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The use of art therapy to deal with low self-esteem among the aged ; selected case studies

Elizabeth Eichelbaum

To the Graduate Council:

I am submitting herewith a dissertation written by Elizabeth Eichelbaum entitled "The use of art therapy to deal with low self-esteem among the aged ; selected case studies." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Education.

Thomas N. Turner, Major Professor

We have read this dissertation and recommend its acceptance:

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Associate Vice Chancellor and
Dean of the Graduate School

THE USE OF ART THERAPY TO DEAL WITH LOW SELF-ESTEEM AMONG THE AGED: SELECTED CASE STUDIES

A Dissertation

Presented for the

Doctor of Education

Degree

The University of Tennessee, Knoxville

Elizabeth Eichelbaum

May 2000

DEDICATION

This dissertation is dedicated to my children:

Stuart and Greta

Edward and Joanne

Marvin and Marilyn

Stanley and Mary Beth

and my grandchildren:

Dennis and Julie

Steven and Belinda

David and Katie

Susan and David

for their help and support.

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I am thankful to many people who have understood my strong desire for an education.

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ABSTRACT

The major purpose of this study was to determine what, if any, effect art therapy had on the self-concepts of elderly patients who were confined to either a restricted living facility or to a nursing home. The researcher, a trained art therapist, developed case studies of eleven patients who were part of a volunteer art therapy program at one restricted living facility and one nursing home in Knoxville, Tennessee. The art therapy given to these elderly patients consisted of activities in which they could engage. These activities were designed to show the patients that they could still function and be more productive than they had previously thought possible. Activities also were designed to give tangible products of the patients work for display. This study focused on, but was not limited to, the relationships of the following to low self-esteem:

1. Specific illnesses
2. History of the individual
3. Race
4. Religious beliefs
5. Family relations.

The researcher worked as an art therapy volunteer with patients over a period of one and a half years in the assisted living facility and four and a half years in the nursing home. Much of that time was spent gaining their

confidence. Most felt that they had little to look forward to and little reason to improve. The researcher observed individual growth over time, and eagerness to participate and to produce works of art as well as pride in the work they could do. Patients began looking forward to sessions, and observable changes occurred in their sense of accomplishment. Exchanges among patients became more free in conversations with one another and with the researcher. Many became very eager to have their work displayed.

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CHAPTER I

INTRODUCTION TO THE STUDY

The use of art therapy among the aged has proven to be very beneficial (Folson and Taublee, 1966). It improves their self-esteem and gives them feelings of self-worth. Art therapy makes the elderly feel productive.

When people are deprived of their daily activities, low self-esteem results. As we mature in age, certain health deficiencies slow people down and they find that they cannot function as well as they once did.

In the past, very little attention was focused on the elderly and their needs. The extended family was a way of life and the future was rather grim for the older parent. If one of the older parents died, the remaining parent spent the rest of his or her life living with the children and grandchildren. If they were in good health, they made themselves useful within the home. If they were sick, they got whatever medical treatment was available at the time, until they began to experience rapid deterioration.

The researcher has worked as an art therapist over a period of four years. Art therapy has been used for years as a way of healing mental and emotional problems. The specific purpose with the aged population is to improve self-esteem and to make the elderly people feel that they are still productive. It is believed that art therapy often gives people a feeling of

self-worth by getting them to use their hands and concentrate their minds into creating something new. It gives them activities to do and shows them they can still function and be more productive than they had thought they were capable of being. They begin to gain self-confidence when they realize they can do things they enjoy. I also get them to talk about success stories of their pasts.

Certain facts about old age cannot be eliminated. According to Hayflick (1979), we are genetically programmed at the time of conception to reach a point of deterioration at a certain age. Throughout our life span, we go through many changes. When we reach middle age, physical and mental impairments gradually occur. Some people deteriorate faster than others do. They begin to experience loss of vision and hearing, changes in appearance, graying hair, wrinkles, body changes, loss of muscle strength, and memory loss (Zielinski, 1979). As a person ages, health problems start to appear frequently which deprive them of the ability to do things they were able to do in their younger years. Dependency of the elderly on others tends to lower self-esteem. As time goes ,on the elderly begin to deal with losing friends and relatives, and adjusting to retirement homes and lower incomes, all of which contribute to lower self-esteem (Lewis, 1979). Because of physical impairments, a large number of the elderly spend most of their later lives in an institution. These elderly have to begin to deal with a strong lack of independence, feeling worthless, and loss of self-confidence.

An older person's deteriorating parts can be replaced to function better. Improved medication can ease pain, but the aged body cannot be renewed. A building can be renovated and remodeled, but if the structure is aged, it is still an old building. An old car can be repaired by replacing old parts and can be useful for many years, but it is still an old car. Even clothes can be remodeled and look good, but if the materials are aged, they cannot be renewed. We are fortunate that modern methods have improved our way of life.

Although the elderly population has increased tremendously due to improved life style, the problems of old age have not been completely eliminated. Modern medicine, better nutrition, exercise, better living conditions, more education, improved economy, and more social activities have all contributed to greater longevity (MSKCC, 1998). Yet, with all the improvements, the aging process still takes a toll on the senior person's self-esteem.

In the late twentieth century and on into the twenty-first century, the elderly will continue to be independent. They continue to have a very active lifestyle after they have retired. They are involved in volunteer work and keep themselves busy. The elderly try to stay independent for as long as possible. The problem, however, arises when they are no longer capable of taking care of themselves. At this point, they begin to experience low self-esteem.

This dissertation has included and describes the research that I have conducted on the effects of art therapy on the residents of two facilities. The case studies presented here combine four and a half years of observations and analyses. The work was accompanied by strong emotional involvement, which is natural when dealing with other human beings.

I. STATEMENT OF THE PROBLEM

It is the purpose of art therapy to awaken the minds of the elderly by giving them activities to work on. When they produce works of art, they feel proud of what they have accomplished. The elderly gain a feeling of self-worth which increases their self-esteem. The problem of low self-esteem increases when older populations reach a stage at which they cannot perform what they expect of themselves. The causes of their problems are many, including physical and mental illnesses as well as emotional distress and psychological traumas. The causes relate to each other. Understanding them and how they relate to each other may lead to better treatments for low self-esteem.

When the time comes and care givers can no longer take care of their elderly relatives, it is important to place them in a nursing home care facility. In order to give them proper care it is then a necessity to place them in a nursing home where they can receive the help they need that they could not

get at home. When their mind is clear and they realize what is happening, they feel degraded. The adjustment to a new lifestyle is necessary, but it is difficult. The elderly cannot function by themselves at home.

Since art therapy is still considered a new field, it is not very well known. Art therapy is using nonverbal expression with art materials for diagnosis and treatment of an individual's emotional conflicts, and to foster mental and physical health through self-awareness and personal growth (O'Malley, 1988). Even when individuals are aware of its existence, they often may be unclear about the purpose of art therapy. Art therapists themselves have contributed to this confusion, for they come from varying backgrounds and have different ways of working and describing what they do. Nevertheless, it is essential that those in related fields, such as art education, be clear about art therapy. It is important to know what it is, but also what it is not.

Rubin (1985) said that many people think art therapy means working in art with those who are different from the norm. But the definition of art therapy does not depend on the population with whom one works. Neither is it a function of the setting in which the work occurs. When art activities are made available to disabled individuals, they may well be either educational or recreational in nature. When one is teaching or providing art for the purpose of constructively filling leisure time, that is not art therapy. Even when the

setting is a psychiatric one, if the main purpose of the art activity is learning or fun, then it is not art therapy.

The essence of art therapy is that it must partake of both parts of its name--it must involve art and therapy. The goal of the art activity, therefore, must be primarily therapeutic. The therapy should include diagnosis as well as treatment. To be effective, therapists must understand who and what they are treating, and they must be trained in art, the media, processes, and their nature and potential. Art therapists need to know about themselves and about others in terms of developmental, psychodynamic, and interpersonal relations. Finally, they must know about the nature of the treatment relationship and the underlying mechanisms that help others change (Rubin,1985).

Because the work includes helping other people to create, there is also an element of education involved. However, the teaching in art therapy is secondary to the primary aim, which is diagnostic or therapeutic. Conversely, there are therapeutic aspects of art education. The very best art teachers are growth-enhancing educators who nurture the student's sense of self and competence in a broadly therapeutic way. Moreover, there is no question that art activities, even in a classroom for "normal" children, may be conducted in a way that promotes social and emotional development.

Nonetheless, we must distinguish between art as therapy and art activities that happen to have some therapeutic components, for the field of

psychotherapy is itself a complex one, exploring many different ways of understanding human beings and of helping them to overcome difficulties in development and adjustment. In order to offer art as therapy, it is essential to know what one is doing as a therapist. Even the most sensitive artist or art teacher is not automatically a therapist, no matter who the student happens to be. Just as it takes years of training and discipline to master the visual arts, so too it takes time and learning to master what is understood about psychodynamics and psychological change. It takes special training, involving hundreds of hours of supervised work with patients, to be able to integrate what one knows about art with what one knows about therapy. Indeed, that task is a lifelong one. It is not one to be mastered without experienced clinical guidance. This is as true for the art therapist working in a school for exceptional children as for the art therapist working in an outpatient clinic or a psychiatric hospital (Rubin, 1985).

II. THE PURPOSE

The purpose of the study was to identify the causes of low self-esteem in a sample of aged people. A further purpose of this study was to determine what, if any, effect art therapy had on the self-concepts of these individuals. The art therapy given to these elderly patients consisted of activities, that they could engage in and that showed them they could still function and be more productive than they had previously thought possible.

This study focused on but was not limited to the relationships of the following to low self-esteem:

1. Specific illnesses
2. History of the individual
3. Race
4. Religious beliefs
5. Family relations.

III. POPULATION AND SAMPLE

In 1995, the researcher began her work for the study. The population for this study consisted of all residents at a single nursing home and a single assisted living facility (see Appendix A). Over a period of time, these residents changed due to various factors. Patients left because of illness and death and new patients were enrolled. The nursing home accommodated approximately 100 patients, while the assisted living facility accommodated approximately 20. The actual sample used in the study consisted of those patients willing and able to volunteer for art therapy. Since all patients at the facility were elderly and suffered from self-esteem problems due to their own diminished capacities, all patients were considered to benefit from such therapy. Over the period in which the researcher worked in these two facilities, 11 subjects were selected to be in the actual study. The study continued until 1999.

IV. LIMITATIONS AND DELIMITATIONS OF THE STUDY

This study was limited to a single nursing home facility and a single assisted living facility. It was further limited to volunteer participants in those institutions. The researcher worked with these volunteer participants over a period of three and a half years, but her work was limited to single weekly sessions of one hour. The limited time of these sessions was certainly a factor adversely influencing any impact of art therapy.

V. DEFINITION OF TERMS

Some of the terms used in the study have been defined as the literature describes.

Art. A visual process of creation.

Art therapy. Using nonverbal expressions with art materials for diagnosis and treatment of an individual's emotional conflict and to foster mental and physical health through self-awareness and personal growth (O'Malley,1988).

Self-concept. Self-concept is defined by Woolfolk (1995, p. 77) as the total set of ideas, feelings and attitudes that people have about themselves. It is often the way that we explain ourselves to others, but is never permanent since self-perceptions vary from situation to situation and from one phase of life to another.

Self-esteem. According to Woolfolk (1995, p. 77) self-esteem is our evaluation of our own self-concept at any given point in life. People with high self-esteem like what they see in themselves.

Self-perception. Self-perception represents the way that we view ourselves in a particular situation and varies with time, place, and group.

Therapy. Treatment of illness or disability, physical or mental treatment.

VI. PROCEDURE

This study was conducted in a single nursing home and an assisted living facility. The researcher made weekly visits to both facilities. Sessions of about one hour were conducted with patient volunteers during each visit. Sessions consisted of the following general procedure. After general greetings, the researcher identified a topic or theme for that day's project. Samples of products had been prepared in advance and were shown to the participants. Participants were encouraged to produce similar projects but were also encouraged to develop their own ideas. The researcher took care that both topic and example were such that they would not intimidate or frighten the participants. Because of the low self-esteem of the participants, they could have easily been intimidated by the prospect of too difficult a project.

Chapter II is a review of the literature as related to research on the causes of low self-esteem in a sample of aged people. This chapter presented several topics relevant to the relationship of the history of art therapy, aging population, depression in the elderly, dementia, and schizophrenia on the low self-esteem of these individuals.

CHAPTER II

REVIEW OF THE LITERATURE

I. INTRODUCTION

The purpose of the study was to identify the causes of low self-esteem in a sample of aged people. A further purpose of this study was to determine what, if any effect, art therapy had on the self-concepts of these individuals. Art therapy gives the elderly activities to engage in and shows them that they can still function and be more productive than they had previously thought possible. This study included but was not limited to the relationships of the following on low self-esteem:

1. Specific illnesses
2. History of the individual
3. Race
4. Religious beliefs
5. Family relations.

This chapter presented the related research. Several topics were deemed to be relevant to the nature of this study. These included: a history of art therapy, aging population, depression in the elderly, dementia, and schizophrenia.

II. HISTORY OF ART THERAPY

For more that 50 years, art therapy has been helping patients deal with illness. The first art therapists, working with patients who included traumatized World War II veterans in the 1940's and 1950's, found that helping patients express themselves in both words and images hastened the psychological and emotional healing processes (MSKCC, 1998).

In actuality, art has been a form of therapy throughout the ages. As early as the Renaissance, people who were not professional artists began turning to art to relax from their daily frustrations and pressures. It was to be many years before art therapy came to be generally recognized as a form of psychological therapy. In 1935 Mary Huntoon, who had previously pursued a career as an artist and educator, became America's first art therapist. Huntoon went on to publish theoretical articles incorporating the results of her research and practice in art therapy. In 1935 Dr. Karl Menninger, founder of Menninger Foundation, Topeka, Kansas, asked Huntoon to introduce work in visual art into patients' therapy at that foundation.

In its early years art therapy was an undefined, largely unrecognized profession. Since no literature on art therapy existed, Huntoon researched the areas of aesthetics and emotional response to art as they related to psychology. She described the mind as a sensitive plate (as in printmaking)

and attributed to it different levels of Freudian awareness. Freud had felt that the unconscious spoke to people in their dreams: Huntoon contended that through art people could represent those dream images graphically. Huntoon claimed that, in graphic form, "conscious reconstruction closely resembles the original unconscious image" (Huntoon Archives, 1938). She further contended that graphic activity eluded the vigilance of the ego and the superego better than speech did.

Huntoon read Veron and Tolstoy on esthetics. Veron had defined art as the direct and spontaneous manifestation of the human personality. Tolstoy had seen art as a means of transmitting to others the feeling that an artist experiences. Good art transmitted the beauty of the highest and best human feeling (Lee, 1950). Huntoon also communicated with Gustav Bychowski, who maintained that the artist sought a way to express personal emotions, whether delightful or painful. He suggested that there was psychological gain to be found in sharing an experience through art (Bychowski, 1951).

Margaret Naumberg, Florence Cane, and Edith Kramer were also among those responsible for the birth and early growth of art therapy in this country. The three of them could be considered to be the pioneers of art therapy as a new profession. In 1958, Naumberg cited the advantages of introducing painting and clay modeling into psychoanalytically oriented psychotherapy as follows: First, she said that art therapy permits the direct

expression of dreams, fantasies, and other inner experiences that occur as pictures rather than words. Second, pictured projections of unconscious material escape self-censorship more easily than do verbal expressions, so that the therapeutic process is speeded up. Third, the productions are durable and unchanging; forgetting cannot erase their content, and their authorship is hard to deny. Fourth, the resolution of transference is made easier. The autonomy of the patient is encouraged by his growing ability to contribute to the interpretation of his own creations. Thus, art is seen as an added ingredient that makes possible an improved and streamlined psychoanalytic procedure. Naumberg came to view art therapy as an independent mode of treatment that depended entirely on verbal exchange. In her later years she yearned for recognition as a psychotherapist, especially in psychoanalytic circles.

Kramer was born about a quarter of a century after Naumberg. Her early years were spent in Vienna. Many members of her family and their friends were engaged in various arts. Her parents were unconventional people who had rebelled against their own families' middle class values. Some of their associates were among the younger members of Freud's early circle. Thus, Kramer was familiar early in her life with psychoanalysts and their ideas. While she was open to the later theoretical developments springing from ego psychology, Kramer never subscribed to any of the schools of thought that repudiated substantial portions of Freud's teachings

(Hagan, 1986). Kramer's writing has been primarily about art and art therapy. She was also an art teacher before she became an art therapist. As both integration and practitioner, she has demonstrated the harmonious integration of insights derived from experiences as an artist working with children in educational as well as psychotherapeutic settings.

Kramer believed that the therapist's skill must include competence as both artist and teacher. She defined the art therapist's special function as making creative experiences available to disturbed persons in the service of emotional health. She felt that the clinically trained art therapist, however, is better equipped than the art teacher to make diagnostic contributions and to establish an intimate relationship between art activity and psychotherapy.

Another prominent pioneer figure in art therapy was Elinor Ulman. In the 1950's Ulman began teaching art therapy to disabled children and developing the concept of art as therapy for diverse populations. This eventually resulted in the establishment of a position as Psychiatric Art Therapist at the District of Columbia (D.C.) General Hospital, which she held from 1955 to 1965. It was here that she developed the Ulman Assessment Procedure about which she had written and lectured nationally.

From 1957 to 1970, she taught art therapy at the Washington School of Psychiatry, and in 1971 she joined Bernard I. Levy, Ph.D., in establishing the art therapy program at George Washington University where she taught until her retirement in1988. In 1981, Vermont College of Noirwich

University, where Dr. Ulman taught during the summers, awarded her an honorary Doctor of Art Therapy degree in recognition of her contribution to the field of art therapy.

III. AGING POPULATION

A second topic of importance to this study had to do with the aging population of the United States and the elderly who are used for art therapy as treatment. As of 1991, 6.2 million Americans were 80 years old or older (Ferguson and Gossman,1991). This means that in effect there are more elderly people in our population than before. One and a half million people, or 5 percent of the population over 65, live in nursing homes (Tamarkin, 1988). Because people live longer than ever before, it is estimated that this figure will double in the next 20 years. The average cost for nursing home care exceeds $30,000 a year (Tamarkin, 1988). Mounting costs make administrators reluctant to change or add extensively to programs.

According to Gould (1992), the scarcity of art therapists employed in nursing homes also has posed a problem for art therapy training programs that require on-site art therapy supervisors for interns. Inclusion of art therapy in a residential nursing home and a day-care facility had positive effects on the elderly. Socialization, self-esteem, and memory retrieval were enhanced by the art experience. In addition, the staff and administrators of

both the nursing home and day-care facility found art therapy to be valuable and arranged to continue the program.

Gould (1992) also claimed that nursing homes in the late twentieth century had become the major residence in the United States for those who have a need for varying amounts of care. People who enter a nursing home at first feel very degraded knowing how important they were in their younger years. New residents look upon the other residents in the homes as disabled people. They see all these disabled people in their wheelchairs, not realizing that these people were also important in their younger years. They resent the change in their lives. It is a part of their low self-esteem feelings. They resent the family members who arranged for them to live there, not realizing and certainly not accepting that they cannot be left alone when the working relatives are away. Life in a nursing home can continue for many years. If a resident's conditions become severe, the next step is hospitalization. Many of the people who are affected by mental and physical ailments like Alzheimer's, clinical depression, extreme high blood pressure, schizophrenia, diabetes, hip fractures, mental retardation, strokes, and others can continue to live in a nursing home for many years.

Of course there are volunteers and other workers who offer activities in which residents can join if they are capable and wish to participate. Some patients fear trying to do something because they have low self-confidence

and fear failure. Volunteers have many ways in which to convince them to try things and the results are usually very satisfying (Gould, 1992).

Donley (1985/86) found that people who live in assisted living homes are not as impaired as people who live in nursing homes. When a sudden failing occurs, like loss of eyesight, arthritis, hearing impairments, or other disabilities that deprive patients of handling matters on their own, assistance is needed.

Psychologists Ferguson and Gossman (1991) developed group art therapy programs for the aged and infirm which consisted of activities with pencils, marker, crayons, paints, paper, and clay. They found that group work infused a sense of community and caused enjoyment not just of doing things together, but of being able to talk about their experiences later. The prominent result was that nursing home residents watched each other taking pride in what the group had accomplished. They also found that individuals who refused to participate in group work would take part in an individual art therapy session.

Ferguson and Goosman also noted that physical illness and hospitalization require many psychological adjustments on the part of the patient. Our society is oriented towards mobility, productivity, and achievement. Illness and hospitalization entail the relinquishment of such activity in favor of a more passive role, with the result that the patient comes to view himself as helpless and oftentimes isolated. Some patients, too,

experience physical deformity or the loss of physical function, either of which has a negative effect on feelings of personal worth.

Too often a family finds it extremely difficult to handle its reactions to a hospitalized member and thus fails to provide the support the patient needs. Both the patient and his family may have problems communicating with doctors and nurses--that is, gaining an understanding of the illness or the medical procedures the patient must passively endure. Frequently medical personal just are not aware of problems a patient may have with accepting or adjusting to hospitalization and illness.

IV. DEPRESSION IN THE ELDERLY

According to research by Brody and Semel (1993), 90% of depressed elderly Americans have not received treatment. To deal adequately with depression, depressed people must make more medical visits, take more tests, and stay longer in hospitals. Their failure to treat their depression as young people is a costly mistake. It can lead to a loss of self-reliance and the ability to live independently. With rare exceptions, depression is a mental illness. People who are ill with diabetes or arthritis are not expected to cure themselves by changing their mental outlook. If they could "just pull themselves together" and "be grateful for all the good things," as they are often told to do, they would. What they need is concern, compassion, and effective treatment.

Depression among older people is often unrecognized and untreated. Problems of depression occur among older people in nursing homes as well as those living independently. More than 5 million Americans 65 and older, which is one in six, suffer from serious persistent symptoms of depression (Dewitt, 1992). Dewitt stated that in many cases major clinical depressions lead to suicide. Forty percent of elderly people contemplating suicide see their primary care doctor within a month before killing themselves (Dewitt, 1992). The failure to treating depression is a costly mistake, because it can lead to the loss of self-reliance and the ability to live independently. The victims of depression lose the ability to care for their families and elderly friends, which causes low self-esteem. There are other factors that can cause depression like hidden strokes and changes in the brain chemicals. Sometimes the medication prescribed for other illnesses can cause depression among the elderly. The symptoms of depression are deep sadness, and lack of pleasure among people and activities they once enjoyed. The aged symptoms of depression are difficulty concentrating, memory lapses, loss of appetite, and diminished energy and physically slowing down (Brody & Semel, 1993).

During any six-month period, 9 million adults suffer from depression (Earl, 1987). The cost in human suffering cannot be estimated. Depression often interferes with normal living and causes pain not only to the person suffering but also to the people who care about them. Serious depression

can destroy family life as well as the life of the ill person; possibly the saddest fact about depression is that much of the suffering is unnecessary. There are medications that can ease the pain and suffering. However, many people do not realize that they can be treated. Some types of depression run in families and could be inherited. People who have low self-esteem are those who constantly view themselves and the world with negativism and who are overwhelmed by stress or prone to depression.

V. DEMENTIA

According to Wald (1983), dementia is the fourth cause of death in the United States and accounts for half of the residents in nursing homes. Dementia was originally defined as madness or insanity. Now the term is used to denote organic loss of intellectual function. Pathologically, Alzheimer's disease is characterized by atrophy of the brain. Victims of Alzheimer's usually die from an infectious disease. However, Alzheimer's can take from 7 to 20 years to run its course (Wald, 1983). The familiar results of Alzheimer's are memory loss, language confusion, and eventually increasing forgetfulness and frustration.

Memory loss is the first and the most significant result of Alzheimer's disease. The patient lacks initiative and becomes overwhelmed by heretofore routine tasks at home and on the job. Language becomes confused, and train of thought may be lost in mid-sentence. Increasingly forgetful,

especially under stress, the patient usually remembers long-past events better than recent ones. At first the person with Alzheimer's disease functions relatively well socially so that the extent of intellectual impairment is not apparent to the casual onlooker, who may misunderstand, or rationalize the early symptoms of the disease. However, as the patient becomes increasingly forgetful and frustrated, the consequent irritability, anger, restlessness, and depression become impossible to ignore. The patients also suffer from irritability, anger, restlessness, and a lingering depression that is difficult for family members to ignore. For an Alzheimer's patient, only the present exists. Hence, the patient creates something and then instantly forgets it. With careful instruction in art therapy, they are capable of making relatively coherent work. Patients respond well to commanded structure and directions. Their attention is focused on their art and this provides momentary calm and relaxation. According to Wald (1983), nurturing art production and the attention of the art therapist has the power to eliminate distortion, reduce functional difficulties, and encourage attempts at artistic expression.

It has been that art therapy is a key to communicate with patients non-verbally and this reduces their tension, isolation, and frustration. A stroke is any acute vascular event occurring in the brain, that leads to brain damage. These include any type of vascular occlusions, hemorrhage, or vessel aneurysm. Common causes of stroke include hypertension, smoking,

diabetes, and valvular heart disease. General weakness, sensory loss, and neglect syndromes typify infarct in regions supplied by the internal carotid artery. Lack of coordination and vertigo may be due to the damage to the top of the vertebrae while lesions deep in the brain may cause specific motor control or sensory loss. Stroke symptoms include one-sided weakness, numbness, and paralysis of face, arm, or leg, and difficulty in speaking or understanding simple statements. In order to decrease the effects of stroke, elderly patients must keep blood pressure under control, cessation of smoking, and have regular routine monitoring of carotid artery.

A team of researchers concluded that hospitalized elders with hip fractures are at great risk of mental confusion. It has been shown that impaired mental status negatively affects long-term recovery from hip fracture. Severely confused patients experience higher overall rates of medical complications and are likely to be discharged to a nursing home. These patients are also at greater risk of being physically restrained. Their residence at a nursing home might be quite prolonged, as will be described in one of my case studies. For this type of elderly person, art therapy can be of great value.

Institutionalized patients are usually surrounded by people with whom they have little in common. Social loneliness occurs when there is not a group to interact with. Feeling of boredom and aimlessness may lead to a

compulsive search for activities. Emotional loneliness occurs when there had been a close attachment to another person now absent. When isolated from family and friends, both types of loneliness stand out and may result in rage, shame, self-doubt, and withdrawal.

A study showed that loneliness and boredom are serious problems among the elderly. When given a list of statements and asked whether they agreed with them, one in six agreed, "I have more free time than I know what to do with." One in twelve agreed that "I have no one to talk to about personal things," and one in twenty agreed, "I have very few friends." One respondent in six had no living children; one in seven reported having no contact with their children.

Social and psychological problems prevent people from being more active. A major problem of the older person is his being separated from a circle of friends. The problem of the aged is a problem of boredom, according to a physician who specializes in treating persons over 60 years old. Senility is preventable, he said. In 90 percent of the people I see, senility is self-induced. The aged become important because of illness; they have no other status. Many of them use their illness to control, to get their children to listen.

The ability to learn at age 80 is as good as at age 20. Nobody dies of old age. No one can diagnose senility on autopsy tables. There is no such

thing as the aging process. The wrinkled hands of an old woman are merely the result of exposure to sun and air.

It is shocking that most of the nerve cells in the brain are not being used and that there is a constant rapid loss of cells. Besides the loss of brain cells, by the time a person reaches 60 years of age, he has lost 2 inches in height.

"Old" is a state of mind that is largely dependent upon how one feels about oneself at any particular point in time and depends a great deal on mental attitude. Each of us has our own definition of "old," and that is generally about 10 years from our own age. As we get older, that span continues to stay some distance from our own age. The social and cultural environments in which one has been raised also contribute to one's attitude toward "old." Old "things" increase in value and are treasured as antiques. Old people, however, are thought to be weak, dependent, senile, talkative, out of touch, and close-minded. There seems to be a prejudice in our society towards aging and the aged. Unfortunately, the victims of that prejudice tend to believe those negative definitions of them and may very well accept and even expect the treatment they receive.

Erikson (1968) has discovered aging, on the other hand, as a normal part of the development of the human being that, like any other stage of development, produces particular needs and stresses. He also posited that aging should bring dignity rather than despair. According to Cumming

(1963), one of the problems of aging is voluntary premature disengagement between the aging person and the social system to which he belongs. This tends to destroy the individual's equilibrium, removing him from roles in the society to which he belonged. Depending upon the social and cultural environments in which one lives, as well as the capabilities and disabilities one possesses, the changes, which occur in all life stages, are always very individual. Research has shown that people live longer if they have a positive outlook (Hoyer, Rybash, & Rooslin, 1998).

Throughout life development, that unique individual attempts to hold fast to his identity, but nowhere is this as evident as in the maturing years. Gradual physical changes, which have negative connotations, appear. These changes are commonly termed "losses": physical losses, social losses, and economic losses. These losses in later life are a direct cause of loneliness in which the older person will expend enormous amounts of physical and emotional energy in grieving and resolving that grief, in adapting to changes that result from the losses, and in recovering from the stresses inherent in these processes. No matter what the loss, its absence will create a gap in life's continuity.

Ultimately the aging process produces biological and physical stresses that require assistance from others at a time when social and emotional resources are at their lowest and when economic assets are also diminished. While the process of aging creates specific needs for the elderly, it must be

accepted that the challenge of helping is to meet those needs. We do this through providing good physical care, overseeing proper nutrition, providing meaningful activities, encouraging social contacts with peers, developing a feeling of usefulness, and supporting the highest level of wellness and independence possible.

Institutional support is important to identify existing relationships within the resident's social network, both external and internal. Key aspects of support include directionalness, durability, intensity, and frequency. Social isolation can be diagnosed by the following symptoms: aggression, powerlessness, confusion of past and present, confusion about being confined, and difficulty in setting goals and making decisions. Unit based activities involving other residents can enhance positive social interactions.

In the 1999 hearing of a senatorial committee looking into the problem of the abused elderly, many serious cases were presented (United States Senate, 1999). As can be concluded from these cases, the elderly experience much neglect, mistreatment, and medical abuse. The effects in the low self-esteem of the victims cannot be anything other than devastating. More subtle abuses also affect in the self-esteem of the elderly. Most of the time it is difficult to uncover them, particular in assisted living or nursing home environments.

VI. SCHIZOPHRENIA

Schizophrenia is an unpredictable, expensive illness with unknown causes and uncertain prognosis. Life does not go on as it does for a person who is seriously ill. Some describe the grief that accompanies by schizophrenia as "chronic sorrow" or "no-end-grief." There is now a drug that can aid in the symptoms but it has many side effects that are very dangerous.

Creative arts have been proven to elicit positive responses from older adults. Weisburg and Wilder (1985) have given strong support for therapeutic expressive art activities. While the inclusion in art therapy as a part of the nursing home care program could increase residents' self-care abilities, art therapy programs are often cut from nursing homes to reduce costs. Consequently, old peoples' need for perception and enrichment go unmet. The increasing incidence of Alzheimer's disease, vascular dementia, and other demented illnesses among the aging population is widely recognized, as are the profound social and medical problems these disorders create. The identification of beneficial activities is important so patientd can enjoy life and cope with their dementia if it becomes severe. Art therapy has proven to be an activity the elderly can enjoy (Weisburg & Wilder, 1985).

Although creating art has been suggested to be therapeutic in and of itself, psychoanalytic theories have played a major role in art therapy. Art

therapy literature describes the interpretive and diagnostic value of art. Art therapy sessions are usually a quiet time when inner feelings and emotions come to the surface. The patients' response to their production and what it evokes in them is most important. Depression is represented in art in various ways, such as using dark colors, drawing at the bottom of a page, isolating parts, refusing to participate, and emphasizing the aggressive components of depression. Art works can help to document the degree of deficits and the stage of dementia and to evaluate what intellectual function is retained.

Art therapy is a useful treatment modality for demented illnesses, providing diagnostic, evaluative, management, and supportive functions. The demented patient can be kept as active and alert as possible in an activity such as art therapy, and can retain a sense of dignity while preserving his functions.

The fact that I am the same age as the elderly people I work with is an advantage in relating to them because I can understand their lives. Those who suffer from schizophrenia, Alzheimer's, strokes, and personality disorders are sad cases, but they are not fully aware of the situation they are in. However, it is hard on their families to watch them deteriorate even if they are institutionalized.

The more serious cases are the ones who have clear minds but are physically deteriorating. Low self-esteem sets in when they are not capable of doing things. They remember their earlier success and capabilities with a

clear mind, and it is very frustrating, especially for those who are dependent on others to dress them and take care of their personal needs. Getting the patients to talk about their past, their families, and how well they did in their earlier years is helpful.

Chapter III details the signals of expected poor self-concept the researcher looked for in three sessions of art therapy for institutionalized elderly patients.

CHAPTER III

METHODOLOGY

I. PURPOSE OF THE STUDY

The purpose of the study was to identify the causes of low self-esteem in a sample of aged people. A further purpose of this study was to determine what, if any, effect art therapy had on the self-concepts of these individuals. Art therapy gives the elderly activities to engage in and shows them they can still function and be more productive than they had previously thought possible. This study included but was not limited to the relationships of the following on low self-esteem:

1. Specific illnesses
2. History of the individual
3. Race
4. Religious beliefs
5. Family relations

The study evolved as a result of my interaction with various patients. Different cases came and went at various times.

My interest in the institutionalized elderly dates back to 1975 when my mother was placed in a nursing home. I have maintained that interest to this day and it was, in essence, instrumental in leading to the current study.

It was my mother's inability to apply herself due to her own humiliation at her loss of ability and the necessity of staying in an institution that led me to art therapy work with elderly in similar situations.

In this study eleven case studies were conducted. In these case studies as the researcher I looked for signals of poor self-concept. Since these cases all were institutionalized elderly patients, it was expected that such signs would exist. Patients might evidence their lack of a strong self-concept by being reluctant to participate in sessions, by being hesitant about trying projects, by using language to describe their own efforts that was characterized by denial of worth of the art product, and by reluctance to show and share their art projects. I also looked for other more subtle and less easily identified indications of poor self-concept.

Beginning in 1995 the researcher worked as a volunteer in a nursing care facility in Knoxville. This work involved weekly sessions in both an assisted living facility and in a nursing home. The researcher volunteered to conduct art therapy sessions with all interested patients. All who participated were volunteers. For the purposes of this study none of the subjects who were selected for the case studies was identified by his or her correct name in any publication and the names of the institutions were withheld. The study itself consisted of the gathering of field notes and notes kept by the researcher following the sessions. These notes chronicled the

progress and participation of each of the 11 individuals studied. Two of the 11 subjects died during the course of the therapy.

Once a week I went into the nursing home for a one-hour session. I did the same in the assisted living facility. When patients evidenced special needs, extra sessions were also scheduled. When I first began as an art therapist, my goal was to give my patients a therapeutic activity each week that would make them feel productive. Part of the therapy included getting them to socialize with one another. Many of the patients felt uniquely deprived and alone. They believed that they were different from the others because they had lost the ability to do important work. Part of the therapy was related to helping them realize that others shared similar feelings. Once they began socializing, I felt they would discover that their neighboring patients had also done important work during their active years and that they too were feeling that sense of loss of importance. Examples of typical sessions in the art therapy follow:

Example One

I recruited patients who were willing to let me wheel them into the art room. Some refused to go. I explained to them that we were going to engage in a group activity. They were provided crayons, markers, and pencils. I selected two white sheets of paper, one cut into twelve shapes. I gave one to patients, and I asked them to do a drawing of anything that they

wished. I also encouraged them to help each other as well. They were nonverbal, but I saw that they understood what I was saying. I gave those who finished first different shapes and told them that we were making a picture puzzle. In their effort to assemble the matching pieces, they began talking to each other, all the while exchanging the pieces among themselves.

Example Two

For the second group session I selected the same patients, who were ready and willing to join me. They were given 11" by 14" white paper and supplied with markers, crayons, and pencils. I asked them to do a self-portrait and when they finished to pass it on to the next patient to the right, improve it, and pass it on again to the right. In this way every person at the table had a chance to work on it until it came back to the original person.

I was successful in my main purpose for this activity, which was to create conversation among the patients. They immediately started talking among themselves as they passed their drawings on. After a while I heard, "I like what you did to my picture" and "You messed mine up." They were all in good humor and were having fun. Getting them to socialize and look forward to future activities increased their self-esteem.

Example Three

In my third session I supplied them with clay. They began to manipulate the clay immediately. This is a stimulating process for their hands. It reminded some of kneading dough, among other memories. They were excited about using the clay.

I showed them how many things they could be doing and reassured them of my help. Among the items I suggested they create were a jewelry box, a cup, a teapot, a bowl, little animals, or a fish. The patients took pride in their accomplishments and made favorable comments about each other's work as well. I gave drawing assignments to those who could not handle the clay.

After a few sessions they began to look forward to the art therapy sessions. I worked with all age groups in different institutions and found it very rewarding to know that through my knowledge and art experience I could help these people get a new lease on life. Samples of the art products from these sessions appear in Appendix B. Works of all eleven cases are shown.

A presentation of the data for the study, consisting of field notes made by the researcher on each case, is assembled and presented in Chapter IV.

CHAPTER IV

PRESENTATION OF THE CASE STUDIES

I. INTRODUCTION

The purpose of the study was to identify the causes of low self-esteem in a sample of aged people. A further purpose of this study was to determine what, if any, effect art therapy had on the self-concepts of these individuals. The art therapy given to these elderly patients consisted of activities, they could engage in that showed them they could still function and be more productive than they had previously thought possible. This study focused on, but was not limited to, the relationships of the following to low self-esteem:

1. Specific illnesses
2. History of the individual
3. Race
4. Religious beliefs
5. Family relations.

In order to achieve the purpose, the researcher first did a review of the related literature. This review covered the history of art therapy, aging population, depression in the elderly, dementia, and schizophrenia. The researcher then did case studies of 11 patients with whom she was

working as a volunteer art therapist at a single nursing home and a single assisted living facility. Those patients were those who were willing and able to volunteer for art therapy. All patients were elderly and suffered from self-esteem problems due to their diminished capacities.

Sessions followed a similar pattern each week. Each began with general greetings and then the researcher identified a topic or theme for the day's project. She displayed samples or models of products that had been prepared in advance. Participants were encouraged to produce similar projects but were also encouraged to develop their own ideas.

Data for the study consisted of field notes made by the researcher on each case. These notes were assembled and are presented in this chapter.

II. CASE STUDIES

Case Study 1 - Peter

Peter was one of the first patients to join in my sessions at the nursing home. He was relatively young to be a patient at a nursing home, well under normal retirement age. He would come and sit down and begin working with me. He went to school in Knoxville. He is the eldest of a family of five boys. Peter went to school only up to the seventh grade, after which he refused to continue. Two of his brothers are illiterate. However, the other two brothers are able to read. He does not know how

far the literate brothers went in school. His mother was also illiterate but the father was self-educated. He could read and was capable of many things. Both parents died about six years previously, eight months apart.

Peter's father worked in what Peter calls a "steel making plant," designing decorative doors, fences, and other finely wrought iron steelworks. Peter's mother had been a sick woman most of the years that he remembered her. She had stayed home and cared for her sons as best she could. Since she had no schooling herself, she failed to guide her children toward a worthy education.

Peter described his parents as loving. However, there is nothing in Peter's description of his childhood to indicate that they made any attempt to enlighten or educate him. As a result, his intelligence seems limited. For three years he worked at a cafeteria as a dishwasher. Later, he worked at many menial jobs, but he never pursued a better life.

When I began in my first sessions, he was always eager to join in. Peter was talented in art and he immediately started working when I showed him a sample of my activity. Whenever I showed him my sample, he would immediately draw an outline of the subject, then add color. He tended to select colors that were dark and dreary. I sensed feelings of depression in his work, although he seemed cheerful.

According to Peter, there is no outside world. He never expressed a desire to explore places outside of Knoxville. I worked with him for three and a half years. I noted his poor self-image although he seemed content.

In the sessions Peter attended he would finish a drawing or a painting and would then tell me to throw it in the garbage. Many times I told him, "If I hear it again, I know who's going in the garbage!" He answered with a big smile; "I'm ready! Do you think you can fit me in to the garbage? Try it!" I asked him once if he would ever marry and he said, " Hell no. I'm too ugly. Who would want to marry me?" Peter would always stay and help me clean up the tables.

I asked him if he had the chance to do it over again, what would he do differently? He replied that he would probably do much the same. Considering that Peter seemed so content with his way of life and so proud to be a dishwasher indicates he never had the ambition or intelligence to improve himself. He had diabetes and high blood pressure. He was 5 feet tall and weighed 370 pounds. His brothers all lived in a house together and they picked him up every two weeks or so and took him home with them.

Peter anticipated these visits eagerly. He also looked forward to my art therapy and offers to help me clean up. He had talent in drawing, but I saw a lot of depression in his work. In spite of his poor self-confidence, he seemed to enjoy the session and his drawings were quite good. He seemed to be capable of expressing what he wanted to express in my sessions

without my help. Recently, I visited him again, and he seemed to be in good spirits.

Case Study 2 - John

John was 70 years old. During his childhood he lived on his mother's farm and worked with animals. He spent many happy days there but slowly his family died away and he then moved to seek other employment. After he left the farm he did odd jobs and that was how he sustained himself until he landed in the nursing home. He never married.

About seven or eight years ago he broke his hip in an accident. This led to his need for permanent, full-time care and so he came to the nursing home. His mobility was limited and he relied on a walker to get around.

I worked with John for three and a half years. Throughout the period it was difficult for him to get to the table to work because of the walker and he was very dependent on the walker because one foot drags as he walks. He would sit for awhile at the table as if he needed a rest after his efforts in walking.

I showed him samples of what I would like him to do and told him if he had other ideas, he should express them, which he did by drawing animals. He would reach for a marker or a pencil, and regardless of what the activity was, he would start drawing what he wanted to do. He was good at drawing and his forte was mainly the outlines of animals. He

started very slowly and increased his speed as he worked. He drew one or two animals a session. He was prone to irritability and it seemed to me that his moods depended largely on his physical well being. During each week he drew for his own amusement and looked forward to my visits. When I would arrive he would meet me at the door, give me a drawing, and say, "This is for my favorite teacher." When I interviewed him recently, he placed a drawing in my hands, just as before. John, as with most other nursing home residents, was resigned to his situation and accepted the conditions of his life. This created feelings of low self-esteem and in turn perpetuated his sense of helplessness. He did not have a lot of hope that he would ever leave the nursing home.

Nevertheless, he looked forward to my sessions and took great pride in what he produced. However, he never attempted to draw anything different from animals.

He was very capable of using his hands and expressing what he wanted to do. Animals took him back to the memories of his days on the farm, which was a very important part of his life.

Case Study 3 - Rosalyn

Rosalyn was born on December 8, 1918, in Knoxville, Tennessee. She was from a large family consisting of four sisters and nine brothers. Rosalyn had a very troubled life. She was a patient at a mental health

facility for seventeen and a half years. She was released and she spent two years on the outside and then returned to the institution for five more years. Her memories of why she was there or what happened before are sketchy at best and she seems unaware of most of the details of her past.

For instance, Rosalyn remembers a car accident she had while traveling with her brother in 1968 but not how she came to the nursing home. She does remember spending the last two years of her mother's life with her before entering the nursing home. Her current diagnosis is residual schizophrenia.

She was institutionalized a big part of her life. She also had physical disabilities. Whenever I would go to her room, she was always ready to come with me to my sessions.

When I began working with her she was a regular in attending my art therapy sessions, but she did not actively participate in the activities. Rosalyn would just sit and make no attempt to do anything. I would put a marker in her hand and tell her to start doing something. I would tell her that anything she wanted to do would be fine. I would place my hand over her hand and move the marker around. She would then move the marker around in different directions. Rosalyn would continue to draw. However, she would never produce anything without my help. She always seemed proud whenever I would tell her she did well. Though she was not very talkative, she followed my directions well. In spite of the fact that her work

expressed many signs of her ability to participate. Rosalyn wore a smile often and seemed cheerful.

Case Study 4 - Lois

Lois was born in Knoxville on July 20, 1911, and lived there all her life. Her education extended through high school. Afterwards, she lived a quiet life with her parents. She worked in a bookstore for many years and assisted local churches in setting up church libraries.

Harold came into her life at a party she gave for her friends. He was a traveling salesman from South Carolina and came to dinner with friends of hers. They were introduced and liked each other immediately.

Later on, they were married. They never had children. Both she and her husband continued their work and were very active in the church. They did not have a large extended family, so they relied on each other for companionship.

In later years, he died of a heart attack. Lois continued on alone until she was injured. She broke her leg doing some gardening around her home. After this, she was unable to care for herself and wound up at a nursing home. She had been there for many years.

Lois was always available to do my art therapy projects and was proud of her accomplishments. She seemed well physically. She did, however, complain often that her legs hurt her. Her attitude has much

improved since I first met her. After she was hospitalized for a while, her mood changed and she adjusted and seemed cheerful when she worked with me. I would cut up different shapes of colored paper and she would then form a collage on white paper. I showed her how to use glue. Her hands were not steady but she slowly formed the collage and was then very proud of the results. She was very polite and always thanked me for my work with the residents. She was aware that I was a volunteer so she was always gracious.

Lois seemed content and was also happy to see me. I noticed some failings in her memory. However, the last visit I made I was informed that Lois had passed away.

Case Study 5 - Jane

Jane was born on December 14, 1913, in Polk County, Tennessee. Her father, Lawrence, was the county court clerk of Benton and her mother, Tina, was a housewife. Of their four children, Jane was the youngest. At 15 she married a man, Arthur, who was 40 years her senior. They were wed for one year and in that time she gave birth to a daughter, Susan.

After her marriage ended in divorce, Jane returned to school and finished her high school degree. She continued her education by enrolling in beauty school and becoming a licensed cosmetologist.

During this time she met her future husband, Henry. They were soon married and the couple moved to Knoxville. A funeral home employed Henry as a mortician. Eventually, Jane and Henry had a son, Henry Jr.

When World War II began, Henry enlisted and the family moved to Albuquerque, New Mexico, where he was stationed. They lived there for many years until Henry died of a heart attack.

After her husband's death, Jane returned to Tennessee, settling in Sevierville. When she developed cataracts, her son suggested she move into the assisted living facility. Jane had been unable to care for her responsibilities, her home or herself. Unfortunately, she was unhappy at the assisted living facility because it was a drastic change from living at home. She was used to a more active lifestyle. She has been there for a couple of months and was eager to work with me. She informed me that she was going home soon. However, I observed that she was adapting to the living conditions. When Jane came to my sessions she seemed like a capable person. However, she was a bitter person during some of the times that she worked with me. She sat down to work with me because it was something to do. She immediately started to work with no trouble using her hands. Even though she acted as if it was a chore that had to be done, she did the work on her own and did not require my help. She was capable of following instructions on her own. However, she did enjoy doing the activities.

One of the activities that Jane did and seemed always to enjoy was a collage. The activity included making a collage of food that she would like to eat for dinner. Jane would do the activity on her own. She was not always enthused but she seemed to enjoy this activity. She reacted in a manner that indicated it was better than doing nothing at all. This was Jane's positive way of thinking. Jane was unhappy about the situation she was in but she hoped that surgery could be done on her, allowing for a return to normal life. Meanwhile, she responded well to my sessions and seemed to enjoy the work I gave her. Jane is still at the assisted living facility and her mood is improving.

Case Study 6 - Kate

Kate was born in Cripple Creek, Maryland. She met her husband, Carl, in their 12th grade math class. He was a football player. Not long after they met they were married.

Carl joined a volunteer program and enlisted in the service for 18 months. He was stationed in Texas and Kate followed him from station to station during the time he was in the United States. They stayed together in a motor home. Eventually, she gave birth to a daughter.

The war ended and Carl came home from the service resolved to finish his education. He became an electrical engineer and worked for General Electric for many years. Seven and a half years into his career they

had a second daughter. When the girls were older, Kate returned to the workforce as a secretary.

Things were going well for them until about five years ago when her husband died of a heart attack. She became very depressed and was unable to take care of herself or her home. She became despondent and lost touch with reality.

In order to regain some control, she attempted psychiatric treatment, which she felt did not help her. She joined a support group and tried Christian fellowship meetings on Saturdays. During this time of hardship and struggle, Kate received another blow. She lost her eldest daughter to cancer. Her daughter left behind three small children, two girls and one boy, who currently reside with their father in New Hampshire.

I believed that Kate's religious faith helped her to cope with her problems. When I first met her, she puzzled me because she seemed so capable and had a lot of vitality and confidence. She actually kept herself busy assisting the other patients at the assisted living facility. I was curious as to why such a capable 65-year-old woman was living in an assisted living program. I thought she must have a physical condition and could not live alone.

The following week, I told her that she had been on my mind since we had met. She proceeded to fill me in on her background, which I have just relayed. After I met her, I felt she improved very much. She was

always ready to engage in my art therapy activities and she possessed a remarkable sense of self-confidence.

Kate was always ready for my sessions. She sat down and did not start working immediately. She thought for a while and always produced something different. She combined love and religion in her artwork. She enjoyed doing the activity and was happy to express her thoughts in art form. She would never miss a session. Her love for others and her religious faith were expressed in her work. She was cheerful and well adjusted and seemed content with her life.

Case Study 7 - Ed

Ed was born on May 28,1923, in Birmingham, Alabama. His father was an engineer for a local railroad company. Ed's mother was a frail woman with poor health who remained bedridden throughout her life.

At the age of six months, Ed contracted polio. He survived disabled and remained with his parents throughout his lifetime. In spite of his disability, he graduated from high school and was able to own and operate a grocery store with his father's help.

For 15 years, Ed ran his store and cared for his ailing mother. He never got married. When his mother died, he moved out of his family home into an apartment and took care of himself. He had a motor scooter for enjoyment. In 1961, he was in a violent collision and wound up in the

hospital for a couple of months. He recuperated well but he still has a metal plate in his head due to his injuries.

Ed's physical limitations never kept him from doing what he wanted. He lived independently until age began to catch up with him. He began to find it difficult to perform his daily tasks. So when his brother, concerned for his safety, tried to persuade him to move to Knoxville, Ed accepted. He moved to Knoxville to be with his only remaining family.

Ed eventually came to live at the assisted living facility. He tried very hard to work on the activities that I gave him to do. Then one day one of the staff members came over to help him with what he was working on. He was very insulted and refused to put his name on the work because she had helped him. After that he refused to come to my table. Regardless of his past frailty, he seemed to be in good spirits. He was proud of what he could do in spite of his disabilities. He walked with a walker and struggled to get into a chair but his spirit was high and his work amazed me. He enjoyed any activity that I give him to do. When he came to my sessions he did not think that he was going to be able to participate, but I helped him get started. I gave him materials to do a collage, a sheet of paper, glue, and cut out pictures to produce a scene. He was pleased and worked on it. I told him he could produce a work of art. We were doing a wooden sculpture with small pieces of wood and as he was working his hands stopped shaking. I am not saying that I cured him; his mind was so

engrossed on what he was doing that this controlled his hands. He was proud of his sculpture and amazed that he was able to control his hands. I did not detect low self-esteem regardless of his difficult situation. Art therapy raised his self-esteem and gave him pride in his accomplishments.

Case Study 8 - Anna

Anna was born in Greenville, Georgia, on April 13,1912. She came from a large African American family comprised of seven sons and two daughters who all worked together on the family farm. Therefore, it is no surprise that her education was limited to grade school. They had a large farm and lots of livestock.

She got married young and her husband died at an early age. They had one daughter, Sylvia. After her husband died, Anna left Georgia and moved to West Virginia.

In West Virginia, she found work as a housekeeper in a doctor's home. She worked there for 30 years. After her husband died Anna remained alone. She sent her daughter Sylvia to Kentucky to live with her aunt who had many other children. This aunt provided Sylvia with a good education and a college degree.

Anna lived in her own apartment for many years but eventually found it difficult to care for herself. Her physical condition was deteriorating so she retired and decided to move to Knoxville. Anna moved here to be with

her family, which consists of her daughter, her grandchildren, and her great grandchildren.

She resided at the assisted living facility because she had a small degree of mobility. The few times I worked with her, she seemed alert and anxious to do whatever activity I gave her. Anna would come to my sessions willingly. She would not start working immediately. She just sat and studied the activity. If the activity for the day was a collage I let her look at samples of a house, trees, hearts, animals and much more. She would study the activity, and sometimes I would have to place a few pieces in front of her so she could understand and begin. Sometimes she would even remove what I had given her and start with her own ideas. She was very capable of expressing herself through the various media I presented her with. She produced interesting pictures with whatever the activity might be. She was cheerful most of the time.

Anna was a devout Baptist, which helped her cope with her aging condition. She also had a sense of humor and seemed to be accepting of the environment around her.

Case Study 9 - Lena

Lena was born in Sevier County on August 7, 1920. She was raised on a farm with her two sisters and two brothers. Her mother stayed at home to raise the children and work the land alongside her father. Her

father was involved in many professions. He farmed, worked for the railroad, and did general carpentry as well. Lena's youngest sister died as a child but her older sister is alive and well and they see each other often. Her brothers both worked for the Quaker Oats Co.

Lena got married at the age of 19. Her husband lived with her and her family and worked the farm for the first four years of their marriage. Then he became a preacher. Lena's husband was a traveling preacher for the rest of his life. Lena accompanied him on many of his preaching tours and they spent most of their lives together being of service to those in need. The marriage produced two daughters who were both married before her husband passed away.

When her husband died, Lena's condition began to deteriorate. She fell and injured herself twice. She had many medical conditions that contributed to the injury. It was the injuries that gave her feelings of insecurity that caused her to be admitted to the assisted living facility where I met her.

Lena's memory is very poor. She is easily frustrated and often irritable. When I went to the assisted living facility to work with the residents there, she was usually quite resistant and refused to cooperate. Whenever I invited Lena to the table she would normally refuse to attend the session. I told her that I did not force anyone to join, but if she wanted she could sit and watch the others work. At times she did not join us but

many other times when I got her to sit down she ended up working. However, when she finally got started she was extremely careful with her work and was eager about creating a complete and neat drawing. She seemed to enjoy expressing herself artistically and the results of her endeavors were usually very positive. Lena's art work revealed her immaculate personality. She knew what she wanted to do and did not need any help. She was rarely in a good mood and was not easily convinced that she did well. Part of her sickness was confusion. I went along with her distorted personality and encouraged her. She was very careful with her appearance, the way she dressed and her hairstyle.

Case Study 10 - Mary

Mary was born in Knoxville in 1947. She was an only child. Her father was a building contractor. She does not remember if her mother was employed or if she stayed at home. Mary is a stroke victim. She lived with her parents until they died. Her father died two years after her mother passed away.

Mary had a good education--grade school, high school, and some college. She does not remember if she has a degree. She has tutored children in her past. She has always done artwork and she still does. She told me if she had money she would have an art show. Mary had talent but I doubt if she ever had any formal art training.

Mary never married. She did not remember if she got sick before or after her parents died. She seemed happy at the nursing home. At the nursing home, they have a church session once a week and she attended it. They had various volunteer activities, which she enjoyed. Mary never missed a session with me. She was very involved with drawing and painting and she would bring all the work that she did during the week. I once mentioned that I have twin sons. She drew a picture of twins in a buggy and with the mother pushing the buggy she presented me with it. I still have it. She never traveled to places other than Knoxville. It was hard for her to converse. At my last visit she was very happy to see me. She made every effort to answer my questions.

She always looked presentable. She still wore nice clothing and always wore her jewelry. She said she had cousins who came to visit her. She was in a wheelchair and her speech has improved since I last worked with her.

When she attended my sessions, no matter what activity was going on, she continued drawing and painting what she wanted to. It was fine with me because she was happy with what she produced. She did not need my help, she just continued with her own ideas. She was very talented.

Case Study 11 - Bill

Bill was 52 years old and was never married. He was a resident at the nursing home when I began working there in 1995. He was in a wheelchair and did not talk. I asked him to come to the table and join in my sessions. He came but sat there and made no attempt to do anything. I gave him a marker and asked him to draw, but he made no attempt to do so. One day after my session was over, I followed him to the sitting room and I told him I would like to talk to him. It was private, just the two of us at the table.

First I convinced him that I wanted to be his friend and help him get well. I asked him if he understood me. He nodded his head yes. I told him that I knew he could talk. I said, "You are 52 years old. Do you want to spend the rest of your life here?" He shook his head no. I said, "I do not want you to shake your head yes or no. I know that you can talk and in time get well, get a job, and have your own place to live in. You will have to try very hard but I know you can do it. How far did you go in school?" He worked very hard to answer me with "eleventh grade." I complimented him. I asked questions and he answered with single words. He never got into conversations. He had high blood pressure and had mini strokes during the time that I worked with him. I did not know much about his background or how sick he really was. I came during the week between sessions and worked with him privately. He looked forward to my visits

and everything that I asked him to do he would do for me. I finally got him to do a drawing during my sessions. I gave him a marker, put my hand over his, and moved the marker until he did it himself. He worked at it and within a couple of weeks he drew a horse and continued every session to draw a horse. I asked him if he ever had a horse, and he said yes. He would answer anything I asked him with one or two words. The staff heard him talk to me but he never spoke to anyone else, probably because no one was concerned or had the time to give him individual attention. One day during my private visits I told him that I wanted him to read for me. It was very hard for him to try but he did. He read two or three words and then stopped; he did that a few times. I then suggested that I would read and he should repeat every word that I read. He did well. He would slur from his mouth, and I would give him a Kleenex. I did not understand at the time that he was slurring from his mini strokes. One day I asked him to stand up from his wheelchair and he did. He held onto the table and the chair and I was right there with him. I asked him to try to walk, and he did try. He made a couple of steps and I was afraid he would fall. He was not at all steady on his feet. So he got back into the wheelchair.

Bill would never refuse anything that I asked him to do. Those who heard him speak were amazed. He looked forward to my visits. He had two sisters who would come to visit. I never met them but I did speak to them on the phone. They said they visited him but he never talked. I met

the resident doctor and he complimented me for what the staff had told him. What I did not know was that Bill lasted a couple of years longer then the doctors predicted. One day I came to work and I was told that he was in Fort Sanders Hospital. It sounded as though he would be back soon, but he only lasted a few days.

I felt awful that I did not get to visit him. It would have meant so much to him. I gave him hope and I was serious about him getting well, not realizing that he was a very sick person.

III. SUMMARY OF THE CASE STUDIES

Eleven case studies were done as part of this study. The subjects were very different and they came from different backgrounds. Each of them had very different goals with different expectations from all the rest. Some had lived what might be termed normal lives and had been institutionalized late in life. Many of these were able to use their physical capabilities and were always eager to work with me during my art therapy sessions. Some who were at first more hesitant were pleasantly surprised at what they could produce. Most of these people would usually be able to identify a particular member of their family to whom they would be giving their work. These patients were the ones who felt capable of producing a product with their own ideas and hands. Many had families who visited regularly. These families might consist of children, grandchildren, or other

family members. This sense that there were people who cared increased their self-esteem and allowed them to make the adjustment accepting the situations they were in.

Other patients had the misfortune to have minds that were clear but a physical condition that made them incapable of functioning. In art therapy I made them aware of every possibility to use those abilities that remained to them. Patients who had the most limited desires and had not strived to accomplish too much in their productive years seemed to be most satisfied with their lives. Patients who had life-long patterns of making every effort to overcome physical problems were among those who showed the most determined attitude even at this stage in their lives. However, such patients were sometimes very impatient.

A major factor in self-concept among the cases was the ability to accept and to cope with any given situation. Only patients who accepted and were to some degree resigned to their situations could take a coping attitude. One patient was so resistant to receiving help that when it was given he was so offended that he refused from that point on to attend sessions.

The conclusions, recommendations and summary of the study are presented in Chapter V.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. INTRODUCTION

Whenever individuals suffer diminished capacities, whether due to illness, accident, or age, it has a negative psychological impact. Even though diminishing abilities is a natural part of the aging process, elderly people have trouble coping with their loss of independence. They often feel as though they are no longer able to be productive and lead worthwhile lives. They know that they were once active and productive and now feel that this is no longer possible for them.

This is especially true for individuals who must live in nursing homes and assisted care facilities. The loss results in severe ego problems and a devastating loss of self-esteem. The use of art therapy is an established way of dealing with problems of low self-esteem and self-worth among aged populations. Art therapy makes the elderly feel productive. Although, as we mature in age, certain health deficiencies do slow us down and we find that we cannot function as well as we did in the past, art therapy can help the aged to find other avenues in which they can do useful and self-fulfilling work.

As cited in Chapter I, Hayflick (1979) observed that we are genetically programmed at the time of conception to reach a point of deterioration at a certain age. Throughout our life span, we go through many changes. When we reach middle age, physical and mental impairments gradually occur. As a person ages, health problems start to appear which deprive the elderly of the things they were able to do in their younger years. This dependency of the elderly on others tends to lower self-esteem. As time goes on, the elderly begin to deal with the losses all around them. Losing friends and relatives and adjusting to retirement homes and lower incomes all contribute to lower self-esteem (Lewis, 1979). Because of physical impairments, a large number of the elderly spend most of their later lives in an institution. These elderly have to begin to deal with a strong lack of independence, feeling worthless, and loss of sel-confidence.

It is the purpose of art therapy to awaken the minds of the elderly by giving them activities to work on. When they produce works of art, they feel proud of what they have accomplished. The elderly gain a feeling of self-worth and which increases their self-esteem.

II. SUMMARY

The purpose of this study was to identify the causes of low self-esteem in a sample of aged people. A further purpose of this study was to determine what, if any, effect art therapy had on the self-concepts of these

individuals. The art therapy given to these elderly patients consisted of activities which they could engage in and which showed them they could still function and be more productive than they had previously thought possible. This study focused on, but was not limited to, the relationships of the following to low self-esteem:

1. Specific illnesses
2. History of the individual
3. Race
4. Religious beliefs
5. Family relations

Beginning in 1995 the researcher worked as a volunteer in a nursing care facility in Knoxville. This work involved weekly sessions in both an assisted living facility and in a nursing home. The researcher volunteered to conduct art therapy sessions with all interested patients. All who participated were volunteers. Later this work was extended to an assisted living center.

Eleven of the participants in these sessions were selected as subjects for case studies for this research. For the purposes of this study, none of the subjects who were selected for the case studies was identified by his or her correct name in this or any other publication and the names of the institutions were withheld. The study itself consisted of the gathering of field notes and notes kept by the researcher following the sessions. These

notes chronicled the progress and participation of each of the 11 individuals studied. Two of the 11 subjects died during the course of the therapy.

Once a week the researcher went into the nursing home for a one-hour session. She did the same in the assisted living facility. Where patients evidenced special needs, extra sessions were also scheduled. When she first began as an art therapist, her goal had been to give patients a therapeutic activity each week that would make them feel productive. This was the major part of the therapy which included getting them to socialize with one another.

Eleven case studies were done as part of this study. The subjects were each very different and they came from different backgrounds. Each of them had very different goals with different expectations from all the rest. Some had lived what might be termed normal lives and had been institutionalized late in life. Many of these were able to use their physical capabilities and were always eager to work with me during my art therapy sessions. Some who were at first more hesitant were pleasantly surprised at what they could produce. Most would be able to identify a particular member of their family to whom they would be giving their work. These patients were the ones who felt capable of producing a product with their own ideas and hands. Many of those had families who regularly visited the institutionalized person. These families might consist of children,

grandchildren, or other family members. This sense that there were people who cared increased the patients' self-esteem and allowed them to adjust and accept the situations they were in.

Other patients had the misfortune to have minds that were clear but a physical condition that made them incapable of functioning. In art therapy I made them aware of every possibility to use those abilities that remained to them. Patients who had the most limited desires and had not striven to accomplish too much in their productive years seemed to be most satisfied with their lives. Patients who had life-long patterns of making every effort to overcome physical problems were among those who showed the most determined attitude even at this stage in their lives. However, such patients were sometimes very impatient.

A major factor in self-concept among the cases was the ability to accept and to cope with any given situation. Only patients who accepted and were to some degree resigned to their situations could take a coping attitude. One patient was so resistant to receiving any help that when it was given, he was so offended that he refused from that point on to attend sessions.

III. CONCLUSIONS

Art therapy has been previously established as a useful treatment for dementing illnesses--often the elderly--because it keeps individuals as

active and alert as possible. Activities such as art therapy help such patients retain a sense of dignity and at the same time helps them preserve mental, social, and physical functions. Although the study revealed little that was new about loss of self-concept and sense of self-worth among diminished capacity elderly patients, the observations of the researcher did confirm the conclusions presented in the literature. Review of the case studies did lead to a number of conclusions related to the effectiveness of art therapy with such patients in nursing homes and assisted living facilities. The following conclusions relate to the self-concepts of the elderly and the benefits of art therapy in their lives.

First Conclusion. Institutionalized elderly patients with family members who regularly visited appeared to have personal feelings of importance and a sense of belonging. Almost every one of the patients who were eager to work in the art sessions had family who visited them on a regular basis. Most of these patients reported loving relationships with some of these family members and were anxious to produce art products with the idea of giving them as gifts.

Second Conclusion. An art therapist who was nearer the age of the patients had a decided advantage in developing their trust and in making progress with their self-concepts. The fact that I was the same age as the elderly people I worked with was an advantage enabled me to relate to them and understand their lives. They were more willing to communicate with me

because they felt I could empathize with their problems. I was not seen as so much of an outsider. This, coupled with the fact that they saw the activities that I provided them in a positive way, produced motivation to communicate. One of the patients communicated with me verbally, although he would not converse with anyone else, including the nursing home staff who were with him for much greater periods of time.

Third Conclusion. For many patients, having products made by their own hands which they could give as gifts was an important aspect of the art therapy.

Fourth Conclusion. Having a strong religious faith was apparently more effective in maintaining the individual's sense of self-worth and drive to be productive than was the hope of eventually being able to leave the nursing home facility.

Fifth Conclusion. A positive side effect of the art therapy sessions was that it gave patients purpose and reason for beneficial social interaction, Getting the patients to talk about their pasts, their families, and how well they did in their earlier years was therapeutic.

IV. RECOMMENDATIONS

The following recommendations were based on a review of the related literature and on the analysis of the case studies used in this research project.

1. Art therapy case studies should be done with a much broader array of elderly people who have been to some degree incapacitated.

2. There is an obvious need to do more research related to dealing positively with the self-concept and life purpose of individuals who have diminished capacities, especially those with little likelihood of regaining their abilities.

3. Research needs to be done about the effects of art therapy with elderly patients when it is made available on a more intensive and regular basis.

4. Developmental efforts need to be made to produce effective and more fully developed curricula for nursing homes and assisted care facilities that are designed to enable patients in such facilities to lead more purposeful and fulfilling lives.

5. A national effort needs to be made to extend the care of the elderly, recognizing that meeting their physical needs and dealing with their physical health is not enough.

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APPENDICES

APPENDIX A

APPROVAL LETTER FOR REVIEW OF RESEARCH INVOLVING HUMAN SUBJECTS

THE UNIVERSITY OF TENNESSEE
KNOXVILLE

Office of Research
404 Andy Holt Tower
Knoxville, Tennessee 37996-0140
PHONE: (865) 974-3466
FAX: (865) 974-2805
URL:http://www.ra.utk.edu/ora

04/17/2000

IRB#: 5858 B

TITLE: The use of Art Therapy to deal with low self esteem among the aged: selected case studies

Eichelbaum, Elizabeth
Theory & Practice in Education
1610 Stonehenge Dr.
Knoxville, TN 37909

Turner, Thomas
Theory & Practice in Education
141 Claxton Addn.
Campus

Your project listed above was reviewed. It qualified for expedited review and has been approved.

This approval is for a period ending one year from the date of this letter. Please make timely submission of renewal or prompt notification of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project include the following:

1. To obtain prior approval from the Committee before instituting any changes in the project.
2. To retain signed consent forms from subjects for at least three years following completion of the project.
3. To submit a Form D to report changes in the project or to report termination at 12-month or less intervals.

The Committee wishes you every success in your research endeavor. This office will send you a renewal notice (Form R) on the anniversary of your approval date.

Sincerely,

Brenda Lawson

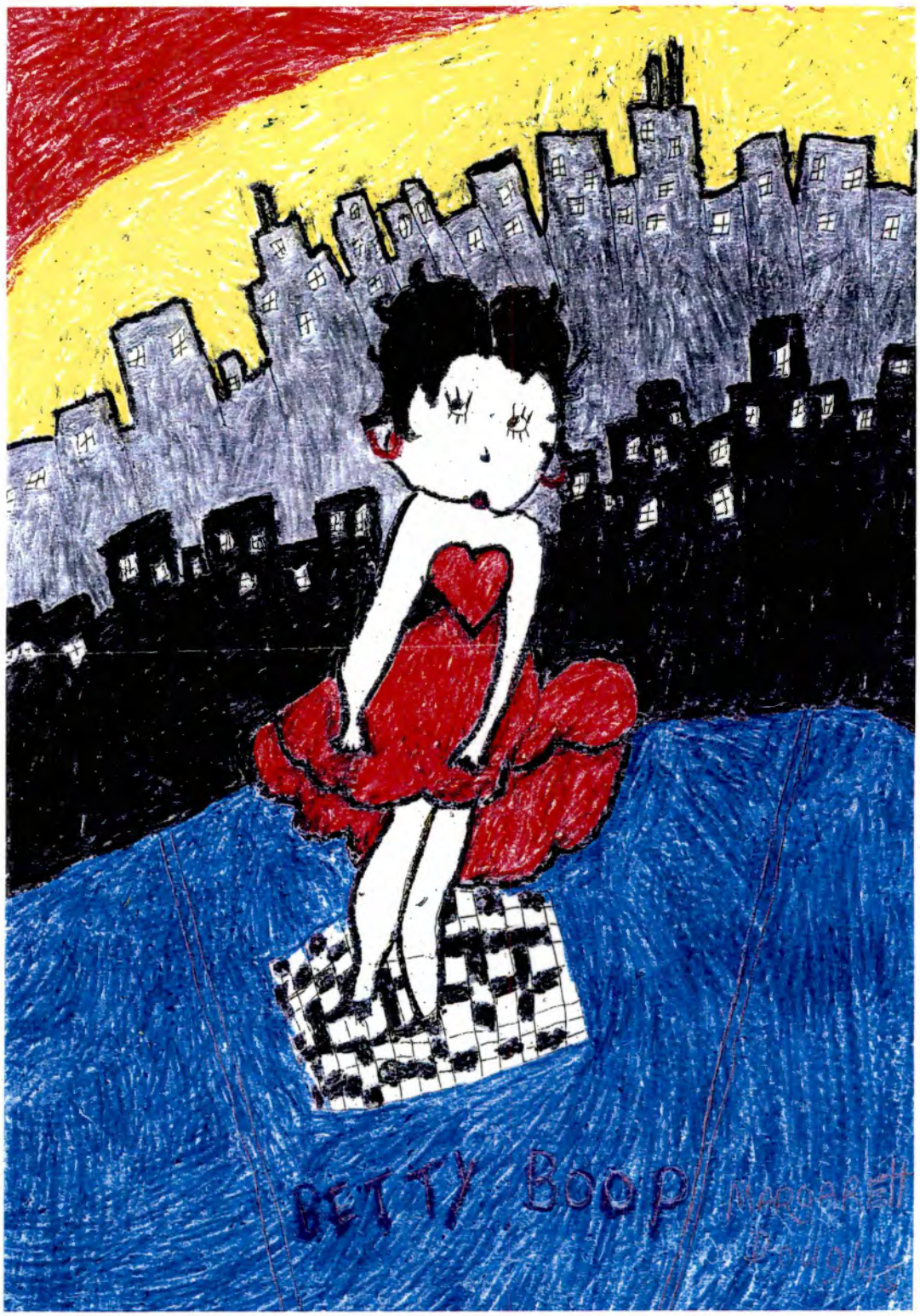
Brenda Lawson
Compliances

cc: Lester Knight

APPENDIX B

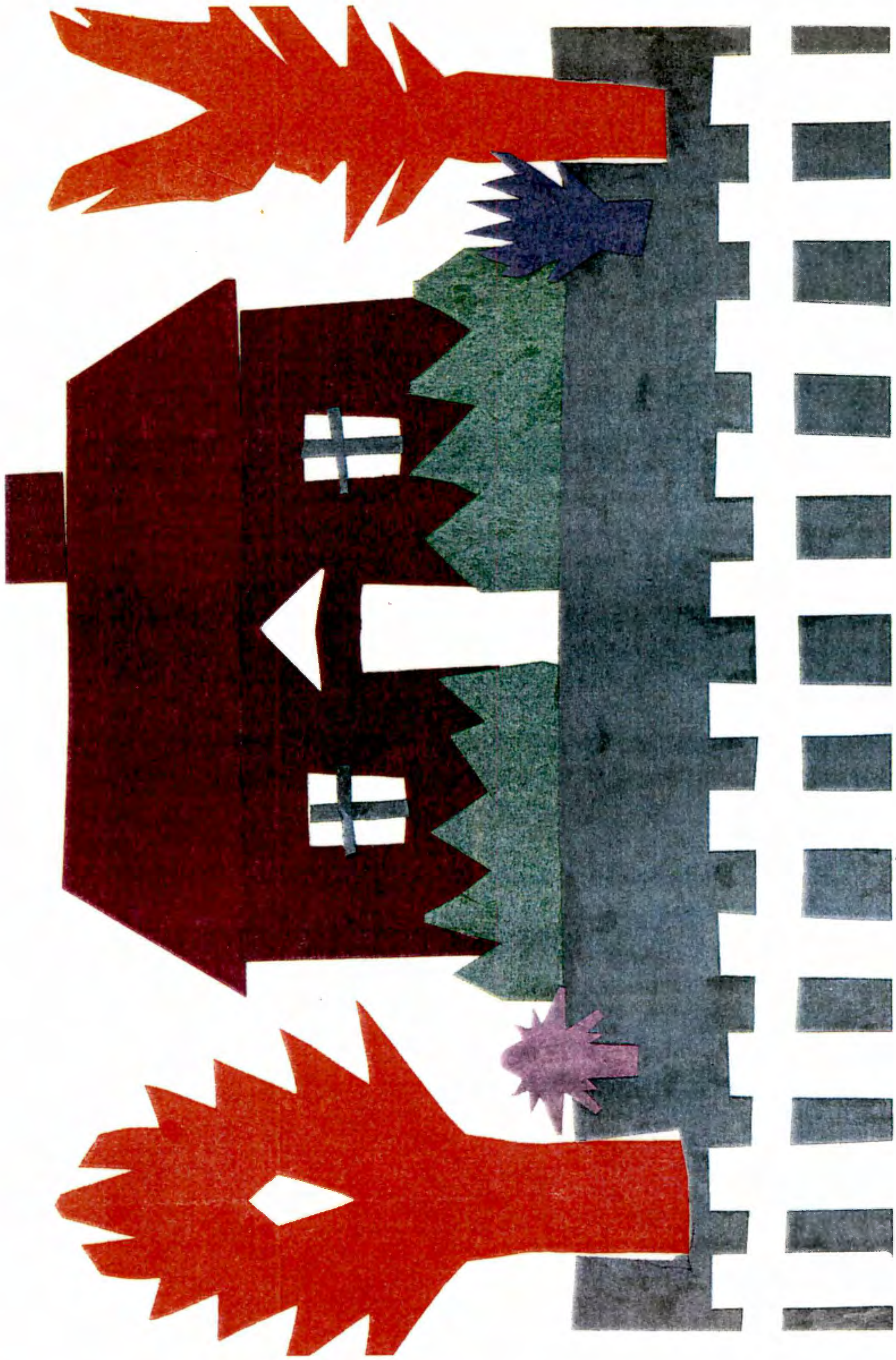
PICTURES PRODUCED BY PATIENTS

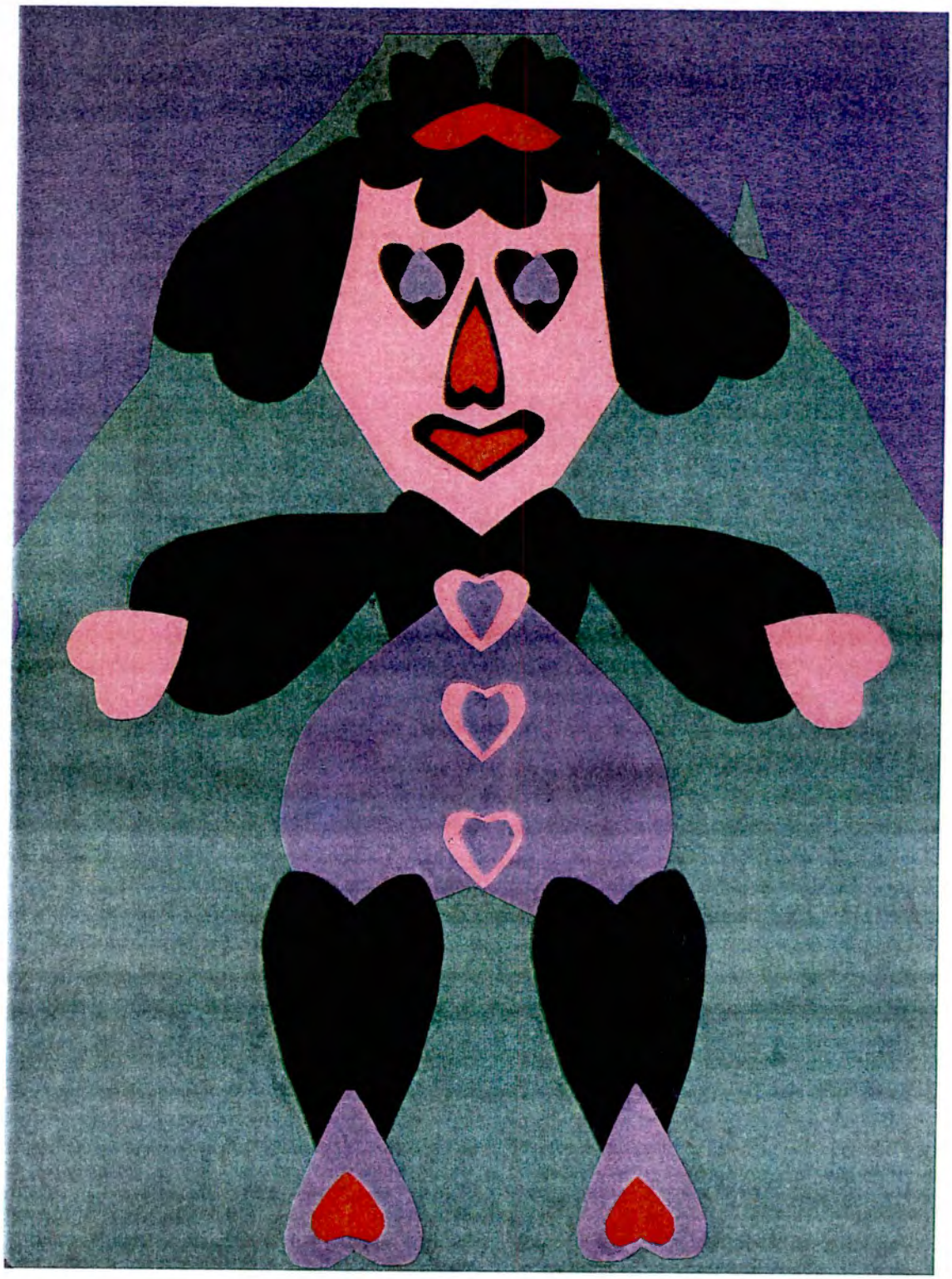
IN ART THERAPY

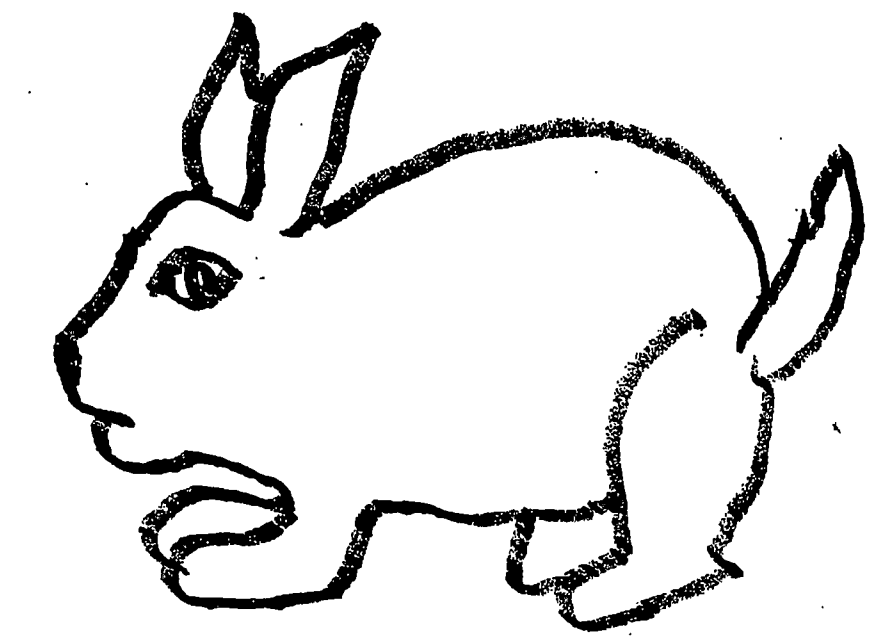

BETTY BOOP
MARGARET
1914

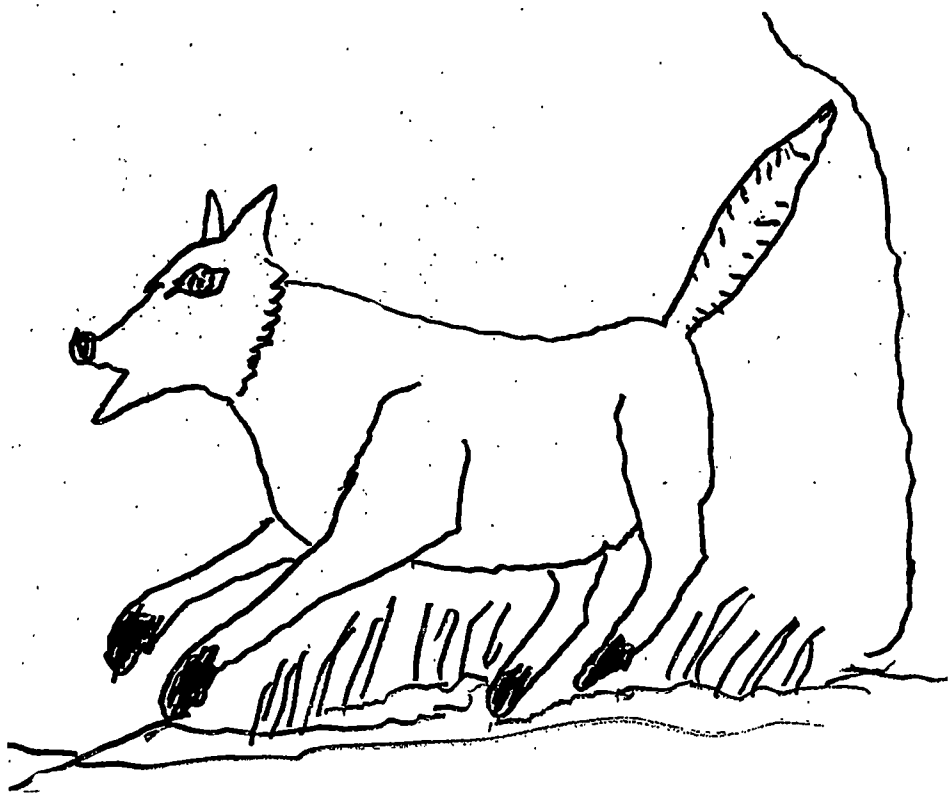

SILVER LINING!!!
FLOWER POWER
SNIF, SNIF!
WHITE FOR PURITY

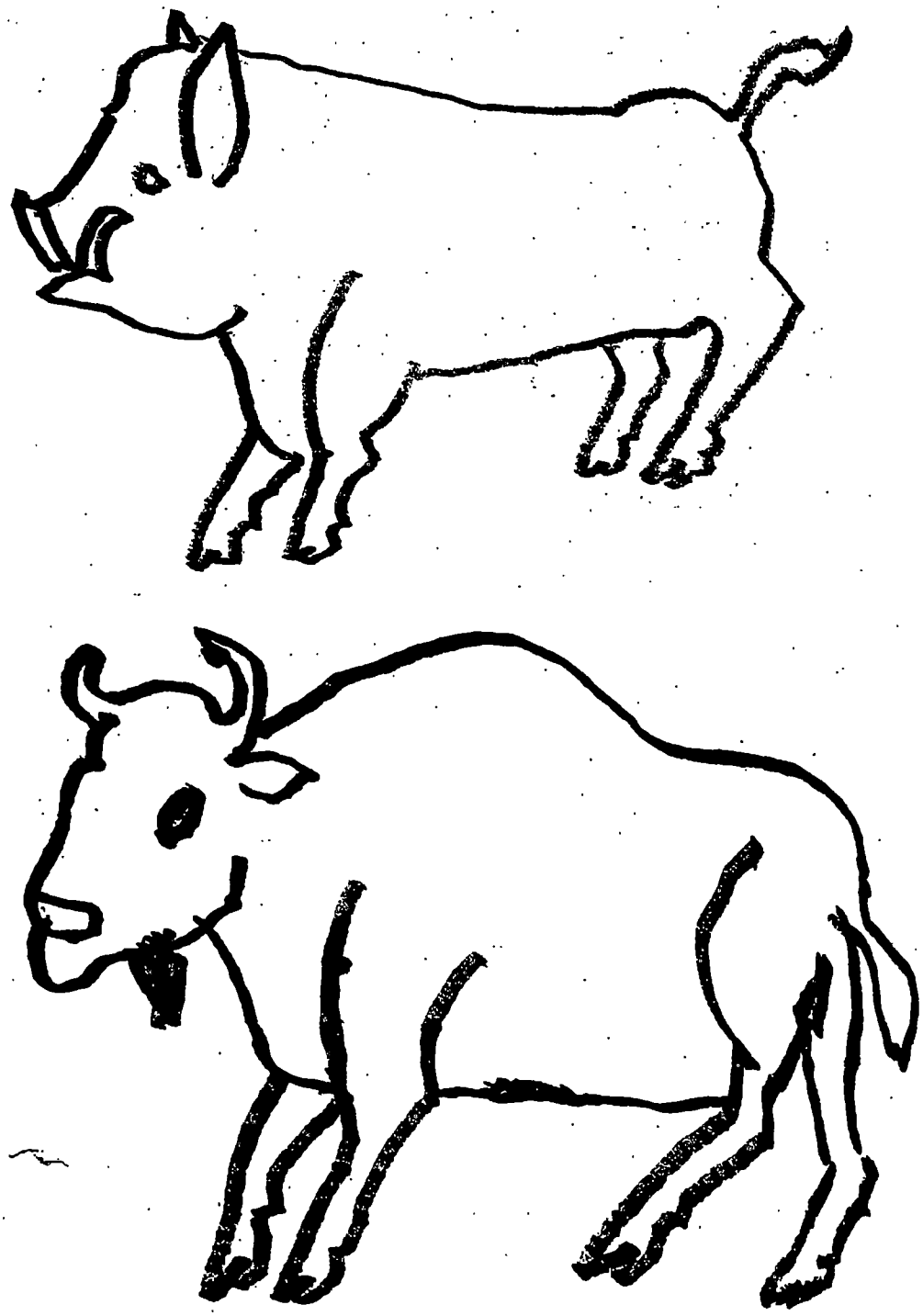

DAY
NIGHT
STARS
CLOUD
BUTTERFLY BUSH!
ONE APPLE REVEALS GOOD & EVIL
EARTH
GOD'S KISS.











VITA

VITA

I was born in Odessa, Russia, March 15,1910. I always wanted to draw and paint but never had the opportunity to do so in my younger years. I came to this country from Russia in 1921 at the age of eleven. I completed grade school in four years and then had to go to work. I worked in a dress shop until my parents bought a candy store in Bensonhurst, just outside of New York City. While helping my parents with the store, I met my husband. He was a steady customer. On our weekly dates, we would go to a Broadway show and then eat in a Chinese restaurant. We also visited relatives and we often talked about getting married.

In 1929, my parents sold the candy store and they started to plan my wedding. But then the stock market crash became a factor for them because they had put all their money in the bank from selling the candy store. All the banks closed. Our wedding plans were delayed. Finally, on November 23, 1930, we got married.

Inwardly, I always felt inferior because I lacked an education and I dreamed that some day I would go back to school. Meanwhile, I was raising four sons. The first were twins. I remember when their teacher called me to come to school to see the murals hanging in the hallway that my nine-year-old sons painted. I was so proud. From then on I gave them every opportunity to nurture their talents.

In the early thirties jobs were scarce. My parents bought a restaurant and we worked with them. In the mid 1930's my husband and I bought a restaurant right across from the racetracks. It was an exciting experience. We catered to the owners, trainers, jockeys, and people who came to the track. Our place was jammed most of the time. Our restaurant lasted three years because they moved the track. The neighborhood soon became deserted. We then bought a new restaurant on the main street in Detroit in the downtown area among several hotels, theaters, bars, and major business places. We were the only restaurants open from 7 a.m. to 4 a.m. After all the show places and the bars closed our place was packed. The local people would also come when they knew a celebrity was in town.

There was one local character named Turk who had a contact with all the celebrities. He would bring the celebrities plus many more people to the restaurant. He would come in with them, a party of 8 to 12 people. They would get the best service and good food. When they were ready to leave Turk would grab the check, sign it, and tell my husband to give the waitress a $10 or $20 tip. Turk never paid a bill. I once told my husband that we had enough of Turk's unpaid bills to paper a wall. Every time Turk came with a party of people my husband would say to me, "If he picks up the check I'll kill him." But nothing was ever said to embarrass him. Others in the party would offer to pay but Turk would not let them pay. Outside of that he was a pretty likable person. Within a couple of years he

moved to California. Some friends who had visited him returned and told us that he was sick, broke and very much down.

My husband asked me, "How about sending him a couple hundred dollars?" I told him that I thought that was a nice gesture. We sent him the money and he sent us a thank you note. My husband said Turk was not a total loss because he helped make our restaurant famous.

There were other disturbances that we had to cope with. Every once in a while a drunk would come in and sat down, got loud, used abusive language. My husband was very good at getting them out of the restaurant. I remember one occasion when he got a drunk out of the restaurant. The drunk stood in front of the place still cussing and swearing. My husband stood outside probably deciding what to do with him. I said to the waitress, "I had better get my husband in here before he gets real angry." As I walked out, I heard, "All you damn Jews--Hitler should have killed you all." My fist went right into his face. He lost his balance and my husband then escorted him off the block. It was the one and only time I ever hit anybody. My hand was sore for a few days.

My husband died in 1973. In the late 1930's we open our restaurant "The---Bagel." I sold the family restaurant two years after his passing. We had the restaurant for almost 40 years. We emphasized kosher style food. It was a restaurant and delicatessen. It was an exciting business with plenty of hard work, but we enjoyed the restaurant. I still am

in touch with some of the waitresses that spent 30 plus year working with us. My boys all received their education and were on their own. So I decided that I would fulfill my life-long dream. I thought that I would have to go to high school, but instead my youngest son convinced me to take my GED test. I took the test and those who gave it to me said I did very well. They asked me what I intend to do next. I replied, "I am going to college."

I first enrolled in a community college. Two years later I got my associate degree and was awarded an honor certificate for a four-point zero grade point average. I received my Bachelor's degree in fine art at the age of 69 and continued taking art courses at Wayne State University. When I heard that Wayne State was offering a new course in art therapy I thought that would be a wonderful way to put my art to use. I wanted to help people of all ages who were emotionally and physically impaired. I received the Masters in Education degree with an emphasis in art therapy in 1991 and moved to Knoxville the same year. I received the Educational Specialist degree and an Honor Certificate for Outstanding Achievement from The University of Tennessee, Knoxville in 1995. In May 2000, I received the Doctor of Education degree from The University of Tennessee, Knoxville.