The Benefits of Art Therapy with Neurodegenerative Diseases

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By

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Abstract

In this review, we will look at how art therapy can be beneficial for patients who have been diagnosed with Alzheimer's disease, dementia and other neurodegenerative diseases. This literature review and experiential is a focus on the coming of age of the baby boom generation and how health care professionals need to think outside of the box when working with this population. This researcher discusses how to develop effective therapeutic methodologies for addressing this population. Utilizing art therapy assessments can be useful in determining severity of the dementia. The research strives to present a variety of effective ways to determine where the individual is at in their illness and how to work with them and their family. There are highlights in the research about changes needed in our society concerning the large aging population along with art therapy as well as other expressive art modalities that are helpful in easing the transition into elderly life. Art therapy provides elderly patients a way to communicate through visual art.

**Keywords**

Alzheimer’s disease, dementia, frontotemporal dementia, art, cognitive functioning, mixed dementia.
The Benefits of Art Therapy with Neurodegenerative Diseases

After contemplating the types of families I would most likely serve, it has become apparent that I have an affinity to work with seniors and the caregivers who take care of them. I have worked with seniors who have been diagnosed with Dementia Alzheimer’s Type for most of my adult life in one capacity or another. When I was first starting out in my adult working life, I was a nurse’s aide in a large nursing/long-term care facility outside of Chicago. I worked there for seven years seeing to the needs of the senior residents.

Throughout the years, I have helped older family members to transition into senior life and have participated in extracurricular activities such as arts and crafts, reading and putting together a family scrapbook. It has been more apparent in the past three years during my graduate studies, that I would garner the most satisfaction working with the elderly.

It has been over the course of three years that I have come to realize that most of my fellow art therapy classmates have stated they would rather work with children, adolescents and younger adults, but not with older adults. I have enjoyed working with older adults who have either a diagnosis of Alzheimer’s disease, or other forms of dementia (i.e. Parkinson’s disease, Huntington’s disease, etc.).

As the baby boomers become older, by the year 2030, it’s been reported that the baby boomers will outnumber children, adolescents and young adults. The National Institute of Health stated that baby boomers would need different services as compared to earlier generations. Even though the services appear to be the same for long-term care needs as in previous generations, the demand for more services available to the aging baby boomers is spurred by several different factors. These factors are quite different from their parents needs as they retired and lived a more leisurely lifestyle. Traditionally the previous generations believed in working hard, saving
money, and planning ahead (Lipschultz, Hilt, & Reilly, 2007). The baby boomer generation had been raised in relative prosperity, received a college education, and had more choices and freedoms than in generations past. It is because of these freedoms and choices that the services being offered to the baby boomers should include ones that initiate a payment and insurance system that is developed for long-term care. Baby boomers also need to be able to take advantage of advances in medicine and behavioral health so they can stay active and healthy for as long as possible (Sade, 2012).

It involves changing the current societies view on integrating community services so the baby boomers may have access to these services. It also includes altering the cultural view of aging, so that all ages can be integrated into the fabric of community life. It makes sense that in order to meet the long-term care needed by this population, they will need assistance when they become an older adult age 80 years or older (National Institutes of Health, 2013).

As the baby boomers become older, it is necessary to look at the type of healthcare services and alternative treatment options that will be available. This is not to say that this population will have more diseases and illnesses than previous generations (Sade, 2012). People who have been diagnosed with Alzheimer’s disease and dementias are being looked at closely within the healthcare arena in regards to how they can care for these individuals in all phases of the diseases’ progression. This is where art therapy as a treatment modality can be beneficial for the Alzheimer’s patient in all phases of their disease (Abraham, 2005).

Art therapy is an expressive art technique that can help persons who have been diagnosed with Alzheimer’s disease. Art production is a process that is able to recruit activity from several different regions in the brain simultaneously (Safar & Press, 2011). Creative visual expression provides a way for those who have lost the ability communicate verbally and serves
as an outlet for self-expression (Kamar, 1997). For example, when a person paints a picture they are able to access complex cognitive activities involving thoughts, emotions, and memories (Belkofer & Konopka, 2008). Since painting is a visual process a person who may be experiencing cognitive decline may be able to stimulate forgotten memories. Art therapy can also serve to increase and sharpen perceptual skills, strengthen social skills, and activate the senses (Wald, 2005).

**Art Therapy and Neurodegenerative Diseases**

Alzheimer’s disease is an irreversible disease that affects older adults after the age of 60 years old, but it can sometimes affect people as early as 50 years old (National Institutes of Health, 2013). The disease was named after Dr. Alois Alzheimer in 1906, after Dr. Alzheimer examined one of his patients who had died from an unusual mental illness. She had exhibited memory loss, language issues, and unpredictable behaviors. When she died, Dr. Alzheimer then examined her brain and noticed her brain exhibited abnormal clumps and bundles of tangled fibers (National Institutes of Health, 2013).

Currently, in the United States the estimated number of people living with this disease is as high as 5.1 million. As the population in the United States ages, this number will double in 5-year intervals for persons beyond the age of 65 (National Institutes of Health, 2013). The National Institutes of Health has estimated the number of people to be affected by Alzheimer’s disease by the year 2025 will be 9 million people (National Institutes of Health, 2013).

The Alzheimer’s Association has reported it and the National Institute of Health even though memory loss is consistent with aging, the amount and severity of memory loss when associated with Alzheimer’s disease is clearly different. A health care professional or doctor should perform an assessment to determine the amount of loss that is being experienced by the...
person and to rule out biopsychology conditions (Wald, 2005; Alzheimer’s Association, 2013). Alzheimer’s disease affects perception of time, space, motor skills, the ability to communicate, and attention span (Genius, Klafki, Benninghoff, Esselman & Wiltfang, 2012).

There are three stages of Alzheimer’s disease, although it is a slow disease, it can progress faster due to environmental changes such as medication side effects, chronic alcoholism, tumors, infections in the brain, blood clots in the brain, and some thyroid, liver or kidney disorders. The conditions mentioned above can be temporary and reversible, but they must be diagnosed by a professional as soon as possible in order to rule out early onset Alzheimer’s disease in order to effect change in the person’s cognitive functioning (National Institutes of Health, 2013).

There can be challenges for some individuals in regards to problem solving and planning capabilities, memory loss can disrupt their daily life, they can misplace things and exhibit the inability to retrace their steps, there is some confusion with time and place, decreased or poor judgment. These symptoms are just a few of the many symptoms for patients who may be experiencing Alzheimer’s disease (Gauthier, 2011; Potts, 2012).

This population is struggling with end of life issues, stress, and significant changes in lifestyle, routines, and the feeling of loss of control over their lives, as they let other caregivers into their home to perform specific duties outside of daily living (Bober, McLellan, McBee & Westrich, 2002). It is the culture in the United States that elders are considered burdensome and subordinate and so it is not surprising that the feeling of loss of control over their lives is prevalent. The decision to enter into an institution is usually against ones own will and gives the individual the impression they can no longer care for themselves (Wald, 2003).
It is the families of persons diagnosed with Alzheimer’s disease who are usually the main caregivers that take on the task of caring for their loved ones at home and are usually the ones who experience burnout, fatigue, financial burdens associated with the care giving role (Alzheimer’s Association, 2013; McElroy, Warren, & Jones, 2006). These family members, friends, or other relatives provide the majority of care to the individual diagnosed with this disease. These symptoms come with additional roles that the caregiver takes on, such as providing daily personal hygiene, and handling behavioral problems which can show up as neuropsychiatric symptoms. They also take on the role of financial advisor and advocating for their family member with physicians, government agencies, and social services agencies (Alzheimer’s Association, 2013; McElroy, Warren, & Jones, 2006).

When working with a family that is dealing with an Alzheimer’s or other dementia diagnosis the family members will most often go into survival mode and become emotional in their decision making when it comes to the care of the patient (National Institute on Aging, 2012; Brown, & Chen, 2008). The therapist can help to ease them into the transition period of caring for their loved one. The lines of communication must be clear and concise between the family members in order to decide which roles they will take on as their family member becomes incapacitated with the disease (Brown, & Chen, 2008; National Institute on Aging, 2012).

In order to nurture their ability to create, these factors are needed to facilitate this process, psychological safety, psychological freedom and the ability to receive stimulating and challenging experiences (Lee, & Adams, 2011). The creative atmosphere is a non-judgmental space; this is crucial for free expression of the patients’ ideas and emotions (Wald, 2003).

Knapp states that the use of diagnostic assessments is helpful in determining where the person is in their disease. It is using the diagnostic-drawing tests that the therapist is better able
to meet the person where they are (Knapp, 1992). There are several art-based assessments that can be utilized to help determine where the deficits are in respect to cognition, task performance, and other physical abilities (Wald, 2003). She suggests utilizing the Silver Drawing Test, free choice painting, drawing a clock to test for concept retention, execution and neglect and other exercises to test for organicity. Most of the time short-term memory loss and personality changes are two of the most predominant signs of dementia (Wald, 2003).

Some of the items to look for in the artwork are perseveration, fragmented images, disproportion of human figures and geometric shapes, and incomplete shapes (Wald, 2003). Although some of these items can be associated with other diseases such as Schizophrenia and other types of dementia, it is important to have the patient properly diagnosed with Alzheimer’s disease. Alzheimer’s disease affects the patient in integrating and organizing information, visual perception, processing sensory input, and organizing ideas into a comprehensive graphic modality (Wald, 2003; Malchiodi, 2003).

The therapist will need to talk with the patient and family members to get a clear idea about what they expect from art therapy and what their feelings are about the process (Carlson, Watts & Maniacci, 2006). The goal for patients is to express their emotions in either words or images and to access these emotions in a healthy and productive way. These expressions will help them feel connected to their family members as well as to other caregivers such as outside providers for example CNA’s, Home Health Nurses’, and other types of health care provider agencies. Through these expressions, they are able to share their stories and the wisdom they have gained throughout their life (Kamar, 1997).

These expressions can take family members; health professionals and caregivers by surprise because of the artwork produced by the patient can provide deep insight into what the
person who is experiencing dementia is feeling. By offering new ways of expression to people with dementia as well as people with other neurodegenerative diseases, we can provide a powerful link so they can communicate between their inner and outer worlds. Art expression is able to provide a bridge to the inner self, their bodies and is able to facilitate a self-discovery journey for the patient and their care giving team members (Institute of Health and Aging, 2012).

When working with people who have Alzheimer’s and other forms of dementia it is important to determine which stage of Alzheimer or dementia they are currently operating at and how engaged they are, the goal for the therapist is to meet them where they are in the disease (Kamar, 1997). Most individuals who have Alzheimer’s disease still want to engage with others even though they may not be able to form words or engage in conversation, they still want to be acknowledged (Halpern, 2013).

They have the desire to be creative and want to express themselves in order to establish a sense of self-worth, to facilitate the creative processes and enhance their sense of well being emotionally, cognitively, spiritually and physically. Art therapy is a process which allows individuals the space in which they can neither be wrong or right, there are no judgments, and the ability to explore images that explain their hopes, fears, dreams and most important of all their memories (Malchiodi, 2003).

It is the ability to utilize many different models and interventions of art therapy so that an art therapist can continue to use what works for individual patients according to the severity of the dementia. Each patient must have a custom, tailor fit therapeutic model so they can utilize these processes outside of the office in order to feel successful at conquering the emotions (Kamar, 1997). The attention span of each patient is different and what works for one patient does not necessarily work for the other.
Kamar states in the article that the groups, which are lead usually, consist of two ½ hours and depends on the group members’ attention span, level of functioning and other extenuating circumstances. Most art therapists will work within group settings for the Alzheimer’s patient because it seems to have a positive response with the participant. The participant can begin to participate and sometimes when the art therapist initiates cooperative drawing they can begin to participate with the others in the group. They can be encouraged to draw with staff, therapist and other group members (Kamar, 1997). Art therapy has been able to find alternatives to verbal communication and to allow people to express themselves and is a great way to work with the older individuals in care facilities.

Hattori and colleagues initiated a controlled study of individuals with mild Alzheimer’s disease to measure the benefits of art with this population. The criteria for this study were men and women aged 65-85 years old, and who were accompanied by their families to the hospital at least once a week. These patients showed mild forms of cognitive dysfunction when they were tested with the Mini-Mental State Examination and their scores were tabulated at a scale of 20 or lower. The National Institute of Neurological and Communicative Diseases and Stroke/Alzheimer’s Disease and Related Disorders Association (NINCDS-ADRDA) utilizes this screening for Alzheimer’s disease (Hattori, Hattori, Hokao, Mizushima & Mase, 2011). The study conducted by Hattori and colleagues, lasted for 12 weeks and was 45-minutes long, once a week at the hospital and each patient carried out a variety of tasks according to their capabilities for approximately 15 minutes daily, then comparisons were made before and after 12 sessions. The tasks consisted of drawing abstract patterns with pastel crayons or water-based paints.

According to results of the study after the designated period, comparison the baseline exhibited no changes between the two groups. These groups consisted of art-based interventions
versus performing calculations so at the end of the study period they were able to determine the effectiveness of art-based interventions as opposed to the calculation group in the Alzheimer’s disease patient (Hattori, Hattori, Hokao, Mizushima & Mase, 2011).

The researchers visited the participants 12 weeks after the study was conducted and noticed the patients exhibited “aggravation of cognitive function and vitality in both groups, which suggested that the continuation of intervention is desirable” (Hattori, Hattori, Hokao, Mizushima & Mase, 2011). In this study, the researchers determined the art therapy interventions used during the study does not have an absolute value.

Halpern at Bucknell University developed a study for Frontotemporal Dementia patients in order to determine the utilization of art with this population. Halperns’ goal was to document aesthetic responses in patients to novel paintings within a small group setting (Halpern, 2013). Persons with Frontotemporal Dementia patients have neural damage to the frontal and temporal lobes and as a whole exhibit fewer memory and visuospatial problems, but they have issues with language or changes in social and interpersonal behaviors, and they are sometimes younger in age than the typical Alzheimer’s patient (Halpern, 2013).

Some researchers have reported that patients have exhibited improvement or onset of artistic skills after a diagnosis of Frontotemporal Dementia. Halpern states that researchers followed an artist who had onset of FTD, but continued to produce art for more than ten years after her diagnosis. Although it is stated her style changed throughout the illness by becoming less precise and more impressionistic, she was still able to produce artwork. Her paintings were compared to her earlier pieces to determine the quality of artwork that she produced over the fifteen-year time span. It was determined that her technique had improved even though her attention to detail had declined (Halpern, 2013.)
The review article by Slayton, D’Archer and Kaplan states there is even more of a need to prove what art therapists have known intuitively, “that art heals”. Because we are in the second decade of the 21st century, there is a greater need for art therapists because of serious and complex trauma due to war, Traumatic Brain Injuries, highly addictive designer drugs, and mental health issues that weren’t an issue in the 20th century (Slayton, D’Archer, & Kaplan, 2010).

Slayton and colleagues looked at the review conducted by Reynolds, Nabors and Quinlan (2000) to pick up where Reynolds and colleagues leagues left off from their research to determine the efficacy of art therapy across all ages whether with clinical or non-clinical populations. Slayton and colleagues reviewed the academic journals in the field of art therapy and determined that there were a number of reports that they could study but after further investigation found that these studies were done before 1999. They did not include them in this review because the studies were combined with other treatment interventions. Slayton and colleagues state the lack of standardized reporting and utilization groups in art therapy research have been hard to demonstrate. The reason why is because the measured results as opposed to treatment outcomes historically have been hard to replicate. There are poor and vague descriptions of the treatment interventions, which make it hard to prove the study is valid and useful in treatment. This review is outside of other studies, which utilized other art-based interventions such as writing, music, movement and other expressive arts (Slayton, D’Archer, & Kaplan, 2010).

**Methodology**

When I was in the initial stages of developing the “Benefits of Art Therapy with Alzheimer’s Disease” education workshop, I was approached by Reverend Dr. Mildred L. Cox to
give a presentation to her support group at St. George’s Episcopal Church in St. Louis Park, Minnesota about art therapy. She stated it was a ministerial support group for families who had a family member with the diagnosis of Alzheimer’s or other neurodegenerative disease.

This ministry seeks to keep persons and families connected with the congregation for active involvement. The goals of the ministry are to keep members active in the congregation as long as possible and to provide resources, mental, emotional, and spiritual support that reflects the congregation they have known and been a part of over the years. The ministry will come to the person when they are no longer able to come to worship.

It is important to provide the emotional, spiritual, and religious support for individuals who are experiencing Alzheimer’s or dementia. Even though they are experiencing Dementia of Alzheimer’s type or other dementias, memories can be centered on their spiritual practice. It is with this background of a loving, caring supportive congregational family within the church and the clergy that these members are able to feel at ease (MacKinlay & Trevitt (2010).

The group at St. George’s has members of the community conduct talks throughout the year centered around therapies available to their loved ones. This ministry works with other churches, synagogues, and mosques in the area. The goal is to educate others in how to assist the members so they may lead a full life even in the face of Alzheimer’s and dementia.

**Description of Project Implemented**

The group was very interested in hearing about what art therapy is, how it is beneficial, and what resources were available to them in Minnesota. I worked with the church, Reverend Cox, and Adler Graduate School on developing the workshop in such a way as to answer all of their questions with the latest research on how art therapy works to ease the symptoms associated with Alzheimer’s disease, dementia and other neurodegenerative diseases.
I conferred with my chairperson, Dr. Marina Bluvshtein at Adler Graduate School to layout the points of information I wanted to cover in my presentation. Dr. Bluvshtein stated that when presenting a workshop of this type, it is commonplace for the audience to ask leading questions in which they will want you to diagnose their loved one or themselves.

I developed a PowerPoint that laid out the key points that I wanted to cover such as the prevalence of Alzheimer’s and the statistics of how many people will be struck with this deadly disease, and other key points that people would need to know about this disease.

I wanted to explain what art therapy is, what it does and what it doesn’t do. I also wanted to cover the points of how art therapy is different for everyone and how each therapy session is tailored to the individual needs of the patient. I also wanted to discuss how the patient with Alzheimer’s and other dementias could benefit from expressive therapies but mainly focus in on how art therapy can benefit the patient. It was after I received confirmation from my advisor, Rev. Dr. Cox and Father Paul at St. George’s, that I proceeded to make copies of the PowerPoint presentation to hand out to the participants as well as feedback forms for the audience.

I had several conversations with Father Paul at the church to get a feel for the use of technology for the presentation as well as how I would record the presentation for use later on. Father Paul explained that the church was not equipped for newer technology and that other presenters had a difficult time hooking up their laptop to the projector and spent a majority of their time trying to make it work. I decided that I would save myself the grief and do the low-tech version of handouts and no computer. A majority of the audience appreciated the handouts because as one woman stated she would like to be able to look at the information later when she got home.
Summary of Outcome

After I had given my presentation I felt there were several people in the audience who really connected with the information that I supplied them. In the presentation, I included a list of art therapists who practiced in the Twin Cities area and I stated that if they needed more information on therapists in the area they could contact the school or MNATA.

Several members came up to me after the presentation and told me they were so glad that I came because they had never heard of art therapy before and the presentation was very informative. They talked with me for several minutes afterwards and I felt that I was able to give them information they could use.

Conclusion

In conclusion, developing an art therapy program for older adults that incorporate art therapy as a therapeutic intervention is crucial for providers to include in their programming. In many cases, older adults who are actively involved in art therapy groups on a regular basis tend to be more social, remain vital in their communities, and are able to work on issues pertinent to the aging adult.

There is a fine line when working with older adults in choosing art media that is age appropriate. When selecting the art media, it is necessary to consider the manual dexterity of the patient, the cognitive ability, and the tactile sense for patients with dementia. All of the materials should be safe and non-toxic; such as crayons, finger paints, and other so-called regressive materials work well for patients who have cognitive loss (Abraham, 2005).

When working with adults who have early stages of dementia and who participate in art therapy programs they are able to include depth, proportion, appropriate use of colors, and also have great detail in their works (Halpern, 2013). Those who are experiencing moderate dementia
are able to utilize colors more appropriately and are able to attempt to draw some representational figures and forms. Those who are experiencing severe or profound dementia use the colors randomly and are not able to draw representational figures, forms, and will mostly scribble. Most of the time these participants will not participate at all, sometimes they will sit and watch others in the group draw and paint, eventually they will start to pick up paint brushes, pencils, and start to doodle (Abraham, 2005).

It has been stated that painting is a visual process it allows the brain to incorporate the visual pathways in the brain, the ventral and the dorsal pathway. These two pathways enable a person to perceive and represent space and the posterior parietal lobes are the key to person’s ability to produce art. It is both of the hemispheres of the brain that are involved in making art (Safar & Press, 2011).

Since there are varying degrees of dementias the changes in the art making will be different for each person and their diagnosis. The artwork with someone who has Alzheimer’s disease will gradually become more simplistic and someone who has been diagnosed with frontotemporal dementia (FTD) will sometimes experience the opposite, whereas his or her artistic skills have developed after onset of the disease (Halpern, 2013). There have been reports where the individual has developed artistic skills that have allowed them to make realistic, more detailed art even though they were nearly mute towards the end of their disease. There are cases where this has been reported, but each person and their diagnosis is different and their treatment plan must be tailor made and suited for each patient (Wald, 2003).

Even though it is helpful for the diagnostic indicators to rule out other diseases, it is important to stimulate the healthy parts of the brain. It is important for art therapists and other
healthcare professionals to understand that the art making process is necessary for the patient with Alzheimer’s disease to be able to keep those areas of the brain strong.

At the time of this writing, scientists are working feverishly to unravel the mysteries of this disease with its tangles and plaques in the brain that cause this disease. The mental health professionals must find new and better ways to reach these patients and allow them alternative ways to communicate with their loved ones. It is with this ability to communicate, they will be able to engage in personal relationships with those around them either in long-term nursing facilities or within their homes.

As mental health professionals, we have come a long way in helping society understand how to help persons with dementia Alzheimer’s and other types to become better able to express themselves through the medium of art. But it is up to us to keep initiating and advocating for more research studies and to utilize the scientific findings, so the people we care for can live a better and more fulfilling life. The patient who participates in an art therapy program is able to utilize new skills and we need to focus on those new skills rather than what is lost.
ART THERAPY WITH NEURODEGENERATIVE DISEASES

References


