

# Art Therapy and Neuroscience Blend: Working with Patients Who Have Dementia

Ellen Greene Stewart, Roxbury, NY

## Abstract

*This paper explores findings from the fields of neuropsychology and art therapy as they relate to treating patients with dementia. It explains the biological, physical, and psychological manifestations of dementia, and current treatment modalities. Art therapy has been shown to be beneficial to patients with dementia. Unfortunately, it is the rare long-term care facility that offers such a program to its residents. The graphic indicators that manifest themselves in the art of patients with dementia are discussed along with four case examples that illustrate the benefits of art therapy programs for patients in varying stages of dementia. The implications of such treatments for society are explored, including the need for more studies integrating art therapy and neuroscience.*

## Introduction

Like the careful blending of colors, art therapy and neuroscience mix together to benefit patients who have dementia. The purposeful blending of these two bodies of knowledge could be the key to understanding the inner workings of this progressive disease. Cognitive decline leaves its imprint on art expression. The more we as art therapists understand the parts of the brain affected by the characteristic plaques and tangles of dementia, and the brain functions they affect, the better we are able to help patients in their struggle for self-expression, dignity, and, in some cases, resolution of lifelong issues. This article provides an explanation of dementia and its symptoms and stages as well as findings from the fields of art therapy and neuropsychology. It then explores the ways art therapy can be used to foster a better quality of life for patients with dementia using case studies to illustrate some methods for working with them.

## What Is Dementia?

Dementia is a syndrome, a group of signs and symptoms without a specific identified disorder. It is one of the top public health issues of the 21st century since life expectancy has recently risen to 77 years in the United

States. Over 4 million Americans—one in five of those 75 to 84 and nearly half of those 85 and older—are now afflicted. The number of Americans afflicted with Alzheimer's disease is expected to approach 6 million by the year 2010, and the number projected to have the disease by the year 2050 is more than 14 million (Cowley, 2000).

Dementia is an umbrella term that encompasses many different diseases. It is also called Organic Brain Syndrome (OBS). There are over 70 known causes of dementia, and many cases are a mixture of two or more different types of dementias. Alzheimer's disease (AD) is the most common form, accounting for 50% of dementias (Buettner, 1997). The average estimated cost for a patient with dementia to receive care at home is almost \$20,000 per year, and for those in a nursing home, the cost can more than quadruple. At this time there is no known cure, cause, or definitive treatment for AD. Almost all types of dementia are irreversible.

According to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (2000), the main criteria for diagnosis of dementia are memory impairment and cognitive disturbances in at least one other area of functioning. Further, these impairments are severe enough to interfere with social or occupational functioning and worsen over time. The most frequently diagnosed type of dementia other than AD is vascular dementia (formerly referred to as "multi-infarct dementia"), in which a series of small strokes, sometimes called TIAs, block small arteries in the brain. The common symptoms associated with vascular dementia include short-term memory impairments, confusion, and other symptoms generally associated with AD and other dementias. Characteristically, the onset of vascular dementia occurs in abrupt steps, rather than the slow onset and steady decline common in AD patients.

Four million people in the United States have AD, the most common form of progressive, degenerative dementia. AD is characterized in the brain by the deposition of amyloid protein outside the neuron, resulting in the formation of plaques, and inside the neuron with neurofibrillary tangles, which are cytoskeletal components affecting the neuron's functioning. These plaques and tangles cause the number of synapses (units of communication between cells) to decrease, resulting in AD. The neurotransmitters most often affected are those involved in learning and memory (Davis & Luddington, 1999).

Because the only way to absolutely diagnose AD disease is by autopsy, it is diagnosed by a process of elimina-

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**Editor's note:** Ellen Greene Stewart, MA, is in private practice in rural upstate New York. Her intergenerational art therapy program, in which high school art students work side by side with nursing home residents, won an innovation award in 2001 from the National Rural Health Association. Correspondence concerning this article may be addressed to Ms. Stewart via e-mail at [peacebaby@catskill.net](mailto:peacebaby@catskill.net).

tion—that is, by ruling out all other possible causes of memory and intellectual impairment. Recently, the medical profession has begun to use MRIs in the diagnostic process, which enable physicians to see the neurofibrillary plaques and tangles. Doctors seeking to eliminate other possible causes give patients a physical exam that includes a thorough medical history, blood and urine tests, EKG and X-rays, history of recent medications and alcohol use, and a neurological exam including a mental status test. It is important to note that there are several rare but reversible types of dementia, which can be brought on by metabolic disorders, infections, severe depression, or other psychological disorders that cause temporary symptoms of dementia. Certain medications may cause a temporary reaction similar to dementia.

According to the *DSM-IV-TR* (2000), AD is considered to be early-onset type if onset is at age 65 or under, and, conversely, it is considered to be late-onset type if onset occurs after age 65. In general, the dementia progresses more rapidly in early-onset cases. AD is made up of four stages. Patients with dementia may show signs of various stages simultaneously. During Stage 1, the patient shows signs of confusion and is becoming aware of a memory problem. During this stage the individual has a decreased ability to learn new things and has difficulty concentrating. This stage can last from about 2 to 5 years.

During Stage 2 of the disease, the patient shows poor judgment, is often disoriented, and becomes increasingly withdrawn in an apparent attempt to shut out an environment that causes increasing confusion. People in this stage often show signs of paranoia and may accuse caregivers or family members of stealing from them. It is usually during this stage that agitation and aggression are first exhibited. This stage can last, on average, from 3 to 12 years.

In the advanced stage or Stage 3 of AD, communication (both expressive and receptive) has usually become very difficult for the patient. In addition, the patient has had a significant loss of the ability to perform daily living skills and usually needs assistance with dressing, bathing, toileting, and so on. The patient often becomes angry and confused and is sometimes aggressive toward caregivers because of the loss of dignity and independence. Boredom and the inability to focus on a task are major problems that lead to behavioral disturbances.

The fourth or terminal stage of AD is characterized by substantial physiological decline. The patient needs to be fed, is incontinent, and is unable to recognize family members. Patients at this stage are unable to walk or talk. At the end of this stage, the patient generally lives a vegetative existence. The actual cause of death for most people with dementia is failing of the organs, infection, or a general physical decline.

## The Neuropsychology of Dementia

A few prescription drugs on the market today claim to slow the progression of AD. Drugs such as Aricept can have some positive effect if used in Stages 1 and 2 of the disease. Although these drugs can prolong the early stages of the dis-

ease, they are unable to arrest the disease process entirely. Aricept usually takes up to 8 weeks to show its full effect. At times it may even cause increased agitation, and in some patients, may have little effect at all. Other than these medications, the prospects for treating AD are bleak.

Snowdon (2001) is well known for his ongoing epidemiological study of the nuns of the School Sisters of Notre Dame. The nun study asks why some of the sisters aged gracefully (remaining healthy, active, and cognitively intact) even past the age of 100, whereas others, who had lived similar lives in the heart of the convent, lost their cognitive ability and become disconnected from reality. As part of the study, the brains of the participating nuns were autopsied without reference to accompanying case information. Snowdon found that the brains of some nuns contained the neurological plaques and tangles characteristic of dementia; however, upon reviewing the case information, he found that these nuns had not presented with any symptoms. He hypothesized that perhaps some brains are structurally stronger than others, owing to prenatal and genetic factors. He further hypothesized that the more educated or well-exercised brains can, perhaps, better ward off the neurological attacks, making them less susceptible to dementia.

Snowdon's methodology included extensive interviews, standardized tests administered at regular intervals, health charts, and a computer analysis of word usage from journal entries written by each of the nuns in her youth. When reviewing these journal entries, Snowdon looked for idea density and analyzed the average number of syllables each nun used in her writing. The computer analysis confirmed that those who used multisyllabic words tended not to develop AD; in contrast, those who used monosyllabic words tended to develop AD later in life.

Another interesting finding from the nun study is that strokes may serve as a trigger in those nuns who have plaques and tangles in their brains but who do not manifest any symptoms. The stroke may activate the trigger, causing dementia symptoms to appear at that point. The main question of validity in this study surrounds the issue of whether or not the nuns can be seen as representative of the population at large.

According to Colling (1999, 2000), a major manifestation of dementia in advanced stages is passivity. Passive behaviors are defined as those that are a diminution of behavior, that is, a decrease in gross motor movement accompanied by apathy and lack of interaction with the environment. When participation in an intergenerational art therapy group was measured, researchers Stewart and Stewart-Fahs (2000) found that passivity was more of a problem than aggression and that the level of engagement of each participant increased significantly when high school art students were in the room. They also found that behaviors such as restlessness and calling out decreased during the intervention phase of the art therapy program. As might be expected, social interactions increased during this phase.

Ricker, Keenan, and Jacobson (1994) hypothesized that there is a strong relationship between visuospatial ability and recognition memory in normal mental processing. A brain that has been injured tries to pro-

cess information habitually. However, the introduction of a degenerative disease process can result in the cognitive processes having to rely upon serial or sequential aspects of processing. In other words, the cognitive system becomes less flexible and incapable of compensating for impairments in processing. This is when colors, forms, and textures can play an important role in providing much-needed visual and tactile stimulus to passive patients with dementia.

## Art Therapy and Neuropsychology Merge

According to Erikson's (1980) model of human development, elderly adults are in the psychosocial stage of life called "integrity versus despair." In my experience, most older adults have little or no experience in using art materials or in expressing themselves visually. For the most part, the generation that is now in its 80s and 90s placed a high value on work and family and little value on hobbies. Art therapy may offer uncharted territory for them to explore and can become a welcome source of involvement and pleasure, particularly when done in groups that provide increased opportunities for socialization. Art therapy also helps exercise those areas of the brain that are still functioning well and increases quality of life by providing opportunities for sensory stimulation and self-expression.

Wald (1986) has explored the fusion of symbols and confusion of boundaries in the artwork of AD patients and makes the analogy that, like a pathologist studying disease through a microscope, the art therapist can examine conscious and unconscious personality through artwork. One woman I worked with, a former seamstress who had severe dementia, consistently drew in the lower left-hand corner of her paper, sometimes along the edge as if intuitively clinging to the boundary. This was direct evidence of organicity and provided a clue as to how much her functioning was compromised by her illness.

In dementia, many highly overlearned skills of adult life may prove relatively resistant to brain damage whereas other relatively low-level skills may be vulnerable to destruction. It is the temporal and parietal lobes of the brain that Alzheimer's disease attacks with ferocity. These are the regions of the brain that govern many higher-level intellectual activities such as language. The frontal lobes, which govern motor and speech functions and where personality and emotional control reside, are often relatively intact until the end stages of the disease (Gardner, 1974).

In general, I have found that almost all who have mild dementia and participate in an art therapy program are able to include depth, proportion, appropriate use of color, and a high degree of detail in their artwork. Approximately three quarters of those with moderate dementia are able to use color somewhat appropriately and attempt representational forms and figures. These artists may even use baselines and skylines. Virtually all participants with severe or profound dementia scribble and use color randomly—if the art therapist is able to motivate them to participate at all.

## Art Therapy with Patients with Dementia: An Underutilized Treatment Modality

The popular notion of aging includes failing vision, aches and pains, joint stiffness, loss of mobility, loss of friends and family, loss of health, loss of self-esteem, loss of previous life roles—the word "loss" comes up over and over. In truth, aging can be a highly enjoyable and creative time in one's life, a time for self-expression, a time for rediscovering oneself, a time for learning to enjoy new activities and relationships or participating in activities one never had time for previously. The desire to remain vital is an attitude that comes from within each of us. In the case of people who struggle to remain vital as they age, the support of a well-developed therapeutic relationship can help immeasurably.

The idea of doing "art" can be intimidating to many people. Most of us have been told we are no good at it and have no creative ability, so we stopped trying long ago. I think of some nursing home residents who are actively involved in my art therapy groups on a regular basis but who became active only after constant reminders that the goal is to enjoy ourselves, that the emphasis is on process not product. In the case of those who resist the most, I tell them it would be nice to have them keep us company and watch. Many eventually can't resist the colors and the feel of the various media.

There is a fine line between art media that is and is not age-appropriate for nursing home residents. Crayons, finger-paint, and other so-called regressive materials actually work well with this population because of cognitive loss, decrease in manual dexterity, and increased importance of the tactile sense for patients with dementia. Even the use of children's scissors has proven difficult for a great many residents with dementia. All materials should be safe and non-toxic as very often materials such as a blob of red paint looks very appetizing.

In many cases, nursing home residents who have had a stroke (cerebrovascular accident or CVA) on one side of the brain have to learn to use their nondominant hand. Therefore, when considering their artwork, factors such as this must be taken into account, making the process of looking for graphic indicators, personal symbolism, and signs of disease progression quite complex. Medication changes should also be taken into account since many alter motor and cognitive functions.

According to Landgarten (1981):

Clinical art therapy for the elderly has three main purposes: (a) to work with the person's immediate problem, (b) to deal with issues pertinent to old age and (c) to help provide the client with a sense of dignity. Therefore, the emphasis with older clients should be on portraying past and current strengths, as well as on creating artwork that increases cognitive skills and increases social interaction. In art therapy, a positive therapeutic relationship is hastened or strengthened through the art therapist's role as a "provider." The therapist furnishes supplies and is considered a person who gives something to the client. (pp. 251-252)

In my experience, many long-term care institutions require that a person minimize his or her personal possessions in order to be admitted, making the providing role of the art therapist even more poignant.

Wadeson (1987) has stated that the elderly, especially those with cognitive impairments, may produce quantities of artwork but little in the way of insight-oriented conversation about the art. Further, Wadeson (2000) has pointed out that art therapists who work with AD patients take on a supportive role rather than an insight-oriented or curative role. She has also stated that in many instances these patients had fewer inhibitions in expressing themselves through art than other older adults.

The Formal Elements Art Therapy Scale (FEATS) developed by Gantt and Tabone (1998) looks at 14 structural components in artwork and attempts to correlate them to a diagnosis. The FEATS assessment requires participants to draw a person picking an apple from a tree (PPAT). The authors assume that diagnostic information is primarily found in how the art is done as opposed to what it is about. They believe that specific global variables are the graphic equivalents of psychiatric symptoms and have extensively researched and tested their hypothesis. Therefore, they suggest that if formal elements of art reflect psychiatric symptoms, these elements should change along with the symptoms. Although the PPAT directive has proved too difficult for patients with advanced dementia, Gantt and Tabone encourage experimentation with other, simpler directives. I have found the FEATS very helpful in tracking disease progression and regression, zeroing in on graphic indicators, and assessing general cognitive and problem-solving ability.

Wald (1986) and Kahn-Denis (1997) have found that the graphic indicators of AD include regression, perseveration, simplification, fragmentation, disorganization, distortions, perceptual rotation, overlapping configurations, confused perspective, the presence of short scattered lines, small or cramped appearance, an overall impoverished appearance where essential details are omitted from the drawing, and apparent difficulty in comprehending or following directions. The artwork, especially when viewed over time, can assist the staff and family in evaluating the progression of dementia.

As helpful as it is to have diagnostic indicators, it is the healthy parts of patients' brains that art therapists must stimulate in therapy. Therefore, it is critical to successful therapy to look into what brain functions are still strong in an individual with dementia and stimulate those functions. In the illustrative case examples that follow, it is clear that, as is always the case when working with people, each person has unique strengths and each situation is different.

### Freddie the Printer

Everyone liked Freddie. He was an 89-year-old nursing home resident with advanced dementia or OBS. A cheerful, friendly man, Freddie was able to talk and to walk on his own. He also retained excellent fine-motor coordination. Until retirement he owned his own printing business, which

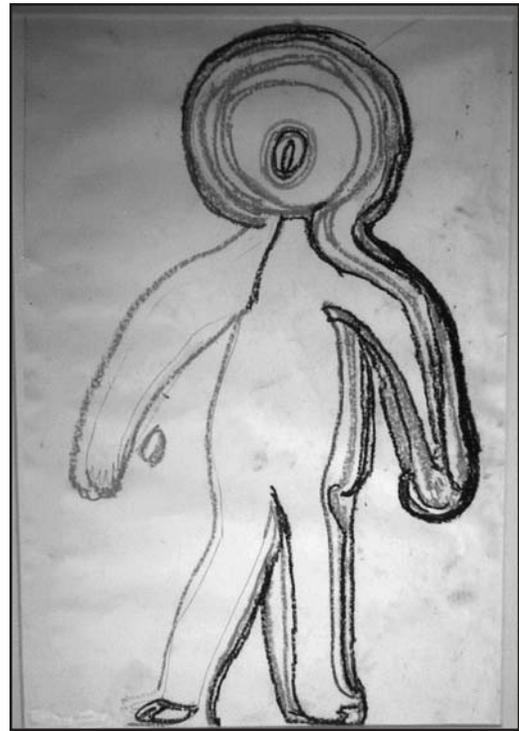


Figure 1

included doing a great deal of silk screening, typesetting, and other forms of graphic designing. He was an avid sports enthusiast and talked about sports frequently.

Upon his arrival at the nursing home, I asked him to tell me the reason he was there. His endearing answer was, "I wanted to see what would happen if I stopped in here." He was easy to engage in art activities, and he enjoyed talking to staff and other residents about his love of animals and sports. When watching a sports program on TV, Freddie would often smile from ear to ear and cheer. Freddie's Mini Mental State Examination (Psychological Assessment Resources, 2001) score was 7 of 30 at the time of his nursing home placement. During his stay, he sometimes became agitated and anxious. If presented with art materials when this happened, he would usually become engaged with them fairly quickly with calming results.

During one of the first group sessions Freddie attended, I presented each participant with the nongendered outline of a human form and pastels. Freddie, who began to work on his form immediately, outlined the entire form in light blue and then heavily outlined the entire head and right side of the form with black and red. Concentric circles appeared inside the head, and a small black circle appeared inside the right foot (Figure 1). This unbalanced form was repeated in two or three colors whenever Freddie filled in a blank form. In my opinion, the repeated right-sidedness in his drawings suggests more lesions on the left side of his brain. According to Gardner (1982), the drawings of a person suffering left-hemisphere disease tend to be simplified with a recognizable form but few details. He states, "Even in an artistic task that is conceptual in nature, left-hemisphere disease proves less crippling than damage

to those regions of the brain that are dominant for visual-spatial functioning” (p. 327).

In other group sessions, when Freddie was presented with a blank paper and colored pencils, he would draw a volleyball net in the center of the page and would fill in with words and lines pointing to parts of the volleyball court. In most cases, the words were spelled correctly and the handwriting was clear. As could be predicted, the words became less clear and the images less detailed as his illness progressed. He used less and less of the paper, fewer colors, and babbled as he worked. One day when he was feeling very agitated, I quickly drew the outline of a t-shirt for him to fill in. He grabbed an orange pastel, drew several lines for a team logo, and with a pencil filled in partial words such as “hock” for hockey and numbers that appeared to be years. He began to talk about his days as a printer and how he loved hockey. Gradually he calmed down.

Freddie was unusual in that whenever he became engaged in drawing or painting, he was able to work for up to an hour, sometimes longer. Whenever he was not painting or drawing, he paced, wandered, and showed constant signs of restlessness. Given a disease that robs people of attention span, his ability to concentrate with advanced dementia was exceptional. Since Freddie had a career in graphic design and printing, his visual and spatial skills were “overlearned.” As previously mentioned, those overlearned skills may have become more resistant to the disease process inherent in dementia.

### Martha, Ever the Farm Girl

Martha entered a nursing home with a significant history of psychotic episodes and OBS and the results of a stroke in the mid-parietal section of the brain, leaving her with right-sided weakness. She could speak, was confined to a wheelchair, and showed some signs of mild depression. Upon questioning, her depression seemed related to the recent decrease in her physical functioning. Martha was eager to tell me about her life on a farm and was passionate about her love for animals. At the time of her admission, she scored 18 of 30 in the Mini Mental State Examination, showing moderate dementia. She had been married several times, was a widow, and no longer had contact with her children. Martha was a very outspoken woman who offended many staff members with her forthrightness. Her episodes of agitation increased in frequency and intensity, and she eventually threatened suicide.

I began working with Martha individually in the hopes of preventing or diminishing agitation. To get to know her, I began with the collage box, a blank paper, and a glue stick. She was initially difficult to engage, but eventually with prompting chose several pictures: a dog, a basket of eggs, a pioneer woman, a group of women with washing boards, and a woman in a rocker holding a baby. She told the story of her relationship to her family members one by one, which included the following:

My mother always wore long dresses like that. Mom’s getting a pail of water for the dishes. They didn’t have running

water. She’ll use some of the water for cooking. She’s thinking I’ve got to get supper. We’re going to have fruit. I’m holding the baby. I’m trying to get the baby, Susie, to sleep. My babies were adopted. I’m rocking the baby in the sunshine. I’m happy. My mother loved the baby. She’s been gone a long time. She worked for 35 years at a hotel doing most everything.

Since Martha showed no interest in drawing or painting, and only little interest in clay or moldable materials, we worked on many such collages. One of the works she was most fond of was a collage of “my favorite things,” which I hung in her room. It contained many animals and farm images and seemed to soothe her. Martha was always asking to return home to her farm, which had been sold long before. At this point in her life, she was physically and mentally unable to care for herself. Eventually she threatened suicide. As her dementia advanced, she used fewer words when talking and was prone to yelling out of frustration. At that time, I worked on a collage with her. She rambled as she worked:

Woman—my mother Hazel. She lives on the farm. She yells, OK, the cows are out! If Martha would come with her horse, she’d get the cow back in. The horse on bottom I believe was called Dave; Nellie was white. Those were my horses when I was growing up. I can’t think what I called my brown horse. Maybe Tommy. Get that dairy back in the pasture. The cows are out, Martha, get the horses and get them in. I get on the brown one and ride. We take right off and I round up the cattle. They’re back in the pasture. I fix the fence. They’ll probably get out again because once they get out they keep trying. I’ll have to get rid of them to save trouble. You’re in trouble if you can’t get out. I get mean and nasty. I don’t know what to do. I feel trapped. It’s not a free country. I feel like a prisoner, like I’ve done something. I’ve always been free, traveled all over the country and paid my way. I took my pug dog with me.

We talked about her kidney problems and the fact that she was feeling trapped. I used some reality orientation techniques with her, reminding her that there wasn’t anyone to care for her at the farm and that no one could take her memories away from her. She was somewhat satisfied and visibly tired. Martha ended up falling asleep in her wheelchair, a stuffed animal puppy in her lap. Eventually, her suicidal threats and depressed mood ceased with a decline in her physical health. The collages, especially those containing her favorite things, were used daily to remind her of things she held dear. A staff member would sit with her and point out images. Even when she was no longer able to speak or move much, she still smiled at pictures of dogs, young children, and farms. Those were her personal symbols, and they soothed her again and again.

### Catherine, the Perpetual Worrier

Catherine was a tiny, frail woman in her early 90s, who had severe dementia and could no longer be cared for at the home of her daughter. A widow, she had three devoted children, two of whom lived far away and were not able to

visit often. Catherine chronically yelled for help, but usually responded if I sat with her, held her hand, and talked to her. She made repetitive anxious statements, worrying about being late for catching the bus and the ferry home, about her children who would be arriving home from school soon, and about not having enough money with her. Her daughter verified that in fact, Catherine had always been something of a worrier and that she is not surprised at the extent of her mother's current worrying. Catherine's worries often began in the morning and became more intense by the end of the day, which is typical of the "sundowning syndrome." Sundowning is a common phenomenon during which patients with dementia show sharply increased agitation toward the day's end. Although there is much speculation, the causes of this phenomenon are unknown. Typically, Catherine's attention span was 5 minutes maximum.

Although she could not always be calmed, Catherine would sometimes allow herself to become engaged with precut images from the collage box. On one particularly anxious day for her, I worked with her individually to create a collage of "things that make me feel good." I knew of her love of children and deliberately pulled some of those images from the bottom of the box. Among the images she chose were several young children of varying ages, a grilled cheese sandwich, a chocolate cake and a brownie, a Dr. Seuss character, and a family whose heads all touch in a circle. When asked how she felt about the finished collage, Catherine, a woman of few words replied, "Everyone here is happy. The food is good and makes them feel good when they eat it."

Catherine adamantly resisted drawing or painting, but would often respond to my requests to write her name and the names of her children and other family members, which soothed her. After a while, Catherine began talking about a child she lost. She began to be tearful, and said she lost a very young baby long ago. I gave her a doll to hold in her lap and she quieted down. She said she couldn't tell me the details because she didn't remember them. Her daughter was unable to verify this loss. The theme of losing a baby came up in at least two other sessions I had with Catherine. My belief is that she did lose a child, was ashamed, and never fully grieved that loss. Her children were probably never told about that episode in her life. She eventually stopped talking about losing the child, but continued to hold the doll in her lap frequently.

### Doctor, I Need a Prescription

Doc, as she insisted on being called, was 94 when she needed skilled nursing care. A former physician, she had moderate to severe dementia and enjoyed talking to people. Her speech pattern mimicked that of an intellectual conversation, but the content was lower than high school level. When she saw a peer creating an interesting pattern on paper, she would say, "My those are interesting test results."

Doc often resisted getting involved with art materials. In group sessions, she would watch others, preferring not to participate herself. One day, I asked her to write me a pre-

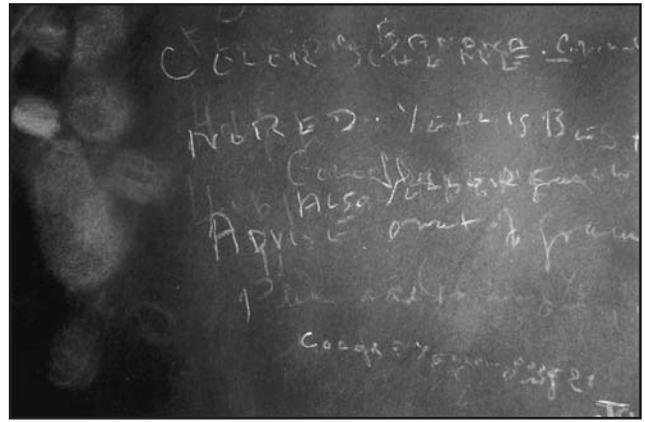


Figure 2



Figure 3

scription. She immediately picked up a piece of chalk and scribbled something before signing her name clearly. She asked me why I needed the prescription, and I responded that I had hayfever. In a later session, Doc began rubbing chalk on black paper and then blending colors (Figure 2). She explained that red mixed with yellow made orange and said she remembered that from grade school. On her own initiative, she began writing the names of the colors with the appropriate color chalk and then wrote across the black paper, "Advise onset of green." It is one of my favorite pieces; it was a real triumph for Doc to be able to express something of herself on paper using colors.

In other sessions, I traced her hands and asked her to fill them in (Figure 3). She enjoyed this exercise as it probably reminded her of her role as a physician. She talked about using her hands to care for sick people. Eventually, Doc allowed herself to engage with watercolors, tempera paint, and clay. Although not a social person, Doc seemed to enjoy sitting around the table, getting involved with various colors and media, and looking at what her peers were creating. She became a regular participant in the art therapy group.

## Benefits of Art Therapy Treatment for the Case Examples

The patients with dementia who participated actively in art therapy sessions allowed themselves to be drawn in by the need for human companionship and by the colors and forms of various art media. They continued to express themselves even though aware of increasing confusion and loss of cognitive skills. As they lost motivation, they were willing to be prompted to continue expressing themselves, to engage with the colors and textures inherent in various art media, and to participate in the creative process, which involves taking risks. As each of them withdrew deeper into themselves because of increasing disorientation, they were motivated enough to engage in personal relationships with those around them, responding to the encouragement to create, to the art media, and to the safe environment in the room.

## Implications for Society of Art Therapy with Patients with Dementia

As scientists work feverishly to unravel the mysteries of the plaques and tangles in the brain that cause dementia, mental health professionals must find new and better ways to reach these patients and to allow them alternate avenues of communication and self-expression. Because the cost of health care in the United States keeps rising, it is important to develop cost-effective programs. In general, the cost of implementing an art therapy program is less than the cost of administering psychotropic drugs on an ongoing basis. Aricept, the drug often given to early AD patients, is highly expensive and usually does not show much effect until 8 weeks into treatment. More research is needed on the effects of Aricept, including those occurring when it is administered in partnership with regular and frequent art therapy sessions. Furthermore, if Aricept is able to slow decline in cognition, the artwork will reflect that.

Long-term care and assisted living facilities throughout the country are subject to tight scrutiny and overregulation by state and federal government agencies. These agencies are raising the standards by which such facilities are measured and, at the same time, cutting their reimbursements. Unfortunately, it is the rare facility that offers art therapy to its residents. In those facilities that do offer art therapy services, complicated documentation procedures cut into the amount of time clinicians are able to spend with their clients. To satisfy the regulatory agencies, it is more important than ever to run goal-oriented programs targeting individualized goals, as well as to document findings appropriately and thoroughly without compromising client contact time. According to Junge (1994):

In the years to come, art therapists will need to be particularly nimble contortionists to both continue to be players in the mental arena and yet also retain enough of the freedom which gives spirit and heart to the endeavor of art therapy. (p. 281)

As clinicians, we can help those who struggle with aging issues to age with grace. We can ensure that our eld-

ers with dementia have opportunities to remain vitally involved and creative and have ample opportunities for self-expression. As people with dementia gradually lose their ability to communicate verbally, it is critical that they be provided with alternate means of expressing themselves.

As a profession, we have come a long way in understanding how to help patients with dementia. The more we initiate and participate in research studies and utilize scientific findings about the way the plaques and tangles characteristic of dementia affect human functioning, the more effective our help will be. I would like to see more studies integrating art therapy and neuroscience, especially those that involve patients with various types of dementia. As a profession, we can advocate for art therapy programs in institutions that care for patients with dementia. Patients with dementia who participate in art therapy set an encouraging example for us. They set new standards from which we can learn. As a society, we can choose to assess them by the ways they adapt to their limitations rather than by the skills they have lost.

## References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., rev.). Washington, DC: Author.
- Buettner, L. (1997). *Simple pleasures*. Binghamton, NY: Binghamton University Press.
- Colling, K. B. (1999). Passive behaviors in Alzheimer's disease: A descriptive analysis. *American Journal of Alzheimer's Disease*, 31(1), 27-40.
- Colling, K. B. (2000). A taxonomy of passive behaviors in people with Alzheimer's disease. *Journal of Nursing Scholarship*, 32(3), 239-244.
- Cowley, G. (2000, January 31). Alzheimer's: Unlocking the mystery. *Time Magazine*, 46-51.
- Davis, K. L., & Luddington, A. V. (1999). Alzheimer's disease: Seeking new ways to preserve brain function. *Geriatrics*, 54(2), 42-48.
- Erikson, E. (1980). *Identity and the life cycle*. New York: W. W. Norton.
- Gantt, L., & Tabone, C. (1998). *Formal Elements Art Therapy Scale*. Morgantown, WV: Gargoyle Press.
- Gardner, H. (1974). *The shattered mind*. New York: Vintage Books.
- Gardner, H. (1982). *Art, mind & brain*. New York: Basic Books.
- Junge, M. B. (with Asawa, P.). (1994). *A history of art therapy in the United States*. Mundelein, IL: American Art Therapy Association.
- Kahn-Denis, K. B. (1997). Art therapy with geriatric dementia clients. *Art Therapy: Journal of the American Art Therapy Association*, 14(2), 194-199.

Landgarten, H. (1981). *Clinical art therapy*. Bristol, PA: Brunner/Mazel.

Wadeson, H. (1987). *The dynamics of art psychotherapy*. New York: Wiley.

Psychological Assessment Resources. (2001). *Mini-Mental State Exam*. Odessa, FL: Author.

Wadeson, H. (2000). *Art therapy practice: Innovative approaches with diverse populations*. New York: Wiley.

Ricker, J. H., Keenan, P. A., & Jacobson, M. W. (1994). Visuo-perceptual-spatial ability and visual memory in vascular dementia and dementia of the Alzheimer's type. *Neuropsychologia*, 32(10), 1287-1296.

Wald, J. (1986). Fusion of symbols, confusion of boundaries: Percept contamination in the artwork of Alzheimer's disease patients. *Art Therapy: Journal of the American Art Therapy Association*, 3(2), 74-80.

Snowdon, D. (2001). *Aging with grace*. New York: Bantam Books.

Stewart, E., & Stewart-Fahs, P. (2000). *Rose Court Portfolio Project final report*. Unpublished study, Binghamton University, Decker School of Nursing, Binghamton, NY.

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