Integrating Nature into Group Art Therapy interventions for Clients with Dementia

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Abstract

The aim of this intervention research is to examine the mental health needs of people living with dementia in long-term care facilities and to explore how nature and art therapy can be used to creatively respond to these needs. This paper explores the possible benefits and adaptations for this population utilizing art therapy methods and materials that make use of nature or natural materials as well as the practice of therapeutic gardening. Further suggestions for how nature and art can be integrated for projects with people who have dementia are also discussed. Using an intervention methodology, this research was conducted by synthesizing various published sources on dementia, long-term care facilities, horticulture, and art therapy. The author's own experiences with art, gardening, and the clientele have also informed the research.

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This intervention is dedicated to my clients, thank you for allowing me to be a part of your journey.

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Introduction

Since my earliest memories, I have been gardening and making art. With parents who taught art and biology, these interests were bound to be encouraged. My own art is often inspired from natural form or materials. As an undergraduate, I spent time in England and it was there that I saw how unique and artistic gardens could be. Visiting English gardens was like stepping into a world of art, full of sculpture and color. I was struck by how some of the major gardens were designed to last by people who had long since passed away and yet, they had planned these gardens to continue, thinking of many variables and how they would change over time.

After applying to the masters of Creative Arts Therapies program, I worked for a woman in her garden for a brief period. She had recently lost a dear friend to cancer and was about to undergo a hysterectomy. Her backyard garden was mostly weeds and mud and under her watchful eye, I proceeded to act as her hands throughout her recovery time. Sometimes we discussed designs and colors over tea while looking through lush pictures in gardening magazines and over time under her direction, the garden began to bloom and flourish. I watched her slowly heal until she was able to join me in the garden, instead of peering through the window.

Through this process, I gained a better understanding of the therapeutic nature of gardening and the natural world and these experiences, connecting gardening and art, have inspired this research.

Statement of Purpose

The aim of this research is to explore how the use of nature, in various forms, can be combined with art therapy with the intention of supporting the needs of people with *dementia* living in long-term care facilities. I have chosen to focus this intervention

research paper on a population which I believe would benefit from a collection of art therapy interventions blended with gardening and nature for therapeutic use. This paper is informed by my personal experience of interning as an art therapist in multiple settings with groups and individuals with dementia, as well as literature available on related subjects. This undertaking is made with the knowledge that each person is unique, and has an identity and life experiences beyond their diagnosis, and that multiple health factors may also be a consideration with this population (Garcia & Petrovich, 2011).

Although ecology is combined with the modality of art therapy for healing within techniques with this population (Craig, 2002), the integration of horticulture into art therapy practice appears somewhat limited, and the research following this therapeutic merger is minimal (D'Andrea, Batavia, & Sasson, 2007; Sweeny, 2001-2002). There is, however, a growing increase in patients with dementia due in part to the world's growing elderly population (Barnicle & Stoelzle Midden, 2003; D'Andrea et al., 2007). Therefore, a pursuit of research in this direction can only gain importance in the coming years. More research into the integration of this type of intervention, along with other alternative interventions, would be an asset to therapists working with clients who have dementia (D'Andrea et al., 2007). It is my hope that this collection of methods and materials would be of interest to long-term care facilities that are looking to implement programs for their clients with dementia and that it may stimulate an increase in the deliberate use of nature in the practice of art therapy. It may prove useful for staff who facilitate groups with art therapists, to better understand the framework from which the therapist is working, as well as for caregivers who may also mutually benefit from the experiences.

Methodology: Intervention Research

An intervention research method has been used for the construction of this paper. Intervention research is concerned with the design of strategies for change in an effort to

improve existing practices (Fraser & Galinsky, 2010). This paper covers the first two steps in intervention design according to Fraser and Galinsky (2010), who include five possible steps; “develop problem and program theories”, “specify program structures and processes”, “refine and confirm efficacy tests”, “test effectiveness in practice settings”, and “disseminate programs findings and materials” (p. 463). In the first step of the process, key elements of the intervention must be defined along with problems and considerations in order to develop a theory for change (Fraser & Galinsky, 2010). In this paper, the literature review will begin by focusing on dementia; the illness, and factors affecting those who have it, and finally show the current need for such an intervention with this population. Existing literature on the benefits of the use of art therapy, natural elements, or horticultural therapy with long-term care residents or clients with dementia has also been reviewed and synthesized. The benefits of previous interventions and adaptations made for working with people who have dementia are included. The literature review will also discuss some of the parallels between art therapy and horticultural therapy, including the considerations and risks of combining their use. This information will be combined and integrated into the second step of the Intervention research process, where possible program structures and processes are discussed following the literature review. This literature, along with my own experience of working as an art therapist with this population is utilized for the formation of a collection of art therapy methods and materials that involve or are inspired by nature. These interventions could potentially be put into practice in a long-term care facility for the benefit of those who have dementia.

Theoretical Orientation

During my on-site training as an art therapist working with people diagnosed with dementia, a therapeutic relationship built on a person-centered approach was encouraged. Much of the literature on art therapy and other therapies with this clientele also

emphasize a person- or client-centered approach (Kasayka, Hatfield, & Innes, 2001; Lipinska, 2009; Queen-Daugherty, 2002; Capstick, 2011; Hughes & Baldwin, 2006). Kitwood (1997) describes five core psychological needs of people with dementia using the image of a flower, with the petals centered on love, representing: inclusion, attachment, comfort, identity and occupation. Person-centered care attempts to impact the environment and quality of our interaction with the individual who has dementia, rather than focusing solely on the diagnosis or disease processes (Kitwood, 1997).

Definition of Terms

Art therapy. *Art therapy* is defined as "...the therapeutic use of art making within a professional relationship, by people who experience illness, trauma, or challenges in living... through creating art and reflecting on the art product and processes, people can increase awareness of self and others, cope with symptoms, stress, … enhance cognitive abilities; and enjoy the life-affirming pleasures of making art..." (American Art Therapy Association [AATA], as cited in, Stewart, 2006, pp. 37).

Horticultural therapy. *Horticultural therapy* is a goal-oriented practice, in which horticultural therapists make use of plants, horticultural activities; such as garden maintenance and design, or garden environments to promote well-being (D'Andrea et al., 2007/2008).

Natural materials. *Natural materials* are any materials obtained from plants, animals, or the ground, such as, natural fibers, clay, pine cones, shells or wood (Whitaker, 2010).

Nature. The term *nature* in this case refers to the natural world and its naturally occurring phenomena and elements, including, but not limited to, living organisms, rocks and minerals, natural landscapes, or the sky (Gillard & Marshall, 2012).

Literature Review

Aging and Institutionalization

While life expectancy has increased steadily over the last century, the normal aging process still often leaves us with dulling senses, and increased discomfort and difficulty (Despelder & Strickland, 2009; Hart, 2001). It can take more effort to breathe, move, sleep, and to heal (Hart. 2001). It is yet another time in our lives where we may depend greatly on others to help fulfill our needs (Despelder & Strickland, 2009). Many elderly people or people with progressive illnesses move to long-term care facilities to better meet their growing needs (Despelder & Strickland, 2009). The new resident is not just leaving behind their home, they may also be facing a loss of health, life long roles, and relationships (Garcia & Petrovich, 2011). Unfortunately, many care institutions are under-staffed by busy nurses, and doctors that rotate between multiple institutions, therefore having no time to do more than write prescriptions (Garcia & Petrovich, 2011, p.225). Social workers in these facilities are typically bogged down with institutional paper work, so communication and interaction with residents or their families becomes limited (Garcia & Petrovich, 2011, p. 225). Group activities are often offered in a mechanical fashion which may not engage the interests or abilities of individuals (Garcia & Petrovich, 2011; Doyle & Singleton, 1999). Gerontologists point out that numerous care institutions are overly routine and understimulating environments that can cause institutional neurosis; which is described as becoming indifferent, having a flat affect, losing motivation, and sense of self or abilities (Cooper, 1967; Despelder & Strickland, 2009; Hayes, & Povey, 2010). Dementia can further exacerbate the process of aging, the person's needs, and an institution's deficits (Hart, 2001). Garcia and Petrovich (2001) paint a bleak picture:

The depressing impact of being placed in an institution, with its attendant loss of

> individuation, can be so profound that residents can turn away from life, stop eating, and give up on living. In this context, dementia and depression can so overlap and potentiate one another that the residents may become lost in a haze of institutional isolation, their uniqueness forgotten. (p. 226)

Dementia

When a person is referred to as having *dementia*, they exhibit typical signs and symptoms including, memory loss (amnesia), decline in reasoning, spatial orientation or perception, and speech (aphasia), as well as, exhibit behavioral changes (Levine, 2010; Morison, 2006). People may lose interest in previously enjoyed activities, become apathetic, or their typical personality traits may become magnified (Morrison, 2005).

They also often lose control of impulses, which can be seen in the form of acting and speaking without restraint (Levine, 2010). Sleep disruption is also very common (Morrison, 2005). The symptoms of dementia often go hand in hand with loneliness and paranoia, and the illness is commonly seen with depressive features (Waller, 2002a; Morrison, 2005). “Neural brain networks are so highly interconnected and interdependent” that damage in one domain will affect the person in countless ways (Galbraith, Subrin, & Ross, 2008). The impact of the diagnosis of dementia on the sufferer and their family and friends is often underestimated. It is a sentence of 'no hope', condemning all concerned to a never-ending series of losses and humiliations (Waller, 2002a, p.1).

Dementia is not a specific disease; it is an umbrella term for symptoms which can be caused by a number of different diseases and conditions (Levine, 2010; Jacques & Jackson, 2000; Alzheimer's Society, 2012). The most common cause is *Alzheimer's disease* (AD), which is responsible for approximately 64% of dementia cases in Canada (Morison, 2006; Alzheimer's Society, 2012). Alzheimer's is a slow and fatal

neurodegenerative disease where abnormal protein fragments called amyloid plaques and neurofibrillary tangles accumulate in the brain and brain cells die (Garcia & Petrovich, 2001; Jacques & Jackson, 2000). Cognitive deficits such as inability to recognize things through the senses (i.e., *agnosia*), losses in the ability to carry out movement (i.e., *apraxia*), and loss of speech (i.e., *aphasia*), may be seen with any dementia, but the combination is more typically found with AD (Garcia & Petrovich, 2001; Alzheimer's Society, 2012). The person's functioning is compromised in the affected areas as they progress through the different stages of the disease (Jacques & Jackson, 2000). The stages are typically called mild, moderate, and severe Alzheimer's, but different sources may offer more stages and each person's progression through the disease is unique (Riley, 2001; Jacques & Jackson, 2000).

Understanding the type and stage of dementia someone has can help to understand how they may be experiencing it (Levine, 2010). The early onset type of AD, with symptoms occurring before the age of 75, presents a significantly more rapid deterioration (Jacques & Jackson, 2000). Lewy body dementia also forms due to abnormal brain deposits, like AD, but progresses more quickly (Levine, 2010; Alzheimer's Society, 2012). Vascular dementia (VaD) represents up to 20% of reported cases (Levine, 2010; Alzheimer's Society, 2012). This is often caused by strokes depriving the brain of oxygen, so the progression is typically seen in sudden declines that plateau (Alzheimer's Society, 2012). Other diseases and syndromes, along with genetics, can increase chances of developing dementia (Levine, 2010).

As the average age of the population rises, higher rates of dementia are being reported (Levine, 2010; Jacques & Jackson, 2000). Being an elderly person does not go hand-in-hand with acquiring dementia, rather, with greater age the prevalence of dementia increases (Jacques & Jackson, 2000). Currently, up to 10% of those 65 and

older have dementia, with figures rising up to 50% and above by age 85 (Levine, 2010, p. 7). According to a study by Alzheimer's Society (2012), in 2010 there were 35.6 million people living with dementia worldwide, which is greater than the current population of Canada. The numbers of those affected are even greater however, as the deterioration of a loved one adds strain to the friends and family members who take on the role of caregiver (Jacques & Jackson, 2000).

There are multiple factors that complicate improvement efforts (Garcia & Petrovich, 2011; Hughes & Baldwin, 2006). First of all, the diagnosis for Alzheimer's disease (AD), the leading cause of dementia, is only confirmed upon autopsy, and is assumed only after ruling out other illnesses (Garcia & Petrovich, 2011; Jacques & Jackson, 2000). The etiology of AD is not yet understood and there is still no cure or effective treatment for the disease (Alzheimer's Society, 2012; Garcia & Petrovich, 2011). Some people have functioned normally while alive and been found to be full of plaques and tangles upon autopsy (Hooyman & Kiyak, 2008). Commonly prescribed medications in the fight against dementia have only shown temporary results in a select few within the early to moderate stages of AD (Garcia & Petrovich, 2011). Testing has shown that most individuals who responded, revert back to their previous level of disability after 40 weeks (Kennedy, 2000).

Medications prescribed for dementia, and over-medicating can also be responsible for lowering the quality of life of these individuals, with the addition of uncomfortable or life threatening side effects (Hooyman & Kiyak, 2008; Levine, 2010). Since many people live approximately 8-10 years after their first symptoms (Cutler & Sramek, 1996), more research needs to be done regarding quality of life (Garcia & Petrovich, 2011). For many, the pharmaceutical treatments available only offer false hope (Levine, 2010); other strategies are needed which allow a full experience of the life (Cossio, 2002; Garcia &

Petrovich, 2011). Matthews (2006) writes

> We are not now, and perhaps will never be, in a position to 'cure' dementia, in the sense of restoring the lost continuity with the person's past life. But it does not follow that all we can do is to 'care for' the person, in the sense of keeping them clean and tidy and decently fed, clothed, and housed. … What we can do, over and above such caring, is to help to keep a person's sense of self, and so of self-respect, alive longer. In part, this means reinforcing any remaining elements of conscious self identity... (p. 176).

Utilizing Art Therapy with people who have Dementia

In the search for alternative treatments that can bring both care and humanity to those who are sometimes considered beyond help, art therapy has much to offer (Hayes & Povey, 2010). Art therapy can provide opportunities to make choices, to connect and communicate with others, and to feel engaged and alive (Abraham, 2005).

Autonomy

When we create, we bring something into existence, and our choices and control over the medium can allow a sense of self-government in our lives (Killick & Craig, 2011). Whether a fine art or craft, to have someone witness or admire what we have created can add to this feeling of self-efficacy (Killick & Craig, 2011), which can serve to increase self-esteem and feelings of accomplishment (Abraham, 2005).At times the directives for some art activities with this population may appear constrained; this is to provide a sense of direction or therapeutic holding (Abraham, 2005). This frame can still allow for spontaneity and freedom, which should be encouraged (Abraham, 2005). As the illness progresses, having too many options can be overwhelming and it is important at these stages to remember, a small choice is still a choice (Galbraith et al., 2008; Abraham, 2005). Clients are free to deviate from a suggestion or specific directive given (Riley,

2001). If the final products are unique or have a personal touch, a balance between structure and choice has been reached (Abraham, 2005).

Cognitive Stimulation

Our senses, mobility, information processing, and memory are all controlled by the brain and allow us to operate and experience the world in which we live (Morrison, 2005; Galbraith et al., 2008). Activation of different regions of the brain is one of the main goals of art therapy with people who have dementia (Stewart, 2006; Waller, 2002a). Through various media and activities, art therapists are in a good position to help enrich lives and help people with dementia to maintain what functioning they have for as long as possible (Galbraith, Subrin, & Ross, 2008). Current research in neuroscience reveals that the brain retains its plasticity, and that despite the deterioration, people with dementia can learn new information and form new neural pathways (Power, 2010). Art therapists can support this growth, help to improve brain function, and work to improve quality of life by targeting different cognitive activities with the creative moments they offer (Killick, & Craig, 2002; Galbraith et al., 2008; Power, 2010). For example, in the simple act of squeezing a piece of slimy clay, the client is receiving tactile stimulation (Hinz, 2009), they are planning and executing movement (*praxis*) (Morrison, 2005), and, in all likelihood, having a love or hate reaction to the experience (Killick & Craig, 2011).

Emotional Wellbeing

Apathy, depression and other mood changes are commonly experienced as dementia progresses (Morison, 2006; Galbraith et al., 2008). Due to this, Abraham (2005) believes that creating a positive art making experience may be useful in these cases. In some cases, chaotic art making can cause a person with AD to become more anxious, and the confusion on the paper inadvertently serves to remind them of their internal struggle and loss of mastery (Abraham, 2005). However, the arts are psychologically therapeutic

and the benefits outweigh the risks (Killick & Craig, 2002; Kaplan, 2010) because art making can increase well-being and provide relief from symptoms (Killick & Craig, 2011). It is also important for clients to feel alive by expressing a full range of emotions (Riley, 2001). Whether art is used as a modality of communication in therapy (Kaplan, 2010), or utilized as art as therapy in and of itself, it can provide opportunities for emotional regulation (Galbraith et al., 2008). Art can sooth, improve mood, and improves problematic behavior (Iliades, 2009, p. 1). In turn, art therapy helps to decrease the exacerbating effects that depression, fear, and fatigue have on cognitive deficits and the person as a whole (Galbraith et al., 2008).

Abraham (2005) states that it is the art therapist who can help the client live fully in the moment. Art making, especially involving the sensory and kinesthetic components of expressive art therapies continuum (Hinz, 2009) can engage a client in the present and, hopefully, provide an opportunity to do something that they take pleasure in (Snow, 2013). The enriching experiences simulated by the viewing of art has inspired museums to offer programs for people with dementia and their caregivers to enjoy (MoMA, 2012). People are often amazed by the lively discussions and the memories that surface (MoMA, 2012).

It is advantageous for the art therapist to know what the person was like, his or her key life experiences, and what they were interested in prior to the disease process, because the therapist and the client with AD often come from different generations (Abraham, 2005; Snow, 2011). This information will also help pique interest in an activity and make it more meaningful (Abraham, 2005; Snow, 2011). This is especially crucial as reminiscing art activities can help a person retain a sense of continuity of self (Abraham, 2005). The imagery created also helps to provide a visual record of the person's thoughts and emotions (Galbraith et al., 2008; Killick & Craig, 2002). Art

therapy also aids those with Alzheimer's to improve focus, whether it be about their own life story or what they are currently experiencing (Iliades, 2009; Galbraith et al., 2008).

Communication

Art therapy can provide an alternative voice for people with Alzheimer's, when their words no longer serve to communicate, allowing them to express themselves and to experience connectedness and understanding (Abraham, 2005). In the later stages of the disease, when speech seems to lose meaning, the ability to perceive, and therefore communicate with colour and composition may remain intact (Iliades, 2009).

Abraham (2005) stresses that there is no 'right' way to create. Naumburg saw the arts as a medium for communication in the client-therapist relationship (Kaplan, 2010). For Naumburg, the smallest line, on an otherwise blank page, held a message and was to be respected and encouraged (Kaplan, 2010). Killick and Craig (2002) discuss two types of communication seen in the art done by individuals with dementia. The first kind is a communication with the self, which may not be shared with the therapist or the group. The second is an outward communication where art provides a way out of isolation.

Not only does art improve communication within the art therapy group, but it serves as a reminder to staff, caregivers and the community that the person is still engaged with living (Iliades, 2009; Basting & Killick, 2003). This is why Stewart (2006) exhibits group member's artwork that is not of a highly personal nature and with informed consent. Taking advantage of the social potential of interventions in group art therapy is another way of tackling residents' isolation (Killick & Craig, 2011) and increasing their sense of belonging.

Ecology and Health

Like art, nature, in its many forms, has been used for therapy as well.

Horticultural therapy, therapeutic gardening, and green space therapy are all practiced in the aid of mental health (Barnicle & Stoelzle Midden, 2003).

Exposure to Nature

"In a nursing home, it would be all too easy for residents to be enclosed by four walls all the time", states Passey a longterm care activities coordinator (Davis, 2011, p. 18). Although we generally associate a natural environment with health, such environments are often inaccessible to this population (De Bruin, Oosting, Enders-Slegers, & Schols, 2012). For residents of care institutions, getting outdoors provides a variation from regular routine (Davis, 2011) and motivation for longer duration of engagement when involved in outdoor activities (Reynolds, 2002).

Witnessing nature allows time for contemplation, relaxation, and escape, and from what we know about dementia, restoration is no less important a mental process than simulation of the senses (Mapes, 2012; Snow, 2013). "Human identity and personal fulfillment somehow depends on our relationship with nature" (D'Andrea et al., 2007, p. 10). As a species, we have spent the majority of our existence living in outdoor spaces (McNair, 2012). Our progress in industry and technology removes us from fields and forests, but our bodies remain evolutionarily connected to nature (Conn, 1998; Sweeney, 2001-2002).

Biophilia hypothesis theorizes that humans subconsciously seek out, or are innately attracted to life or other living systems because survival depends on it (Heerwagon & White, 1998). The emerging field of ecopsychology is based on this conclusion, and attempts to improve well-being through increasing ones connection with nature (Conn, 1998). Nature provides both food for the body and nourishment for the soul (Mapes, 2012). When we witness the beauty, awe, and symbolism inspired by nature, it can also lead to personal and spiritual growth (De Vries, 2006; Chalfont, 2007).

In a pilot study by Davis (2011), residents in nursing homes were involved in bird watching, building nest boxes, and the creation of wildflower meadows and other natural habitats. Ninety percent of participants reported that access to wildlife and green spaces improved their experience in the home. The benefits of this project also included increased physical and mental activity, a sense of purpose and opportunities to develop friendships (Davis, 2011).

The presence of green spaces in residential environments has been linked to a reduction in fatigue, stress, and aggression, and an improvement in social connections, perception of the environment, and general well-being (De Vries, 2006). Lifestyle changes, such as spending more time outdoors, can be as beneficial as prescribed drugs in decreasing anxiety and depression (Walsh, 2011). Ulrich, Lunden and Eltinge (1983) has found that interaction with a natural environment or natural elements, even simply a view from a window, can restore attention and reduce healing time. In a study on hospital art using interviews with patients recovering from surgery and staff reports, art that depicted nature, such as flowers or landscapes, was preferred and received less negative reactions (Ulrich, Lunden, & Eltinge, 1993). Images of a natural environment has been shown to lower stress levels after exposure to an anxiety-inducing situation (Hartig, Book, & Garvil, 1996).

Our circadian rhythm, the wake-sleep cycle, is regulated by our exposure to daylight (McNair, 2012). With regards to dementia, researchers believe the symptoms of fatigue and cognitive impairment, are exacerbated by lower levels of rapid-eye -movement (REM) sleep, which is partially due to disruptions in the circadian rhythm (McNair, 2012, pp. 23). Studies have shown that exposure to bright morning light can increase the efficiency and duration of sleep by up to two hours, as well as lowering behavioral disturbances in those with dementia (McNair, 2012, p. 23). It appears to

reduce a condition called 'Sun Downing', where clients with dementia show higher restlessness and confusion levels in the evening (McNair, 2012, p. 27). This occurs because it lowers the sleeping hormone, melatonin, and increases daytime serotonin production (McNair, 2012, p. 27). Seasonal Effective Disorder is also linked to lower light levels (McNair, 2012). Sunlight is also used by the body to create vitamin D, which among other health benefits, reduces the severity and occurrence of falls in elderly patients (McNair, 2012). Most long-term care facility lounges, provide well below the light level requirements necessary, meaning residents would need up to 33 hours of light in a typical lounge to receive the beneficial results of an hour spent outdoors in indirect sunlight (McNair, 2012, p. 26).

Horticulture Therapy and Gardening

Not only do we need nature, we are drawn to interact with it and create with it (Sweeney, 2001-2002). The propagation of plants for beauty or science has been a hobby of all ages for centuries (Tubbs & Drake, 2012). Although modern agriculture has eliminated the necessity of a garden, for many it is burden of love and leisure (Tubbs & Drake, 2012). Horticulture also has a history of usage in medical and mental health settings, with some facilities including the practice of horticultural therapy in treatment plans or adding healing gardens to the grounds (Tubbs & Drake, 2012). For clients with dementia, working with plants engages the senses and it can be nostalgic activity (D'Andrea, Batavia, & Sasson, 2007). The inclusion of plants can also make an institution appear more homey (De Bruin et al., 2012). For some, gardening was a part of their identity, socialization, and home before the diagnosis and reconnecting with this activity eases their feelings of loss (Litherland, 2012; Larner, 2005).

A study of day programs at long-term care facilities in the Netherlands compared games and craft work to “green care farms”, which offer normal daily living activities as

well as farming activities (De Bruin, Oosting, Enders-Slegers, & Schols, 2012). The research found that participants on the farms were more engaged, physically active, and spent more time outdoors. With a variety of activities being offered, there were more chances for clients to find a fulfilling activity that suited their current abilities or preferences.

Growing and harvesting food and herbs may help to encourage a healthier appetite among those who are losing an interest in food (United States Environmental Protection Agency [EPA], 2011). If the foods are also eaten, the clients can also have a feeling of control over their diet (EPA, 2011). Gardening is especially appealing for those who want to share what was grown with others; clients can also pass on knowledge, recipes or life stories to others (EPA, 2011). This offers a natural way for group members to create friendships (D'Andrea et al., 2007/2008).

In a 12-week study done with AD patients in a nursing home, horticultural therapy appeared to improve decision-making and socialization while decreasing helplessness and isolation among the 40 residents tested. D'Andrea and colleagues (2007/2008) claimed that the therapy increased cognitive functioning with improved levels of concentration and short-term memory. Feelings of helplessness and lack of control were lessened, as participants commented on the pride and sense of accomplishment that they felt in caring for living things. Tending to plants and cleaning up after activities also aids participants in independent self-care practices (Garcia & Petrovich, 2011**;** D'Andrea et al., 2007).

Larner (2005) suggests that there are a variety of mental abilities put into practice when gardening: memories for the identification of plants by shape, color, or name, visuospatial skills and praxis are necessary for the arranging and handling of plants or garden implements, and executive function is required for focus and planning (p.796-

797). Due to these demands, and the variety of ways in which dementia can effect cognitive functioning, the importance of a person-centered approach is implied (Larner, 2005)

Gardening, as a hobby or as therapy, offers treatments that allow for the amelioration of negative symptoms associated with dementia, such as sleep disturbances and behavioral problems, without adverse side effects (Lee & Kim, 2008). Moreover, as studies showing the efficacy of these claims report participant feedback, it affirms that their quality of life and self-esteem has shifted for the better (Lee & Kim; De Bruin et al., 2012; EPA, 2011). This is coupled with the aforementioned therapeutic benefits of creation and self expression (Moore, 1989).

The Combination of Nature and Art

Commonalities between Art and Gardening

Although art therapy and horticulture therapy come from different fields of study, they share some commonalities. They both use art or gardening as a therapeutic activity offering the patient a chance to practice physical skills and memory function and the therapist a mode of assessment (Abraham, 2005; Larner, 2005). Both are also used as a means of self expression or exploration by an individual in psychotherapy (Killick & Craig, 2002; D'Andrea, et al., 2007). The meaning of an individual's creations in either may change over time, as art and gardening can evoke strong feelings, thoughts and reminiscences (Litherland, 2012; Abraham, 2005). In addition, these two ways of working allow the client to engage in a creative process that allows for decision making, the simultaneous stimulation of multiple senses, and a sense of self-worth (D'Andrea, Batavia & Sasson, 2007; Killick & Craig, 2002; Mapes, 2012).

The engagement in art or gardening can offer a continuity of identity or role (Larner, 2005; Abraham, 2005) and both can be framed as a skilled craft or a simple

activity regardless of age, gender (Tubbs & Drake, 2012; Killick & Craig, 2002), or culture (Lenzo, 2001-2002).

Many art therapy techniques or interventions involve nature. Art therapists can employ nature to inspire art making or take advantage of natural materials as a medium in the therapeutic process (Boettger, 2002). Images in collage, photos, or video can also depict nature, along with natural objects or miniatures in sandplay therapy (Capstick, 2011; Killick & Craig, 2002; Hegman, 1992). Some art therapists relax or focus clients with guided nature meditations (Alliex, 2010). All of these can provide rich symbolism and metaphors of life for a client (Sweeney, 2001-2002). With all of these approaches, the client is given the opportunity to relate to the therapist, the creative process/product, or other clients through verbal and non-verbal means (Abraham, 2005; Larner, 2005; Sweeney, 2013). Practical and meaningful activities enable residents to feel healthy and useful, and in a group setting these activities offer a more natural way for residents to meet and create relationships (Garcia & Petrovich, 2011, p. 220; De Bruin, Oosting et al., 2012; Yalom & Leszcz, 2005).

Combining Art Therapy and Nature

Art and nature have been linked since man's history began (Sweeney, 2001-2002). It is in our very nature to create, and the way in which we live our lives is an art in and of itself (Lenzo, 2001-2002). This, coupled with our instinct to connect with the natural world, has led some art therapists to use nature to expand their practice in a physical or theoretical manner (Sweeney, 2013).

Marie Revai, was a pioneer of art therapy in Canada and her work contributed to the founding of Concordia's art therapy masters program (Woolf, 2003). Revai was deeply interested in art as a diagnostic tool, and also used nature as a tool within her practice (Woolf, 2003). Her therapy room had large windows overlooking a small stand

of trees, and with her intentional inclusion of plants, birds, and animals, nature was an integral part of the healing environment in Revai's therapy room (Woolf, 2003).

Sweeney's (2013) still-emerging approach of 'Eco-art therapy' is based upon applying ecopsychology theory to art therapy practice. Lenzo (2001-2002) claims that eco-art therapy encourages a person to find a connection with nature and to feel a sense of their place in the natural world. This felt connection in nature's presence requires no words (Sweeney, 2001-2002). Yet, it can invigorate the senses and draw out emotions, memories, and wisdom which can sustain and offer clarity (Sweeney, 2001-2002).

Outdoor Art Therapy

The natural environment invites creativity in those with dementia (Hayes & Povey, 2010, p.41). Nursing home residents need the vitality radiating from flowers and trees; it provides beauty, pleasure, and inspiration (Cossio, 2002; Hayes & Povey, 2010). In addition to the benefits of natural atmosphere and subject matter, providing art therapy with clients outside the facility can be practical (Craig, 2012). There may not be a room indoors for an art therapy studio, so the outdoors may be the only space available (Craig, 2012). It is also a space that may better accommodate mess-making and spontaneity, in that the caregivers and clients are not as worried about unsteady hands spilling paint, or being more free with mark making (Killick & Craig, 2011). The grounds may also offer a quieter atmosphere to allow for better concentration (Killick & Craig, 2011).

When art work is displayed in this space it has a different feeling, and can alter the environment dramatically too (Craig, 2012). The environment can also affect the art in a more direct way, such as letting the wind blow a sand drawing away, or creating a work that the sun would shine through (Sweeney, 2001-2002). It can also give the residents and their caregivers a reason to go outside and lessen the separation between indoors and out (Craig, 2012).

Mitchell (2005) invited this kind of interaction with the space in a project that offered disposable cameras to dementia clients so that they could explore and record an outing. Participants reminisced and connected the photographed scenes to their own lives, and communicated with each other during the process. The facilitator also found that they showed an increase in self-esteem, and that their identity and sense of self were reaffirmed.

Craig (2012) suggests doing art therapy interventions outside which will hold up to the elements, recommending ceramic mosaics, wooden structures, jars, or the application of varnish. Themes, like a remembrance garden, a color garden, or a seaside garden, can be offered as suggestions for personal gardens that could be designed by participants. Planters can be decorated and even named as a work of art (Craig, 2012). Stones or flagstones can also become paintings or mosaics (Craig, 2012). Craig (2012) suggests using creative writing, with themes such as fondly remembered outdoor spaces, or identifying different senses, thoughts, or feelings when in an outdoor space. However, for some, coming up with words may seem daunting (Abraham, 2005).

Despite the benefits of holding art therapy sessions in the outdoors, there are also many challenges (Craig, 2012). The grounds may be inaccessible, unsafe, or too far from the residence (Craig, 2012). Getting too cold, becoming overheated, or receiving a sun burn, getting lost, or taking a tumble while navigating uneven surfaces are real concerns that need to be addressed before such a venture can be considered (Hughes, 2012; Craig, 2012). Craig has found that the idea is not always met with optimism either. Staff and caregivers worry about safety issues, and even the residents can feel uneasy about going outside if it is not a part of the institutional culture (Craig, 2012).

If residents cannot do art therapy outside, they can still experience and depict nature through imagery and by using natural materials (Killick & Craig, 2011). A

multitude of art works could be made with, or inspired by, these objects and images (Craig, 2012; Tubbs & Drake, 2012). Many aboriginal arts and folk arts continue to make use of locally available and economically practical materials; these may also serve as further inspiration for methods or materials (Lenzo, 2001-2002; Sweeney, 2001-2002). Natural materials such as stones or wood can also provide a weather resistant canvas for paintings and collage (Craig, 2012; Tubbs & Drake, 2012).

Adaptations have to be made and projects may need rethinking when preparing art directives with this population (Snow, 2011; Capstick, 2011). Capstick's (2011) pilot project intended to take residents with dementia out into the community with video cameras to record their personal journeys and engage the senses. The project required adjustment to fit the participants' cognitive abilities, physical mobility and comfort (Capstick, 2011). Instead of filming themselves, the participants were invited to add commentary to the film that had been taken in a local outdoors market (Capstick, 2011). The footage, with added commentary, is now used to educate health professionals about people with dementia. The film stimulated reminiscence and involved an otherwise marginalized group of people (Capstick, 2011). The project still brought in the sights and sounds of the outdoors, and activated the participants' working and short-term memory as they processed the new information (Capstick, 2011; Galbraith et al., 2008).

Abraham states that we need to change our ideas about healing. Neither art or gardening can restore a person to full health as dementia damages brain cells trying to heal. However, Seawall (1998) suggests that by perceiving the natural world and expressing it in art, we create new neural pathways (Boettger, 2002). Therefore art therapy that intentionally makes use of nature can offer vital creative experiences, which can also increase self worth and feelings of mastery by making use of the patient's current abilities (Abraham, 2005; D'Andrea et al., 2007/2008).

Nature Art Therapy: A Model

Based on the above literature, the following chapter will propose a model for a nature art therapy group in a long term care facility for persons with dementia. Prior to this, each section of the chapter will discuss elements of the model in order to provide practical knowledge for the creation of such a group and its implementation.

Setting up the parameters of the sessions is important, and the success of the interventions can depend on the art therapist's ability to fine tune the frame based on outcome evaluations and client feedback (Riley, 2001). However, consistency is crucial, and a routine needs to be established to help alleviate anxiety, confusion, and to allow a sense of order and control over the environment (Queen-Daugherty, 2002).

The Group

Groups can be a challenge with this population and many authors discuss the need for one-to-one support for mobility, disorientation, and other individual needs, especially in the later stages of dementia (Kwack, Relf & Rudolph, 2005). However, group therapy is effective (Yalom & Leszcz, 2005), and can be particularly helpful in providing the clients with a chance to meet and create important ties with others who live in the facility, and who may also share similar interests or circumstances (Riley, 2001; EPA, 2011; Chia, Heathcote & Hibberd 2011). Having multiple members provide more opportunities for visual and auditory cuing as well as the practice of social skills, which need to be retained as long as possible (Abraham, 2005; Livine, 2010). Hayes and Povey (2010) claim that, “we need others to set our creativity alight. In a group the creative energy grows as we witness and enjoy each other's creative contributions” (p.42).

If the group of people is to be set up by the art therapist, there are many considerations to take into account: Size of the group, staff ratio, stage of dementia, etc. (Snow, 2011; Riley, 2001). Riley finds a group of two or three creates a more positive

experience with those who have trouble orienting themselves or if higher levels of anxiety are present. This is backed by other authors who state, "[...] a sub-group ratio of one art therapist to two group members better serves effective communication than the traditional one or two co-therapist model for a group of six to eight participants" (Galbraith et al., 2008). However, when clients are in the early to moderate stages of dementia, Riley will work with groups of six. Adequate staff support for the "level of prompting and QA required for active participation" is still required (Stewart, 2006, p. 117).

Creating groups based on a person's functioning may prove problematic as it can shift (Levine, 2010; Riley, 2001). Still, according to Snow (2013), groups of clients should be created based on their stage of dementia. The behaviors exhibited at different stages can cause conflicts between members, and what is planned can be more accurately modified to fit the group so that it is not under-stimulating, or too great of a challenge (Snow, 2013).

Clients may be solicited, or the staff may provide recommendations for people who would enjoy the group or would benefit from the goals of the group (Yalom & Leszcz, 2005; Riley, 2001). Familiarity can aid with memory and offer a sense of comfort and safety, so a closed membership would be preferable (Waller, 2002b; Queen-Daugherty, 2002). This would also mean using the same staff members each session (Waller, 2002b).

Place

An ideal indoor space for an art therapy group with dementia is free from noisy distractions, with adequate space for the group members to sit, to move, and to create their art without feeling crowded or overwhelmed (Killick & Craig, 2012, pp.143). Alternative surfaces should also be available if a clean smooth surface is required (Killick

& Craig, 2012).

Due to diminished fat in the skin of most elderly people (Snow, 2013) and the problems with circadian rhythm (McNair, 2012), the room needs to be warm enough, but not to the point of inducing sleep (Killick & Craig, 2012). The room should be well ventilated (Waller, 2002b). Access to a sink is important for cleaning up, and if plants are grown, it is also necessary for watering (Lee & Kim, 2008).

Lighting conditions are important for the participants, their art, and for plants, (McNair, 2012; Killick & Craig, 2012). If an outdoor garden space is not accessible, McNair (2012) suggests providing bright spaces to residents through increased artificial light (full spectrum if possible) or to provide opportunities for them to sit within two meters of large windows. The latter of these two is often the more cost efficient way to offer the recommended light intake if available (McNair, 2012). Plants may need to be moved to accommodate people during the session. Placing plants next to the window, on a shelf or table, would be good for the plants and would give participants further incentive to sit near the window. Contrary to the need for light, blinds may be necessary to reduce the light of a glaring sun or to provide privacy.

Outdoor spaces must offer a similar setting to indoor spaces with some additions. Especially for elders who wander, it is helpful to maintain a secure outdoor area available for the enjoyment of nature (Garcia & Petrovich, 2011, p. 220). A table in shade or with an umbrella is recommended (Craig, 2012). With mobility problems and a decline in bodily functioning, the pathways and location of toilets are another important consideration. Gathering materials outside and making art indoors, or making art indoors and then setting up a display outside, could provide other options. This may be better for windy, wet, or cold weather (Criag, 2012; Hughes, 2012).

Time and Duration

Just as space options may be limited, the session time or duration may be dictated by when the space, facilitators, or clients are available (Killick & Craig, 2012, Capstick, 2011). Ideally, the sessions would take place in the morning, to avoid sun downing and to take advantage of the benefits that working in the morning sun can have on the circadian rhythm, cognition and behavioral symptoms (Lee & Kim, 2008; McNair, 2012). However, it may be better to have some individuals participate at other times, to allow them to attend other beneficial activities. Reactions to morning medications might also effect scheduling (Levine, 2010).

The time it takes for individuals to sit, create, share, and close, is going to depend on the activities, clients' engagement level, attention spans, and their current abilities (Liebmann, 2004; Abraham, 2005; Killick & Craig, 2002). Begin with 45 minutes and adjust the duration for that specific group after a few sessions if possible. Less than 30 minutes may not allow time to dress for the outdoors and create art. This decision should be made with regard to the clients' capacities and present needs (Riley, 2001). It is important that clients have enough time to feel successful and not rushed (Baines, 2001). Due to the acute and continuous need for such an intervention (Garcia & Petrovich, 2011), and the desire for continuity with this population, a weekly on-going group is recommended (Riley, 2001; Wadeson, 2000).

Materials

The materials provided do not need to be expensive, but they should be of decent quality, to show the therapist's respect for the work and to initially avoid materials that the clients may feel are too infantile (Stewart, 2006; Abraham, 2005). If materials are messy, gloves and aprons may be offered, and drop cloths are always useful (Killick & Craig, 2011). Materials must be non-toxic and water-based, as clients may have an undeniable urge to taste things, or their muscle memory may be better intact for eating

than for painting (Killick & Craig, 2002; Snow, 2011). Acrylics and oil paints are difficult to clean and can also require solvents (Killick & Craig, 2011). If a sealant or glaze is required for the weather proofing of art works, the therapist can apply it outside of sessions (Craig, 2012).

If sessions can be held outdoors, clients may need additional materials for personal safety or comfort, such as: sunblock, umbrellas, proper footwear, blankets, jackets, or other outer wear (Hughes, 2012; Craig, 2012). Sturdy walking sticks may be useful and could be created by the group. Styrofoam does not absorb the cold or water, so a flat piece could be used for additional comfort for seating.

Art therapy supplies do not need to be elaborate. However, Wadeson (1987) states that a good selection might include: oil and chalk pastels, markers, tempera and watercolor paint, flat and tapered brushes, canvas, scissors, glue, and paper of various sizes, colors, and thicknesses appropriate for the medium being used. Stewart (2006) suggests the use of items that are not too heavy, tiny, or hard to manipulate. Wadeson (1987) also included collage items and images. Among a wide variety of other images, nature related images or shapes would be good for this group. These may be easily found on calendars, cards, or in gardening, nature, and travel magazines (Tubbs & Drake, 2012).

Natural materials are often found in the art therapy supplies list; however, they will be included here for greater coverage: soil, clay, stone, sand, seaweed, shells, charcoal, water, grasses, pine cones, pine needles, rose hips, seeds, flowers, ferns, feathers, nuts, lichen, mud, bark, herbs, cinnamon sticks, leaves, berries, and edible plants, wool, felt, thread, handmade paper, beeswax, natural fabrics, wood, branches, and straw (Whitaker, 2010, p.123).

D'andrea and colleagues (2007/2008, p.12) mention the following items for

horticultural use: individual work trays, soil, assorted pots, seedlings, light weight planting tools, small watering cans and spray bottles. Rocks or gravel may be useful for drainage or decoration (Tubbs & Drake, 2012). As with the rest of the materials, horticultural materials must also be non-toxic (D'andrea et al., 2007/2008). If growing crops outdoors, soil should be quality tested if questionable; container gardens allow control over soil quality and may provide better accessibility (EPA, 2011, September; Kwack et al., 2005). It is important to research each specific plant offered to the clients, as some common plants, even edible varieties have components that are highly toxic (Kwack et al., 2005). A client may also have an allergy. Plants that grow from cuttings or that grow easily with little care, such as succulents, are also good choices (Tubbs & Drake, 2012; D'andrea et al., 2007/2008). Due to mobility issues, it may be best to choose plants under two feet tall when using raised gardens (Kwack et al., 2005). It would be beneficial to have multiple plants for each client, and additional seedlings or clippings that could be offered in case plants die.

Queen-Daugherty (2002) used the same colored tablecloth each time to protect the table and create familiarity. In order to immediately engage the participants attention, horticultural therapists and art therapists prepared the table, or space, with the necessary materials before the session started (Stewart, 2006; D'andrea et al., 2007/2008). For the end of the session, it is helpful to have a portfolio or a box to store clients' artworks in (Queen-Daugherty, 2002).

Structure

Following the previous chapter sections, this closed membership art therapy group would be composed of no more than six participants if in an early to moderate stage of dementia, and as little as two members if in moderate to later stages. The art therapist and staff members would also be consistent members of the group. The group would run for

45 minutes once a week minimum, and up to three times a week if possible.

In order to lessen anxiety or cognitive difficulties regarding starting, and to provide a common shared experience, the sessions would be structured (Abraham, 2005; Leibman, 2004), meaning that the group would have specified tasks or be working towards a common goal (Leibman, 2004). This structure is offered with autonomy and individual flexibility in mind, as preservation of identity is key (Abraham, 2005; Garcia & Petrovich, 2011). Therefore, if an individual were to depart from the proposed task due to personal choice or perseveration, their individual expression or contribution would be accepted and even encouraged (Abraham, 2005; Galbraith et al., 2008). The therapist working with this population needs to expect the unexpected and allow the clients creative control over the sessions, as long as safety and therapeutic goals are being met. Doing something that is truly enjoyed is optimal, and can also work against apathy and depression (Zoutewelle-Morris, 2013; Spitzer, 2011; Snow, 2013; Riley, 2001).

Rituals are an integral part of the session's structure (Galbraith et al., 2008; Riley, 2001). A staff member can visit the clients just prior to the group as they may need to be reminded about the group, require motivation, or need assistance with getting ready or going to the room (D'andrea et al., 2007/2008). The art therapist and facilitators would greet everyone as they arrived, to welcome the residents and assess how they are doing (Riley, 2001). A very brief overview of what will happen in the session can be stated before beginning (D'andrea et al., 2007/2008). The tasks presented should be success oriented, clearly defined, and offered when clients are ready to receive the information (Stewart, 2006).

Warm up and closing activities are especially important (Riley, 2001). Riley suggests that these rituals can be simple and that the group's rituals can naturally evolve into what is more meaningful to them.

> Procedural memory can be more resilient to the effects of AD. The repetition of rituals supports procedural memory, helping both short- and long-term memory. The rituals used in the opening and closing of the group [could] include stretching, guided visualizations, drama, hand holding, giving a round of applause for work well done, and/or music and songs. (Galbraith et al., 2008, p. 258)

Cleaning up is a good closing ritual as it naturally suggests that something is finished. It is common that individuals with dementia have their roles taken away and are often not offered ways of contributing when they are still capable (Snow, 2013; De Bruin et al., 2012). Anything that group members can do should be encouraged (Hughes, 2012; Snow, 2013).Wiping soil and paint off a tablecloth, and folding it, can translate into greater independence through holding onto self-care skills (De Bruin et al., 2012).

When the session is coming to a close, the clients can be thanked for their participation or cleanup efforts, wished a good day, and reminded that the next session will be in a week's time (D'andrea et al., 2007/2008). Sessions should end on a positive note if possible (Liebmann, 2004).

Therapist's Role

First and foremost, the therapist needs to create a holding environment, which offers acceptance, respect, encouragement, and safety for the clients and their creations (Queen-Daugherty, 2002; Riley, 2001). The emphasis is on the process of the session rather than the product with no pressure to create a work of 'fine art' (Queen-Daugherty, 2002). However, the product is a means of communication and an accomplishment that needs acknowledgment (Stewart, 2006).

No matter what the client's cognitive awareness or verbal ability is believed to be, all team members should also communicate with the clients and not about them in their presence (Tyler, 2002). The therapist should prepare other staff members involved and

communicate well with the team, as a good staff attitude is associated with higher attendance, less reluctance in sessions, and more observed improvements in clients (Waller, 2002b). The additional staff members have a crucial role since the level of prompting required can be high. The methods of prompting that can be used by the therapist and team include verbal cues, such as step-by-step instructions, gestural cues, and hand–over–hand assistance (Stewart, 2006, p117).

Assuming participation with your words is also recommended: 'I have a chair right here for you,' or, 'Choose a color that you like,' (Snow, 2011). When encountering resistance, an understanding of the whole person before and after onset of the disease, their current stage of dementia, and the situation, is useful for coming up with a plan of how to engage a person (Snow, 2011). Autonomy is important, but some people with dementia will settle on a 'go-to' answer when they are unsure (Snow, 2011). It is good to further encourage and offer those that have said “no” a solution which may be found by: re-explaining the activity more simply (Snow, 2011), breaking things down into manageable procedural steps (Galbraith et al., 2008), altering materials for ease of use, various cuing or hand-over-hand work (Stewart, 2006), or getting another group member to work with them (Snow, 2011).

Art often has room for error, and what is not working can be solved or become a new direction. Some plants can be quite forgiving, but plant death is also a possibility. It can be said that we need to avoid humiliation or defeat; if clients are using materials in a way that suggests disorientation (such as writing with the wrong end of a marker), therapists need to get involved in a way that preserves the client's dignity (Wald, 2003; Abraham, 2005). However, if a plant dies, it could provide an opportunity to discuss death (DeSpelder & Strickland, 2009). So often, people try to protect those with dementia from unpleasantness (Riley, 2001). Although it may be true that uplifting experiences are

preferable (Greenblat, 2012; Snow, 2013), part of the attraction to growing things is that they do die, and that by caring for them, feelings of being needed and accomplished are fostered (Davis, 2011). The clients are also facing death, and the opportunity to express their full range of emotions can allow them to feel heard, less isolated, and give them a sense of release, an insight, or a laugh (Riley, 2001). As with the art work produced, the therapist needs only to relate to the work and to validate the client's experience, without projecting meaning (Abraham, 2005; Queen-Daugherty, 2002).

The art therapist would also be in charge of storing the groups' creations (Queen-Daugherty, 2002). If a client has made a work with the intention of displaying it or giving it away, the therapist can make exceptions that respect the client's autonomy or current connection with the work (Stewart, 2006).

Treatment Goals

As mentioned, providing a safe, consistent, and accepting environment is a key treatment goal (Wadeson, 1987). In light of the literature on art therapy with this specific population, this would be combined with offering a balance of activities which aim to stimulate the senses, practice fine and gross motor skills, target different cognitive tasks in planning or execution, offer a platform for communication of thoughts and feelings by verbal or non-verbal means, and work toward group cohesion or social engagement, while respecting an individual's uniqueness and autonomy (Abraham, 2005; Riley, 2001; Snow, 2011). Particular to the nature art therapy group is the focus on connecting with nature, in an effort to meet the above goals and to increase well-being through exposure to natural elements as well as the additional benefit of a sense of belonging and purpose (Sweeney, 2013; D'Andrea, et al., 2007/2008; McNair, 2012).

Sample Intervention Directives

...it is not necessary to have long list of tricks to provide art opportunities. It is

> important to carefully construct the task to fit the dynamics of the group, the needs of the members, and the psychological and behavioral level of the clients. Simple does not mean stupid. Sometimes simple tasks allow for greater inventiveness and a more satisfying experience (Riley, 2001, p.183).

This section offers a sample of weekly art therapy directives. It is important to keep in mind however, that the following suggestions require flexibility because involving the use of plants or the outdoors can make advance planning difficult (D'Andrea et al., 2007; Craig, 2012; Hughes, 2012) because the weather alone can cancel outing plans and greatly affect the successful growth of plants (D'Andrea et al., 2007; EPA, 2011). More important is the necessity of adjusting to the needs of the clients (Capstick, 2011; Riley, 2001), while still offering a consistent frame as the clients' feelings of success may hinge upon many factors covered in this document (Riley, 2001; Leibmann, 2004). A weekly intervention plan would be of greater use with a specific group and facility in mind. The following weekly plan for several weeks of art therapy directives has been created to offer a more concrete picture of how the proposed intervention of nature art therapy with clients who have dementia could be approached.

Week One: Personal Planting Pots

Main therapeutic goal. Reinforcing a continuity of identity

Materials. A selection of medium- large sized glazed terracotta pots, a variety of pre-cut collage images, plenty of natural materials that are not too heavy or round to attach (pebbles, sticks, moss, shells, etc.), and materials that could be wrapped like rope or ribbon, or sprinkled into the glue such as beads or sparkles, modge podge or Crafter's Pick The Ultimate, thick handled flat brushes and good scissors for each person, and shellac or spray varnish to coat.

Directions. After greeting each client and facilitating introductions in the group,

let the clients choose a pot to personalize, explaining that they are creating a personal garden (Craig, 2012) and will add plants next week. Let clients know that they can cover the pot in anything they like, whether images or items that represent them or the things they are most attracted to on the table. Use brushes to add the glue and stick on the chosen items. Offer help only if needed. A demonstration pot that shows some techniques, without being too well done, can be useful for demonstration. Have clients show each other what they have done. Ask if they have gardened or used art materials in the past, if they have any favorite plants, hobbies they enjoyed, what they might like to plant in their pot, etc. This discussion can occur during the activity if not too distracting. Clean up together. After pots have dried, the therapist can apply a liberal amount of waterproof sealant.

Week Two: Planting

Main therapeutic goal. Maintaining fine and gross motor skills and procedural memory.

Materials. Pots from the previous session, planting trays (old cafeteria trays), a selection of safe and easy to grow seedlings or cuttings (clients' preferred plants if feasible), potting soil, gravel for drainage, as well as various toppings (rocks, shells, glass stones, potting moss, or cedar chips), a small watering can and spade for each person, and blank larger plastic plant labels with nontoxic permanent markers (optional, for plant labeling or poetic words).

Directions. Greet each client and look at the pots from last week. Show what is available for planting and let clients choose two to three seedlings, or some succulent cuttings, and place them on their trays. Start the pot by scooping in some gravel and then some soil; the therapist can use the demo pot from the last day if needed. Place the plant in and add more soil around the plant, being careful not to bury the stem and to leave

space on top to allow for rocks (if desired) and water absorption (Tubbs & Drake, 2012). Invite clients to add a surface topping if they wish (nothing that could hinder plant growth or turn moldy). Get the clients to name their garden (Craig, 2012), and add a label if desired. Lastly, the table can be cleaned and plants placed by the window and watered.

Now that the residents have plants growing, caring for the plants can be involved in the opening and closing rituals of each session. Clients can warm-up for each session by checking on the growth of their plants and removing any dead leaves while settling in and greeting each other. Each session can close with the act of watering the plants together, as water may be needed for cleaning up art materials as well.

Week Three: Sensory Still Life

Main therapeutic goal. Increasing sensory stimulation.

Materials. Natural objects chosen for their sensory aspects in order to set up a still life: brightly coloured flowers or leaves, fake flowers for those allergic to pollen, strong smelling plants or herbs (lemon balm, mint, marigolds, potpourri), different textured plants or objects (Rough and smooth rocks, pine cones, tree bark, Lamb's Ear, Pussy Willow, feathers, but nothing that might pierce skin), for sound (hard dried pods or gourds with rattling insides), edibles (Bumpy strawberries, or fragrant oranges). Bowls and vases, small pastel paper, and oil pastels, or large paper with a circle or spiral drawing.

Directions. This session could begin with a walking tour of the grounds to scavenge for objects that appeal to the senses (Craig, 2012). After warm up, explain that the natural objects will be used to draw from. All of the objects can be passed around while stating why the therapist, or the client, picked that item in relation to the senses. Discussion and reminiscence should be encouraged. The inedible objects can be chosen by clients and collectively placed to create a still life that then the group can draw from.

If clients appear intimidated to begin drawing, the therapist can encourage them to just let the colours or shapes they see inspire them. They do not need to copy what they see. Alternatively, larger paper with lines could be used as a starting point, such as a large circle or spiral shape to fill in with the objects. End with discussion while tasting any edible materials, gather the unused materials, and water the plants. Offer to take a picture of the table art and wait until clients have left to deconstruct the arrangement.

Week Four: Bird Houses and Feeders

Main therapeutic goal. Develop a sense of purpose.

Materials. Small, inexpensive wooden bird houses or bird feeders, pre-cut collage images and other collage items, scissors, modge podge, watercolour or tempera paint, flat and tapered brushes, string, and sealant.

Directions. Greet each client and check on the plants together. After warm-up, invite clients choose a bird house or feeder. Ask clients to paint or cover the house or feeder to make it more attractive to birds who may be hungry or need a home and add a string for hanging feeders. Have the clients step outside or look out the window to pick a location to place bird houses or feeders. End with discussion, clean up and plant watering. The therapist can add sealant once the pieces are dry.

Week Five: Group Garden Mural

Main therapeutic goal. Building group cohesion.

Materials. Poster sized paper (blue if possible to represent the sky), with green construction paper cut into grass and stems at the bottom, pre-drawn flower images on paper, pre-cut natural collage images, scissors, packing tape, oil pastels or markers.

Directions. Greet and warm-up. Show the clients the backdrop and a couple ready-made pieces to be placed onto it. Ask the group to help fill in the space and create a paper garden together. Some clients can make multiple contributions as their pace allows.

Clients who have good dexterity, but are unable to decipher visual information very well may need help cutting out the images. It may be difficult to decipher the lines they added from the lines that are meant to be cut. Show appreciation for each contribution, and discuss how the clients felt about what they did or how they felt about creating the work together. Close by watering the plants and filling the bird houses and feeders with food or nesting materials (wool, grasses, yarn), then install them, preferably outside a window off the group art therapy room, or where they can be enjoyed by all the residents.

Week 6: Leaf Rubbing Watercolor Resist

Main therapeutic goal. Maintain cognitive functioning.

Materials. Watercolor paper (strong but not thick) attached to an individual board on one side, a large variety of dried leaves, Oil pastels (stripped of their covering for side usage), watercolor sets, brushes, and water.

Directions. Greet and check on the personal gardens. Initially, have the table set with the boards, leaves and pastels first. Demonstrate with a variety of colors and introduce the activity in a sequence of steps. Show the clients the leaves and explain how they can be placed under the paper, held at the edge, and rubbed through in order to pick up the shape of the leaves. Then the leaves can be removed. Alternately, the clients can arrange the leaves or the leaves could already be under the paper. Clients may need help with holding the paper, pastel pressure, or leaving enough paper to absorb paint. Lastly the watercolor paint can be applied as a wash, a pattern, or to create a scene. The abstract quality of the results can lead to positive comments and a discussion about the diversity of the collection of images. Close the session by cleaning up and watering plants.

Sessions would continue on like this, sometimes repeating activities, emphasizing different aspects or building a series of those activities most enjoyed by the group. Ideally the group would be ongoing. However, a session acknowledging loss and the experiences

of grief could be addressed by a termination session.

Week 7: Final Week: Memory Book

Main therapeutic goal. Explore grief and loss issues.

Materials. With permission, prints of some collaborative artworks by the group, a 'before' and 'after' photo of their seedlings/plants, a print of the view from the art therapy window and their bird houses, colored construction paper, markers, pre-cut collage images, glue sticks, stapler, A4 paper, clients folders, snacks if desired.

Directions. Warm up and greet. Remind the clients that it is the last session and introduce the activity. Ask participants to pick a coloured pieced of paper and staple it with the A4 paper to create a thin book. Offer the pictures of group works and of their plants to glue or tape into the book. Let the discussion be stimulated by sharing images. Offer clients time to write in, or offer an image for each other's books, reminding each person of the owner. Invite clients to open their folders and to choose the images they want to keep. Ask what it was like to be a member of the group. Tell each person something you enjoyed or will miss about them, and point out the group's accomplishments. Lastly, clients may take their planter and artwork home. A small watering can would be an appropriate parting gift. If edibles were grown, they can be shared or eaten as the gardener wishes. If there are many plants the group could add them to the collective garden or to a community room in the facility.

Conclusion

The inclusion of nature in the art therapy room may increase participation of clients who are experiencing symptoms of dementia by increasing their ability to relate to art therapy intervention and to each other, due to past or present connections with art, nature, or gardening (Litherland, 2012). Adding gardening to art therapy allows clients to be involved in the purposeful care of living things (Davis, 2011; Tse, 2010; Chalfont,

2007). Clients also appear to focus more when in a natural setting, which allows them to stay with activities for longer periods (D'andrea et al., 2007/2008). As plants need light, involving gardening in the art therapy process brings the clients closer to light themselves, where they are more likely to absorb the recommended daily intake of sunlight (Chalfont, 2007; McNair, 2012). Art and nature can be integrated and experienced in countless ways in order to match different strengths and deficits, while improving the environment and the quality of interactions with the person who has dementia (Larner, 2005; Abraham, 2005).

As this document has emphasized, adding nature to art therapy, though somewhat whimsical, is backed by current literature (Lee & Kim, 2008; McNair, 2012; Galbraith et al., 2008; Tse, 2010). Its roots can also be traced back to the establishment of art therapy in Canada with Revai's use of nature to inspire and heal (Woolf, 2003).

It may not be accurate to say that access to natural elements, green spaces, or gardening causes the reported benefits independently. Many of the positive effects described through the literature are not isolated variables and interactions between each mechanism exist (De Vries, 2006). Further evaluation and research is needed to better understand the reported improvements and benefits. These benefits, however even if they are from a ripple effect, are consistently reported by researchers, caregivers, and participants alike (De Vries, 2006). With more studies, the practice of using gardening as part of art therapy, or a more mindful approach to using natural elements and imagery in interventions with this population would more likely attract funds allocated for this purpose.

A cure for dementia may be a scientific breakthrough away (Garcia & Petrovich, 2011; Levine, 2010), and yet, the need for quality of life, continuity of identity, and self worth exists right now (Mapes, 2012; Garcia & Petrovich, 2011). Attempting to plan

interventions that can accommodate for all the ways in which dementia of various stages and types can affect individuals in a group, and to engage the interests of all involved, is a challenge (Riley, 2001; Abraham, 2005). Adding gardening or the outdoors to art therapy, while aiming for these goals, can further complicate care (Tse, 2010; Craig, 2012; Kwack et al., 2005). However, considering the prognosis and need for support, of a growing aging population, how can we not evolve and make available a greater variety of treatment interventions? It is not simply about fighting the disease; it is about continuing to see the person as worthy of such care (Kitwood, 1997). For those who have witnessed moments of vitality and creativity in an individual affected by dementia, the effort does not go unrewarded.

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