three most common forms of the disease will be offered. An in-depth look into the symptoms of dementia, stigma and marginalization that these individuals are subjected to, and how art therapy can aid in alleviation of these aspects of the disease will be presented. Case studies from practicum internship experience will be provided to further demonstrate the effects that the creative process has on people who are living with varying degrees of dementia.
ACKNOWLEDGEMENT

Firstly, I would like to express my sincere gratitude to my professor, advisor, and mentor Ms. Gloria Eslinger of the graduate art therapy program at University of Wisconsin-Superior for her continuous inspiration, patience, motivation, creativity, and guidance. I would also like to thank my mother and step-father, my father, my brother, and my partner for providing me with unfailing support and endless encouragement throughout my educational career. This accomplishment would not be possible without them. Thank you.
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The Power of Art Therapy and The Mind of Dementia

Introduction

An Elder is a person who is still growing, still a learner, still with potential and whose life continues to have within it promise for, and connection to the future. An Elder is still in pursuit of happiness, joy, and pleasure, and her or his birthright to these remains intact. Moreover, an Elder is a person who deserves respect and honor, and whose work it is to synthesize wisdom from long-life experience and formulate this into a legacy for future generations.

-Barry Barkin (Malchiodi, 2012, p.275)

Working with older adults was something that I always imagined for myself, even in the very beginning of my art therapy education. It came as no surprise to me that throughout my graduate studies I spent the majority of my internship hours working with individuals in the late stages of life; more specifically with those who have cognitive and memory deficits. As my educational career continued it became increasingly more evident the significance and the influence the role of art therapy played in the lives of the individuals that joined me for art therapy sessions. Personally, I have seen the positive effects that the creative process has on persons with various forms of dementia; from simply observing an improvement of mood to witnessing an individual come into awareness of themselves and their surroundings. These findings strengthened my perception of just how impactful the creative process is for those suffering from the debilitating symptoms of dementia.

Individually, I have seen the healing power of art making in my own life and wanted to share this experience with others; little did I know just how powerful this modality of treatment could actually be. According to Ellen Greene Stewart (2006):
Art therapy is the therapeutic use of art making within a professional relationship, by people who experience illness, trauma, or challenges in living, and by people who seek personal development (p. 37).

Stewart (2006) also adds that “Art therapy is utilized in part to reduce the need for pharmacological or physical interventions...[it] has been proven to be effective in improving self-esteem, reducing depression, increasing affirmation of a person’s existence” (p. 37-38). Furthermore, art can provide a form of communication for those that have cognitive impairments or perhaps are unable to verbally articulate how they are feeling. Above all, the goal in art therapy for individuals with dementia is to enhance life. When we think of the aging process many ideas come to mind; for example, loss of mobility, loss of friends and family, loss of health, loss of self-esteem and loss of life roles (Stewart, 2006, p. 38). However, through the inherent nature of the creative process and the involvement of art materials the losses listed above can be offset, but also a reintroduce to feelings of self-worth, socialization, and positive new areas of one’s own self-image can be established (Stewart, 2006, p.38).

The beauty of art is that it can be a catalyst for unlocking areas of the mind that are hidden below the surface. This is particularly important for people with dementia; it is as if certain aspects of an individual’s consciousness are locked away, seemingly with the key to be lost forever. Through the artistic process “some of the deeper layers of consciousness are stimulated, bringing to bear on the creative processes richer resources than may be ordinarily available” (Wadeson, 2010, p. 8). In other words, through art therapy areas of the brain or aspects of personality that appeared to have vanished are rediscovered.
Despite the personal struggles that come along with a diagnosis of dementia there is also an overwhelming amount of social stigma associated with aging and the physical and cognitive decline that can occur simultaneously. Ellen Greene Stewart (2006) makes this abundantly clear when she states:

Aging is not for the cowardly. But aging in America is made more difficult by the fact that we segregate our old people, cast them aside rather than giving them the respect other societies show their elderly. Even the elderly with cognitive impairments have much to offer. My sincere hope is that as the Baby Boomer generation, with its multitudes of members, reaches old age, more assisted living facilities, more adult homes, senior programs, and more ways to keep people vitally involved and as independent as possible will be available. Perhaps by then we will have begun, as a society, to show our older citizens the respect they deserve. Aging is for the very brave (p. 7).

Furthermore, it is necessary to view aging individuals, regardless of physical, psychological, and/or cognitive ability as persons with much to offer and that have a plethora of life experience, knowledge, and sense of humor as any other individual at any other age. There is much complexity to aging and it is without a doubt not for the faint of heart.

The following pages will discuss in greater length what the disease of dementia is; as well as, its symptoms and the stigmatization that accompanies it. An overview of how the brain is affected by the various forms of dementia will be offered and how art therapy can assist in alleviating the symptoms associated with the disease. The use of art therapy will be presented in greater detail, more specifically how it is used with this population of older adults; hands on
experience and case studies regarding the application of art therapy will also be available to further validate the effects the creative process has on individuals with this disease.

**What is Dementia?**

Dementia is not a specific disease, but rather an umbrella term that defines deterioration in cognitive ability that is severe enough to interfere with daily life (Alzheimer’s Association, 2017). In 2010, dementia was estimated to affect 35.7 million people world-wide (Camicioli & Quinn, 2013, p. 3) with the most common form of dementia being Alzheimer’s disease. The second most common forms are vascular dementia and dementia with Lewy bodies (Alzheimer’s Association, 2017)

Although there are several symptoms that could lead to a diagnosis of one form of dementia or another, the most persistent and common symptom is that of memory loss or lapse (Alzheimer’s Associate, 2017). Other symptoms that are associated with dementia are communication and language, ability to focus and pay attention, decline in reasoning and judgement, as well as, loss of visual perception (Alzheimer’s Association, 2017); it is important to remember that these symptoms must be severe and intrusive enough to interfere with daily activities in order to be classified as a form of dementia.

One commonality between each disease that falls under the dementia umbrella is that the disease is progressive; this means that the symptoms may start off slowly and gradually worsen over time (Alzheimer’s Association, 2017). Ellen Greene Stewart (2006) describes dementia as:

A slow, steady decline in cognitive ability. First comes confusion, which leads to poor judgement and disorientation. Victims gradually lose the ability to dress, bathe, toilet
themselves, and perform other routine activities of daily living. Eventually, the dementia leaves many unable to feed themselves, speak, or walk (p.14).

It is imperative that an individual who experiences memory difficulties is seen by a physician for several reasons. First of all, the earlier the detection of dementia is the more beneficial treatments can be, as well as, being more treatment possibilities available (Alzheimer’s Association, 2017). There are also several reversible types of dementia, “which can be brought on by metabolic disorders, infections, severe depression, or other psychological disorders which cause temporary dementia symptoms” (Stewart, 2006, p. 14).

**Types of Dementia and Symptoms**

**Types of Dementia**

Dementia is caused by damage to the brain; with each particular type of dementia there are different brain cells that are affected, as well as, varying regions of the brain (Alzheimer’s Association, 2017). Alzheimer’s disease is by far the most common form of dementia, making up an estimate of 60 to 80 percent of cases (Alzheimer’s Association, 2017). According to the Alzheimer’s Association (2017) the two second most common forms of dementia are dementia with Lewy bodies at 15 percent and vascular dementia making up roughly 10 percent of cases. However, there are several other forms that need to be mentioned; these include: mixed dementia, Parkinson’s disease, frontotemporal dementia, Creutzfeldt-Jakob disease, normal pressure hydrocephalus, Huntington’s disease, and Wernicke-Korsakoff Syndrome (Alzheimer’s Association, 2017). It is significant to indicate that there are over 70 known causes of dementia, and that “many cases are a mixture of two or more different types of dementia” (Stewart, 2006,
p. 14). In the context of this paper the top three forms of dementia—Alzheimer’s disease, dementia with Lewy bodies, and vascular dementia will be discussed in further detail.

<table>
<thead>
<tr>
<th>Types of Dementia</th>
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<td>Vascular</td>
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<td>• Signs of vascular disease</td>
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<td>• Vulnerable to cerebrovascular events</td>
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<td>Lewy Body</td>
<td>Insidious onset, progressive</td>
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<td>with fluctuations</td>
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*Figure 1 (Grohol, 2013)*

**Symptoms**

When thinking of dementia Hass-Cohen and Carr (2008) leave a vivid picture about the beginning stages of Alzheimer’s disease, “Imagine reading a book, watching a movie, or being engaged in a conversation with friends, yet experiencing difficulty holding on to the thread of conversation, or the names of the other people talking” (p. 255). Furthermore, these individuals share “short-term memory problems, fear, embarrassment, sadness, and concern for the future” (Hass-Cohen & Carr, 2008, p. 255) in regards to the onset of their disease.

Generally speaking the essential feature of a dementia diagnosis is the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances:
- Agnosia- the deterioration of language functioning
- Apraxia- the inability to carry out motor functions
- Agnosia- failure to recognize or identify objects despite intact sensory function

(Stewart, 2006, p. 15)

Other warning signs of possible onset of dementia is if there is notable problems with short-term memory, for instance “keeping track of a purse or wallet, paying bills, planning and preparing meals, remembering appointments or traveling out of the neighborhood” (Alzheimer’s Association, 2017).

Alzheimer’s Disease. Alzheimer’s disease is considered to be a slowly progressive form of dementia; which means that the disease itself begins well before any symptoms begin to surface (Alzheimer’s Association, 2017). This particular disease is classified by symptoms including impaired communication, poor judgment, disorientation, confusion, behavior changes and eventually having difficulty speaking, swallowing and even walking (Alzheimer’s Association, 2017). According to Richard Camicioli and John Quinn (2013) other symptoms that are associated with this type of dementia are impairment in executive functioning, which is one’s ability to focus attention, plan, remember instructions, and the ability to multi-task, as well as, visuospatial functions. Why these symptoms occur is due to the fact that plaques and deposits build up within the neurons of the brain, which result in something called “tangles” (Stewart, 2006, p. 15). This causes a significant decrease in the communication and misfiring between neurons within the brain, and thus, ultimately leading to the fore mentioned symptoms.
Vascular Dementia. Unlike Alzheimer’s disease, this type of dementia is not slowly progressive, but can immerse in rapid and abrupt steps after an individual has suffered a stroke; previously known as multi-infarct or post-stroke dementia (Alzheimer’s Association, 2017). Vascular dementia is more prevalent in people over the age of 85 and can cause such cognitive impairments as short-term memory, confusion, and other symptoms similar to that of Alzheimer’s disease (Stewart, 2006, p. 21-22). This disease is a result of disruptions to the brain’s blood supply to the cells, commonly associated after a stroke; additionally, both cortical and sub cortical regions of the brain are also affected (Stewart, 2006, p. 21-22). Typical symptoms also include sudden changes in mood, deviations from normal walking patterns, and frequent urination or incontinence (Camicioli & Quinn, 2013, p. 10).

Dementia with Lewy Bodies. It is common for those with dementia with Lewy bodies to have similar memory loss, confusion, and thinking problems seen in Alzheimer’s diseases, however, there are differentiating characteristics that set this form of dementia apart. First of all, initial disturbances are more apparent and can occur more rapidly; these symptoms include abnormal or sudden change in sleeping patterns, visual hallucinations, slowness, and trouble keeping one’s balance (Alzheimer’s Association, 2017). Another defining characteristic of this type of dementia is the presence of Parkinsonism, which is movement abnormalities similar to those seen in Parkinson’s disease, including tremors, slow movement, impaired speech or muscle stiffness (Matsumoto, 2017). It is important to note that Parkinsonism is not the same as having Parkinson’s disease, which can in itself cause another form of dementia. According to Camicioli and Quinn (2013), “The diagnosis of Lewy body dementia is also reserved for patients whose motor symptoms have been present for less than 1 year when dementia appears, in contrast to the 8–10 years of motor symptoms without dementia in Parkinson’s Disease” (p. 10). Other
symptoms associated with dementia with Lewy bodies may include disproportionate visuospatial dysfunction, and rapid eye movement (REM) behavior disorder (Camicioli & Quinn, 2013, p.10); these and other symptoms that cause the onset of this disease are classified by abnormal clumps of protein that develop within the cortex part of the brain (Alzheimer’s Association, 2017).

Problems with Current Classifications

Sometimes there are abnormalities in the brain that are linked to more than one type of dementia; in this case one would have a diagnosis of mixed dementia (Alzheimer’s Association, 2017). Having mixed dementia is becoming increasingly more common than previously thought and is typically characterized by having a combination of Alzheimer’s and vascular dementia, but sometimes dementia with Lewy bodies, as well (Alzheimer’s Association, 2017). In other words, the onset of dementia is associated with having the protein build up that effects neuron communication, as seen in Alzheimer’s disease, but also having blood restriction to brain cells, as in vascular dementia. Perhaps, this is one of the reasons why the term “dementia” is a blanket or umbrella word to describe numerous diseases with extremely similar symptoms. It is helpful in knowing whether or not it is a type that is reversible or if a person is having symptoms that mimic dementia, when in fact an environmental factor could be the cause of said symptom. Furthermore, having an understanding of the numerous types of dementia, their symptoms, and their causes is vital for delivering the most promising treatment possibilities for the individual; as well as, what type of care would be most appropriate for a person diagnosed with one form of dementia or another.
How the Brain is Effected by Dementia

The human brain is a fascinating organ with many, many, many different functions; it is what controls all functions of the body, as well as, our thought processes and memories. In fact, a healthy adult brain houses nearly 100 billion nerve cells, or neurons, and with branches that connect at more than 100 trillion points; this is called the neuron forest (Alzheimer’s Association, 2017). Neurons are the main part of the brain that are effected by dementia, particularly Alzheimer’s disease; the signals that travel through the neuron forest are what house our memories, thoughts, and feelings (Alzheimer’s Association, 2017). Different types of dementia affect the brain in different ways; however, the early stages of most forms of dementia start with shrinking in brain tissue (Alzheimer’s Society, 2017).

Alzheimer’s Disease Brain

One of the first areas of the brain to be effected by Alzheimer’s disease is the hippocampus (Alzheimer’s Society, 2017). This area helps in forming and retaining new memories; someone with early signs of this form of dementia may not remember things, such as, what they had for breakfast, but can remember events from their childhood. Other areas of the brain that become damaged by Alzheimer’s are the amygdala, the cortex, and the left hemisphere, which is linked to somatic memories and language; as well as, the temporal lobe which is associated with visual memories, this is why someone might not recognize you just by looking at your face (Alzheimer’s Society, 2017).
As Alzheimer’s progresses significantly more damage to the brain can occur; for instance, the parietal lobe and frontal lobes; these two areas are what makes it possible for an individual to make decisions, plan and organize, and judgement (Alzheimer’s Society, 2017).

**Vascular Dementia Brain**

Although the symptoms of vascular dementia can seem quite similar to those of Alzheimer’s disease, their causes and how the brain is affected are drastically different. There is a broader and more capricious assortment of symptoms in those that have vascular dementia and this is due to the fact that it is caused when blood is restricted to an area of the brain; depending on what area is lacking blood supply depends on what symptoms may occur (Alzheimer’s Society, 2017).

Vascular dementia can form after someone has suffered a major stroke; in this case an area of brain tissue dies because the blood supply has been entirely cut off (Alzheimer’s Society, 2017). However, this form of dementia may also arise from a series of mini-strokes, where smaller areas of brain tissue are left without blood supply; when this happens it is called an “infarct” in the cortex (Alzheimer’s Society, 2017). Sometimes it is easy for a professional to determine what area of the brain is damaged based on the early symptoms that an individual is displaying; for instance, “problems with episodic memory can be caused by an infarct in the hippocampus, and problems with executive function can be caused by an infarct in the frontal lobe” (Alzheimer’s Society, 2017).

**Dementia with Lewy Bodies Brain**

Dementia with Lewy bodies often shows less shrinkage to the brain than in other forms of dementia. Lewy bodies, or tiny deposits of protein, form within the cerebral cortex, limbic
system, and brain stem (Alzheimer’s Society, 2017). These proteins are microscopic abnormalities that damage brain cells over time (Alzheimer’s Association, 2017).

Lewy bodies are mainly made up of a protein called Alpha-synuclein and aid in the development of symptoms such as:

- Problems with movement
- Hunched posture
- Rigid muscles
- Shuffling walk or gait
- Trouble initiating movement

(Alzheimer’s Association, 2017).

These problems with mobility could be due to protein build up in the brainstem; however, early damage to the brain can typically be detected in the visual pathways of the brain, as well as, the frontal lobe (Alzheimer’s Society, 2017).

**Ageism and Social Stigma Related to Dementia**

Ageism can be defined as “an ideology, which condones and sanctions the subordination and marginalization of older people within society and legitimizes (or at least ignores) poor quality care, neglect, and social exclusion” (Milne, 2010, p. 228). The social stigma and isolation felt because of it is a very real and serious aspect of the aging process. Ageism or age discrimination is an important element in which older adults experience in later stages of life; Alison Milne (2010) makes this point abundantly clear when she states:

Old age stereotypes are almost universally negative and are associated with dependency, limited social and sexual lives, and incapacity to exercise autonomy and self-
determination. Age discrimination has been identified as having a pernicious impact on the well-being of older people...as a multi-level barrier to opportunity and inclusion (p. 228).

Because of these stereotypes there is resulting impacts on aging adults that could otherwise be avoided, such as, “feelings of worthlessness and despair, it lowers self-esteem and expectations, limits access to services, and underpins a lack of respect shown to older people” (Milne, 2010, p.228).

It could be argued that anyone with a mental health diagnosis feels the effects of social stigma because of their perceived illness; it is as if they are no longer seen as a functioning individual with an enormous amount of potential and much to offer society, but instead become defined by their diagnosis. This is no different for those that have been diagnosed with dementia. In fact, these misapprehensions can perpetuate an individual’s illness and compound their existing “disability.” Milne (2010) strengthens this concept by indicating:

Although it has been observed that all those “assigned a label of mental illness, take on an identity that is stigmatized” (Keating, 2006), this appears to be a particularly powerful facet of dementia. It confers a “master status” on the individual; “having dementia” not only becomes the most prominent aspect of the person’s life but it also serves to subsume all their other attributes and features into a single stigmatized identity (p. 228).

The misconceptions that lead to stigma associated with dementia is due to a lack of understanding, as well as, unfamiliarity about the disease; leading to further isolation in hopes to avoid negative reactions to behavioral and psychological symptoms (Batsch & Mittelman, 2012, p. 2).
According to Batsch and Mittelman (2012) it is estimated that over 75 percent of individuals with dementia feel that they are marginalized by their disease and experience negative associations from others (p. 28). Additionally, stigma is being reinforced by the avoidance of others who are unfamiliar with dementia:

The most common negative association was the feeling of being discounted or marginalized by others (28%). The lack of understanding of what to do when having a conversation with a person with dementia or how to involve the person more was also a common theme (24%); 14% recognized fear in others (Batsch & Mittelman, 2012, P28).

In other words, because of a lack of understanding of the disease and the severe symptoms of confusion, memory loss, agitation, and anxiety the perpetuation of social stigma that befalls upon individuals who have been diagnosed with dementia increases; which directly influences and prolongs feelings of isolation, seclusion, and ultimately more misinterpretation from friends and family.

Art Therapy with Individuals with Dementia

Addressing Psychological and Psychosocial Needs

Art therapy is growing in the area of palliative and gerontological care facilities and programs. This is because art therapy serves a vital purpose and supports areas that individuals in late stages of life are experiencing; such as, the impact of cognitive and physical challenges,
emotional issues, and grief and loss (Malchiodi, 2012, p. 275). Raquel Stephenson (2006) states that:

Older adults face a staggering number of life changes associated with loss: They may lose family, friends, homes, and cognitive and physical capacities. Art therapy can help the older adult cope with, adjust to, and adapt to age-related changes. It can elicit a cathartic and creative experience, give support during loss or crisis, or provide care related to physical loss, such as loss of memory, mobility, sight, or hearing (p. 24).

Additionally, a goal in art therapy with older adults, specifically those with dementia, is not to “fix problems” or “gain insight” into their lives, but rather to focus on the strengths of an individual, more importantly the strengths that have successfully carried them to old age. Stephenson (2006) reinforces this idea when she states, “Art therapy can provide an opportunity for self-expression and introspection, allowing the individual to build on his or her strengths and life experience” (p.24). Regarding changes in later stages of life art therapy can aid in adjusting to health, body image, circumstances, behaviors, and relationships (Gilroy, 2006, p. 132); it also “helps to improve self-esteem, maintain identity, and offers purposeful individually expressive and validating activity that improves the quality of life during its last stages” (Gilroy, 2006, p. 132).

Not only does art therapy provide an avenue for clients with dementia to explore their strengths, to boost self-esteem, and to express themselves; but it can also be a way for individuals to address and cope with fears regarding their illness, as well as, an escape and a means of retaining memory (Gilroy, 2006, p. 126). Andrea Gilroy (2006) furthers this notion by saying:
The sensory nature of art materials and opportunities for self-expression in individual and group art therapy with clients who have dementia can counteract the effects of memory loss, improve communication, enhance self-esteem and reduce depression (p.126).

According to Stewart (2006) art therapy services three primary functions when working with the elderly and dementia:

- To work with the person’s immediate problem
- To deal with the issues pertinent to old age
- To help provide the client with a sense of dignity

(p.40)

Furthermore, art therapy should focus on building upon positive self-worth and self-esteem; as well as, focusing on past and present strengths and artwork that increases cognitive skills and reinforces social interaction and community (Stewart, 2006, p.40). It is also important to recognize that the role of the art therapists is to take on an affirming and giving role, as well as, providing a supportive relationship (Stewart, 2006, p.41). This is especially important when working with individuals who are experiencing loss during a critical period in their life.

**Addressing Neurological Needs and Brain Functioning**

Not only does art therapy address the psychological and psychosocial needs of its clients, but it also offers a variety of ways in which different areas of the brain can be stimulated. Hass-Cohen and Carr (2008) state that “art activates visual pathways, stimulating self-narratives and emotional expressions while reinforcing existing language, memory, socialization, and visuospatial abilities” (p.255). They continue by saying:
[Art-making] stimulates the senses, supporting brain reserve, brain plasticity, the growth of new neurons in the hippocampus, and activates alternate or adaptive connections in the brain, potentially alleviating stress or depression (Hass-Cohen & Carr, 2008, p.256).

In other words, the link between creating artwork, an inherent ability in all human beings, has a direct relation to our mind and body. As Cathy Malchiodi (2012) helps to make this clear, “[there is] neurological and physiological phenomena related to memory, how images are conceptualized, and how they affect the brain and body” (p. 17).

The human brain was once believed to be binary; that is that it was divided into two hemispheres, the left and the right, and either side had specific duties when it came to brain functioning. However, it is now known that the brain is actually quite fluid and not nearly as binary as was once believed (Malchiodi, 2012, p. 19). Continuing on this idea, it used to be believed that art therapy was valuable because it tapped into the right hemisphere of the brain, the area known for creativity and intuition (Malchiodi, 2012, p. 18). Conversely, Malchiodi (2012) argues this point and verifies that in fact art making requires the use of both hemispheres of the brain:

In reality, the brains left hemisphere (where language is located) is also involved in making art...both hemispheres of the brain are necessary for art expression. Evidence can be seen in the drawings of people with damage to specific areas of the brain...even simple drawing involves complex interactions between many parts of the brain (p.18).

The salient point being that art making is not limited to one part of the brain, but instead uses several areas simultaneously; thus, exercising areas that could be lacking which could spark new neuropathways and keep others healthier longer. Because of this there are several areas of the brain that are effected as a result of artmaking. These areas include, “the cortical (symbolizing,
decision making, and planning) [and] the limbic (affect and emotion), and the midbrain/brainstem (sensory and kinesthetic) systems” (Malchiodi, 2012, p. 19-20). Likewise, art therapy can enhance integration of trauma or deficits through “bilateral art making,” which naturally encourages individuals to cross the midline in hands-on ways (Malchiodi, 2012, p.20). Although art therapy will not reverse the progressive symptoms associated with dementia, it is evident that there are ways that art making and creative processes affect the brain that give it possibilities for growth, plasticity, and guarding active healthy areas by slowing damage caused by a deteriorating disease.

**Considerations When Working With Dementia**

With any population it is essential to be considerate of what art materials and directives will be beneficial, as well as, the physical or cognitive abilities of the clients you will be working with. This is no different when working with individuals who have dementia, if anything it might be the most vital aspect to consider when working with this demographic. Similarly, it is also significant to have knowledge regarding specific limitations of a group of people you may be working with. Malchiodi provides a list of four key areas to keep in mind when working with older adults with physical and cognitive deficits:

1) **Physical aspects.** Aging affects vision, hearing, perception of size and color, mobility, and coordination.

2) **Cognitive Functioning.** Perhaps the most noteworthy area to think about when working with dementia; how memory and executive functioning are impacted.

3) **Self-perception.** As roles shift with retirement and within family and community it is inevitable that our views of self also shift. Self-perception can also be altered by loss, grief, and self-concept.
4) *Psychosocial changes.* Fears about changing social status and negative stereotypes revolved around aging is a very real and valid concern that individuals have to deal with.

(Malchiodi, 2012, p.276)

It is equally relevant to be considerate and mindful about specific art materials to use when working with dementia. By doing so you are able to provide structure and stability to the art therapy session/group; which, in turn, decreases feelings of frustration, agitation, and regression (Malchiodi, 2012, p. 277). For example, a simple thing like taping down a piece of paper to the table to keep it from moving can make or break someone’s creative course for that session. It is also essential to make sure that other materials are of standard; for example, glue sticks, paint brushes, paints, markers, and paper are of medium to high quality to be used by varying levels of ability.

**Working in groups.** When working in groups with individuals who have dementia a vital aspect is realizing that symptoms, abilities, and deficits will be varying among members of the group. This is why it is necessary to create art directives that are easy to adapt; that they can be made more complicated for some individuals and less complicated for others. This leads back to the idea of decreasing frustration and agitation within the group.

Besides the practical applications of working in art therapy groups of clients with dementia, it is also necessary for alert observation on the part of the therapist. For instance, keeping track of how many pairs of scissors are on the table, how many glue sticks, and not to leave art materials or personal belongings unattended; this may seem like a silly notion, however it is not unusual for clients with dementia to have the idea that these items belong to them and
therefore feel free to take them. This can also pose a dangerous problem if staff are unaware of missing materials. Likewise, the therapist must stay vigilant about art materials because sometimes with dementia a person does not realize that a bag of buttons or a bottle of glue is not food; ingesting these items can pose health complications.

Art Therapist as Third Hand

The art therapist’s third hand is a concept developed by a leading pioneer of art therapy, Edith Kramer. Cathy Malchiodi (2014) defines Kramer’s concept as:

[T]he art therapist’s ability to facilitate a person’s artistic process [such as strategically helping the individual mix paints for a desired color or intervening at critical moments during art making]. To me, the “third hand” exemplifies our modern-day interpersonal neurobiology paradigms of attunement and empathy as well as...[the]concept of “mindsight”...ideas about “focus” and emotional intelligence.

Basically this is the idea that the art therapist recognizes when to assist a client in order to maximize the potential of an individual’s creative idea. This can be particularly useful when working with people who have dementia that causes physical and cognitive impairments. The art therapist is there to assist in whatever way possible so that a person is able to bring their ideas to light and expression themselves in an accurate manner.
Art Therapy Practicum Experience with Dementia

When I began my graduate career I was placed in my first practicum location; a memory care facility that housed an average of 40 residents. It came as no surprise that I wanted to work with an elderly population, but I had no true experience working with individuals with various forms and at various stages of dementia. However, this did not deter me from learning as much as I possibly could in the time I would spend with these wonderful people. When I first began my practicum hours at this facility there was a period of development of art therapy directives as I learned what activities were successful and which directives did not work as well. My initial thoughts were that I would have to start brand new at the beginning of each session; however, after about three weeks of returning twice a week for art therapy sessions I realized that people began to remember who I was. They could not remember my name, but they knew why I was there and that I was a familiar face; this was the first time that my preconceived perceptions of what people with dementia were like were completely shattered. At this time I began working with a few individuals that I would continue seeing throughout my two years working in the memory care unit. Additionally, more people would move into the facility and begin creating artwork at the group art therapy sessions.

For the confidentiality of the clients that I worked with names have been changed in the case examples provided. It is noteworthy to mention that I am not familiar with the specific diagnosis of each individual or what stage they are at in their disease; I can however, identify certain areas that these individuals excel at and which they struggle with.
**Doris: Self-expression and Introspection.** Doris was one of the first persons that began working with me through art therapy. I was told by my supervisor that she enjoys doing artwork and is always willing and able to join the group. I learned early on that Doris has an active imagination and uses it wildly to create her artwork. At one of the first sessions that I had she took out a bag of miscellaneous beads and buttons and began putting together a mosaic type piece of artwork. When it came time to glue the items to the paper she was using we only had Elmer’s glue; this would not hold the weight of the items she chose, nor would it dry in time for her to enjoy her masterpiece. This was the first lesson I learned, always be prepared with the materials you have with you. This project also indicated that Doris had an understanding of spatial reasoning by telling me which pieces needed to be glued first in order for all the pieces to be fastened to the paper.

![Figure 4](image)

Something unique about Doris was her desire to understand all steps of an art therapy directive before trying it herself. This was evident in a *Tissue Paper Sun Catcher* activity that utilized several steps to achieve the preferred outcome. I demonstrated the entirety of the activity and then helped her through each step one-by-one.

As time went one it became more and more clear that Doris had a specific style to her artwork, from her brush strokes, to the way she lined up art materials, to her thought processes in execution. Doris had the unique ability of taking the materials provided to her and going above and beyond what was asked of her via the art therapy directive. This is apparent in the following works of art.
It became clear that Doris' mental capacities in the two years that I have known her are in a slow decline. More and more often she would be sleeping in a chair upon my arrival and it would take a longer amount of time for her to decide to come to the art therapy sessions. Towards the end of the two years the staff and my supervisor pointed out that it was becoming more difficult to get her to join in with different activities. She still recognizes me and understands that we are going to create art together; this usually gives her the motivation to participate in art therapy.

**Elsie: Fostering Communication.** When I first met Elsie I had the assumption that she was non-verbal except for a few words like “yes” and “no.” It didn’t take long to realize that this assumption was completely false; you just had to take the time to learn how to communicate with her and what she enjoyed talking about. With time it became apparent that Elsie had a great sense of humor, loved to read and dance; I also learned that she was fluent in Finnish.
One of the first projects I worked on with Elsie was a fabric mosaic. For this project I utilized the art therapist’s third hand in assisting Elsie in her artwork. I would assist her by adding glue to the pieces or showing her where she left off. This technique would be useful in helping Elsie with future projects.

As I realized how much Elsie loved to read I would bring materials to encourage her to do so. For example, when a collage project was planned I would prepare extra word cut-outs for Elsie to look through and create with. Sometimes she would not want to create art during the art therapy session, but instead stayed with the group and would be provided with a book or magazine to look through.

The more I developed a relationship with Elsie the more it seemed that she would be happy to see me. Sometimes when asked to participate in art she would stand up and follow me and other times she would simple say “No;” she never ceased to give the honest truth about how she was feeling. It appeared that she also became more independent in her art making; in the beginning of a session she would need some assistance, but then had no problem completing an entire activity on her own or with little assistance from the art therapy interns.

**Barb: Reminiscing and Remembering.** As Barb and I got to know each other she began to associate me with someone that she worked with at her job. She would
always start conversations with me about what department I am working in now and how she is ready to go home after a long day of work. Barb became a regular at the art therapy sessions and always created artwork in her own unique way. It was rare that she would follow the directive that I had brought that day, but instead would work on her own artwork. It was clear that Barb enjoyed representational artwork and wanted to create items that she knew or memories of her past.

During a still life painting session Barb demonstrated her distinctive art style by taking some of the items laid on the table and created a three-dimensional collage. She integrated driftwood, flowers, and paint into her piece of; showing yet another facet to Barb’s artist personality.

One thing I had to keep in mind when working with Barb was that she did not want to give back art materials at the end of sessions; she would state that she received these items as a gift from her brother or something along those lines. In order to combat this behavior and to make sure we always left on a good note, I began to put my name on art materials, such as, markers, scissors, pens, etc. When Barb would see that it had someone else’s name on it she would always give it back; which relieved feelings of frustration that Barb was having at the end of sessions.

**Irene: Relieving Anxiety.** When Irene arrived at the memory care unit of the facility it was abundantly clear that she was experiencing a tremendous amount of anxiety. She had trouble
knowing where she was and why she was there. Often times she would sit at a table and yell “HELP!” almost in an incessant manner; finding no relief from the reassurance that the staff and interns were giving her. Consequently, this also affected the moods of the other residents that had difficulty understanding why she was so worried about everything. I discovered that if there was time to just sit with her and hold her hand she would calm down momentarily; however, this was challenging because neither the staff nor the interns had time to dedicate solely to sitting with Irene for long periods of time.

On a day that we were painting mandalas I decided to see if I could encourage Irene to try painting. At first it seemed that she could not escape her anxiety long enough to sit down and work on a painting. After some time and patience I was able to help her complete a painting. Each time there was new paint on her brush I had to remind her, “Irene, this is a paint brush, we are painting today;” and she would continue working on her painting. As we painted together, hand-in-hand, Irene said “This feels good.” This was also when I discovered that for the time Irene was painting her anxiety subsided, whether this was for 5 minutes or 20 minutes. The act of painting gave Irene the opportunity to escape her confusion and be completely in the moment.
**Arnie: Coping with Transitions.** I met Arnie shortly after he moved into the memory care facility; at this time he was struggling with understanding where he was, why he was there, and almost always wondered why his wife was not with him. In other words, he was having trouble coping with the transition of relocating to a new and unfamiliar environment. I decided to invite him to an art therapy session to see if myself and the group could offer some comfort and community through the difficult time he was having.

Right away Arnie showed his talent, imagination, and humor through his artwork. He created numerous pieces while in the group and also enjoyed sharing stories about his life. He reminisced about his time as a physical education teacher and a pilot; he created drawings of airplanes, ships, landscapes and abstract images. Each time he joined art therapy sessions his concern and agitation about his new environment would be subdued and he focused completely on the materials in front of him and his creative process.
It was a common occurrence for his wife to be visiting and join in the sessions, as well. They would create artworks collaboratively which supported Arnie’s feelings of being more interconnected to the community within the memory care facility.

**Resident Art Show.** At the end of my third semester at this facility my co-intern and I, along with several staff organized an art show that showcased the work of the residents from that past year. This art show was not to give recognition for the art therapy interns, but to exhibit the hard-work, enjoyment, talent, and pride that the residents generated during their time in the art therapy sessions. This was the largest event of its kind at this facility and friends and family were invited to support their loved ones and admire artwork. There was over 60 pieces of artwork displayed within the facility, each numbered; those that came to the event were encouraged to vote for their favorite piece.

Irene’s piece (Figure 13) won the art show, which the facility staff had framed and gave it to her husband. Many were happily surprised at the artwork that Irene created and some expressed that they did not know she was able to create like that. This is an example of how art can help break down walls and reconstruct stigma and stereotypes associated with dementia.

About six months later Irene passed away; her husband expressed his appreciation for the time
myself and the other intern spent working with her and that he is thankful to have her framed painting to remember her by.

Additionally, a collaborative art piece was installed at the art show. A kite made of prints created by the residents. Since not everyone wants to or is able to join in the art making process, I found it important to be able to incorporate more residents and family members into this art installation. We asked several residents about their favorite memory or part of spring time and recorded their answers; we also left blank paper and writing materials next to the kite so others attending the art show could include their answers as well. This piece allowed others to take part in the creative process and ultimately evoked a greater sense of togetherness within the community.

**Outcomes and Observations**

First of all, through my experience at this facility I have witnessed first-hand the isolation and alienation that people with dementia face. There are several residents that have not had a single visitor in the two years that I have been at this facility. The group art therapy sessions provided a greater sense of community for the residents in the memory care unit; it was not unusual for them to compliment and praise each other on the art work they were creating, which aided in building self-esteem and sense-of-self. As relationships were built within the group it was evident that there was a greater psychosocial dynamic happening, as well.
There is also a great deal of anxiety and confusion in regards to dementia; this is especially true during times of transition. It was not unlikely for a staff member to mention that an individual is new and feeling isolated, anxious, and confused about why they are there; if I could get them to at the very least sit at the table during art therapy it was obvious that they felt less isolated and it took their minds off of their current struggles; I witnessed this first hand in the cases of Irene and Arnie.

Finally, it was a common occurrence for staff, family members, and other people in the facility to be surprised by the creative potential within the residents. Staff members would join the art therapy groups and learn more and more about the residents and their capabilities; they would discover aspects of their personality that was able to shine through during art making; and consequently giving them a greater sense of who they are as individuals. This also helped in breaking down barriers and the stigma that is attached to a dementia diagnosis; they were able to be seen for who they truly are beyond their disease.

**Conclusion**

With aging comes a plethora of ailments; whether they are psychological, neurological, or physical. Art therapy is an effective modality at addressing these issues with older adults, particularly those with dementia. Cathy Malchiodi (2012) states that:

Work with older adults requires attention to physical, mental, and emotional abilities that may have been compromised by age, bereavement, or the end of a career. Inevitable end-of-life issues are also present, along with the loss of independence for many individuals (p.275).
Dementia encompasses multiple types of diseases that cause memory loss and other cognitive impairments. It is a progressive and pervasive disease with no cure; however, through artistic expression the symptoms associated with the disease may be lessened or temporarily inhibited. Despite the debilitating effects that dementia has on the minds of the individuals who have this disease, art therapy is one way to help them regain a sense of who they are, to hold on to their memories, and restore autonomy and self-esteem.

It is known that art stimulates multiple facets of the brain and enriches the lives of the people using it (Malchiodi, 2012, p. 19); this is an absolute certainty for individuals who are suffering from the effects of dementia. Art therapy serves a vital purpose in that it helps them during the late stages in their life, particularly the impact of cognitive and physical challenges they are facing; as well as, help in dealing with interpersonal and intrapersonal issues and support during loss or crisis related to physical loss, memory, and mobility. Perhaps most importantly, art therapy with those afflicted with dementia enhances the opportunity to gain insight into their lives and the strengths they have attained that have successfully carried them to old age.
References


