5-1980

Life-Enhancement with Art Therapy for the Institutionalized Aged

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by

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May, 1980

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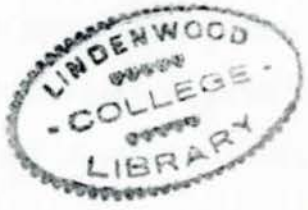
Submitted in partial fulfillment of

the requirements for the degree

of Master of Arts

The Lindenwood Colleges



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The aging of the populace is causing Americans to consider the ways in which education, medicine, housing, and leisure will be affected by this rapid growth. In this paper I will review some of the literature on aging that delineates the individual differences in physical and mental characteristics of the old. Some of the more prominent theories of the aging process will be presented briefly, with an examination of physical and psychological changes that affect the older person's ability to cope with an environment characterized by multiple loss, both physical and emotional. Myths about how age influences the capabilities of the aging person will be looked at, including what roles society perceives for its oldest citizens. Some sociological implications of earlier and mandatory retirement on leisure activity will be included. The disengagement and activity theories of normal aging are described. The issue of dependency for the elderly and some of the initiating causes of institutionalization will be discussed.

The purpose of examining aging and the principles of art therapy in this paper is to propose that art therapy can be a means of enriching the lives of many old persons who can no longer live in the community. The introduction of art therapy and art activities with institutionalized aged, with the goal of increasing the possibilities for better verbal and nonverbal communication, is explored by the presentation of some case studies of several residents in a Jewish center for aged. Jewish values and perspectives on the care of its

elders are reviewed. Some suggestions for appropriate creative activities with older persons are presented.

For more than a dozen years and at an accelerated tempo, writings have been appearing about the human problems of the aging process in present day society. I will review some of the more significant theories of aging and senescence, examining the biological, psychological and sociological aspects. Some behavioral patterns that emerge with advanced age will be considered in an attempt to understand their implication for doing art therapy with the aged. An overview will be given of some basic literature of art therapy with the purpose of understanding its application for use with a particular population, the institutionalized elderly. The limitations of this paper do not permit an exhaustive treatment of the subject of age or art therapy. Rather, its ideas are presented with the intent of increasing and understanding the possibilities for using the creative process to enhance the lives of the special population mentioned above.

Theories of Aging

Age an Individual Process

When is a person old? Neugarten suggests that it may be when one emotionally realizes that the road yet to walk is shorter than the one already traveled. (Smith, 1972) The answer to when old age arrives is far different for the baseball player than for the grim-faced man sitting in the hall of the nursing home. Aging takes place every day and along myriad paths for each human being, with various meanings for various persons.

In earlier cultures parents had little time left to rest from their labors once their child-rearing tasks were accomplished. At the turn of the century the average life expectancy was 47 years, (Butler, 1975) but a boy born today can expect to live to 66.8 years and a girl to 74.3. New medical advances and lowered infant mortality rates have contributed to the population explosion of those in this country who are 65 years of age or older.

Fastest Growing Segment of Population

This fastest-growing segment of the population now numbers over twenty-four million. Research in cancer and heart and vascular diseases could increase the average lifespan from ten to fifteen years by the beginning of the next century. Public health experts and demographers regard the ever growing elderly population not only as a triumph over disease but also as 'the aging dilemma'.

Because of their growing numbers and high visibility we can reasonably assume that this phenomenon will necessitate changes in every part of society. Research into the aging process has lagged in relation to need. The medical specialty known as gerontology has only recently been included in medical school training. Research is beginning to show that some of the physical, mental, and emotional conditions seen in old people are the result of disease, and not due to normal aging processes. (Smith, 1972)

Arbitrary Definitions of Age

Society's choice of age 65 as the beginning of old age is an arbitrary one. The scant research into the diseases and difficulties of later life has been concentrated on the 5 percent of the elderly who are in institutions. (Butler, 1975) Many of the debilitating diseases of older age do not begin there.

Primary aging is said to occur when one's functions decline; as one grows older, these include speed and strength of response. According to Smith (1972), secondary processes such as heart disease, strokes, or debilitating injuries may cause faster biological aging. Much of the research in gerontology being carried out today is an effort to clarify the interwoven elements necessary to produce and support physical and mental health until the very end of life.

For most of us it is decidedly unpleasant when we realize that no matter how well we care for ourselves, and even though we escape natural disaster, accidents and disease, our progressive loss of energies and the ability to resist disease will result in aging and eventual death.

No Universal Theory of Aging

While no one theory of aging is universally accepted, aging can be described in terms of observable changes that occur fairly consistently from individual to individual, with advancing age. Biologists refer to aging as senescence, a process of deterioration resulting in decreasing vitality and increasing vulnerability. Senescence affects individual members of the species in varying ways, and the time required

for senescence to end in death varies greatly. Aging in its broadest sense defines the accumulation of changes in an individual throughout the course of life from birth to death. Senescence, a more specific term, refers to changes occuring after maturation, and terminating in death.

Biological Aspects of Aging

Senescence

The research currently underway on over a half dozen different major theories of senescence has failed to produce firm results as to the causes. However, it is possible to identify differentiating criteria from other biological processes: the criteria must be universal, appearing in all people; senescence comes from within the organism; and characteristics are gradual rather than sudden. "Finally, the processes of senescence contribute to the decline in function and consequent increased mortality which we observe as the organism ages. The changes which mark senescence thus have a deleterious effect on the organism." (Strehler, 1962)

Curtis (1966) has catalogued a wide range of theories of biological senescence, illustrating that it is not a single process, but many.

"Wear and Tear" Theory

The most frequently proposed is the "wear and tear" theory. The idea here is that the body's parts, like those in a machine, wear out

from constant use, and then the machine breaks down. Though this theory is true in a limited sense, it falls short in the fact that no specific organ wears out in all older people.

Age Biologically Programmed

Another theory claims that the amount of life to be lived is individually fixed. DeBeauvoir (1972) in referring to this theory quotes Escoffier-Lambiotte: "So it appears that aging and subsequent death are not related to a certain level of expenditure of energy, a given number of heart-beats, but that they occur when a set programme of growth and ripening reaches its end." This theory has largely been discredited by research giving evidence to the body's remarkable ability in many cases to heal itself.

Waste Product Theory

The "waste product" theory assigns the body's chemical wastes a key role in senescence, but it has not been shown that their collection in certain tissues has any effect on cell function.

Curtis (1966) says that collagen, a connective substance present in most organs, gets stiffer with age and causes those tissues affected to age. Excessive collagen in tissues may decrease function, but apparently it is not a basic cause of aging.

Autoimmune Theory

The "autoimmunity" theory holds that as the body ages, mutant cells produce proteins which then act as foreign bodies; this is

called autoimmune reaction. Several diseases of old age such as rheumatoid arthritis are known to be caused by autoimmune reactions; others, such as diabetes have not been linked with autoimmune reactions. (Walford, 1964)

Mutation Theory

The "mutation" theory has probably received the most support from scientific research. It relates to the process in which cells are controlled by genetic material (DNA). Once mutations in DNA occur, they will be perpetuated by cell divisions and most of the cells in an organ may become mutated. Most mutations are destructive; they function less efficiently, and organs consisting of these cells become senescent. There is still an unknown mediating factor which geneticists can not explain: in some cases genetic mutations may increase many times over without the usual shortened life expectancy.

Heredity's Role

Heredity may account for the extreme variability of human aging. Atchley (1972) points out that there is moderate correlation between the longevity of parents and that of their children. Among twins who have been separated and exposed to different environmental influences, marked similarities are seen in bodily characteristics and longevity. The strong influence of hereditary factors becomes clearly apparent in research done in isolated communities where, because of their isolation, marriage between close relatives has been commonplace for generations. (Bortz, 1963) The result of the

inbreeding was a high incidence of hereditary diseases associated with old age.

From birth to old age the individual is subject to a great variety and complexity of internal and external influences. The most important of these influences may be classified as biological, psychological, and sociological. All of these factors are interdependent processes, each having importance according to one's particular experience of aging.

Pyschological Aspects of Old Age

Changing Roles

Psychological age refers to the individual's environmental adaptation capacity. There is a pattern to the developmental tasks that one must accomplish in connection with differing roles to be played in outstanding events of life such as marriage, childbirth, changes in career and residence, loss of loved ones, death of spouse, and retirement. Failure to adapt to a new role may result in crisis or in illness.

Sensory and Perceptual Processes

Age-related changes in sensory and psychomotor processes lie at the heart of the individual's social functioning. Sensory impairments, says Butler (1975), are particularly important in old age because they contribute to depression, anxiety, suspiciousness, and accidents. Many of these impairments go undetected and untreated. Hearing impairment initially affects the higher frequencies after the age of 50.

Over 29% of the over-65 population have significant hearing loss according to a 1964 national health survey. Ten percent of the elderly population have some impairment of vision. About 86 percent of persons 65 and older have one or more chronic conditions, from mild aches and pains to long-term disability; on the other hand, Butler (1975) says that acute and chronic health problems do not keep the majority of elderly from being active and independent.

Reversible brain syndromes that could possibly be provoked by treatable ailments such as anemia, infection, drug reactions, head trauma, alcohol, or reaction to surgery are widely misdiagnosed. If not diagnosed and treated promptly, reversible brain syndrome becomes chronic and irreversible. Depression, especially common in the institutionalized aged, can cause the same symptoms as reversible brain disorders, but when properly diagnosed responds to treatment.

Senility in old people, according to Dr. Morton Leeds, is the biggest single health problem facing our aging population today. He describes it as a process of decline; some of the symptoms are forgetfulness, disorientation for time, place, and person, and regression. Senile psychosis comes about with actual atrophy of the brain cells. When it occurs the patient begins to change personal living habits. Serious errors of judgement become frequent and delusional traits may develop.

The second most common disorder in the elderly is psychosis associated with cerebral arteriosclerosis, hardening of the blood vessels of the brain. Many of its behavioral components are the same as those mentioned above connected with senile brain disease.

Fortunately, the majority of older people show a relatively mild decline in mental functioning in later years. Those in nursing homes with psychiatric disorders have been variously estimated. Alvin Goldfarb (1962) found that 87 percent of patients showed significant evidence of chronic brain syndrome. Dienstfrey and Lederer (1979) in a more recent estimate, set the percentage at only 60 percent senile in nursing home patients over 65. Psychiatric symptoms usually accompany such brain damage. The incidence of severe mental disturbance accelerates with late old age. The average age of entry into nursing homes is advancing--Butler found in 1975 that it was approaching 84. Because the persons entering institutions are sicker, it becomes imperative that a wide range of services be provided.

Declines in the efficiency of the central nervous system make for slower reaction time, but all age groups can learn (in the absence of disease) if given a bit more time. There is diminution in small-muscle skills, and complex task performance suffers.

There is also a gradual decline with age in the evaluation process by which sensory information is organized. This process, which we call perception, functions for every conscious sensory input. Closure is the ability to come to a decision about what is perceived. What may appear to be indecisiveness on the part of some of the elderly may be accounted for in part by waning capability of closure. These declines in sensory and perceptual processes do not often appear to hamper behavior until after age seventy. "Until that time, disease and other unique circumstances would appear to be more relevant than an intrinsic age-related change would be." (Birren, 1964)

Memory

It is commonly believed that all types of memory show a decline as persons age; however, studies do not support this idea. There are three stages of the memory process: registration of perceptions, retention over time of what was registered, and recall, or retrieval of what was registered and retained. If any of the stages is short-circuited, memory dysfunction results. Botwinick (1967) points out that there appears to be greater loss with age in short-term or recent memory (involving recall after very little delay) than in remote or old memory, and the decline with age in memory function is less for rote than for logical memory. As age increases, the retention of things heard becomes increasingly superior to the retention of things seen, and use of both gives better results than the use of either separately.

Bright people are less susceptible to memory loss with increasing age than their less intelligent counterparts, and some older people escape memory loss altogether. People who exercise their memories tend to maintain both remote and recent memory.

Problem-solving and Productivity

Thinking is the process of developing new ideas, or concepts. Older people have been found to resist making the logical inferences and generalizations involved in concept formation. Part of the consistent decline in performance in this area may be due to the fact that past training and experience of older people leaves them ill-prepared to deal with abstract items found on most tests of thinking

ability. The schools of over fifty years ago did not emphasize the skills of inference and generalization. "There have been studies which suggest that those who retain the greatest degree of verbal facility in old age are also those who retain the greatest amount of skill in concept formation." (Atchley, 1972)

Problem-solving means making choices and decisions involving the use of acquired skills and perceptions. Older persons are at a disadvantage if many items of information must be dealt with at the same time. They have trouble interpreting stimuli presented as well as recalling information later when needed to reach a solution.

The idea that the elderly are unproductive and lack the ability to do creative work is disputed by Butler (1970), who cites that the elderly manage to acquire about a third of their aggregate income by working. More would work if not inhibited from doing so by society.

Studies indicate that creativity peaks in the thirties, and declines very gradually thereafter. Other studies show that as age increases the elderly spend less time in creative pursuits, presumably due to declining energy levels. (Atchley, 1972) Clearly, what passes for low energy levels in many of the aged may be boredom and apathy, the result of limited stimulation and the lack of any meaningful activity.

Creativity

Michelangelo, Tennyson, Verdi, Freud and more recently Horowitz, Churchill, Schweitzer, and Margaret Meade are examples of creative

individuals whose creativity lasted into old age. Creativity occurs not only in the famous but is common in everyday life. Butler (1975) says that these creative older people are lively, resourceful and highly adaptive, actively involved in voluntary as well as paid roles.

Potential for Change

The late Rabbi Abraham Heschel spoke at the 1961 White House Conference on Aging about the capacity of the person at older ages to grow and change:

> Our work for the advanced in years is handicapped by our clinging to the dogmatic belief in the immutability of man. We conceive of his inner life as a closed system, as an automatic, unilinear, irreversible process which cannot be altered, and of old age as a stage of stagnation into which a person enters with his habits, follies, and prejudices. To be good to the old is to cater to their prejudices and eccentricities.
>
> May I suggest that man's potential for change and growth is much greater than we are willing to admit and that old age be regarded not as the age of stagnation but as the age of opportunities for inner growth?
>
> The years of old age may enable us to attain the high values we failed to sense, the insights we have missed, the wisdom we ignored. They are indeed formative years, rich in possibilities to unlearn the follies of a lifetime, to see through

> inbred self-deceptions, to deepen understanding and compassion, to widen the horizon of honesty, to refine the sense of fairness. (Butler, 1975)

Life Review

One of the myths about the old is that they are "living in the past". Because the elderly living in the community have not been studied as often or as much as the mentally disturbed in institutions, and because garrulousness and reminiscence are frequent in these persons, the tendency has been to devalue the significance and content of this life reviewing activity.

In New Thoughts on Old Age, Kastenbaum (1964) includes a chapter by Butler dealing with the universality of occurrence of the mental process of life review in the aged. The reconsideration of life's past events occurs not only in the elderly, but also in younger persons as response to crises of varying types, death being but one. It is the internal perception of approaching death, however, that instigates this naturally-occurring life review process in the old. It is characterized by the progressive return to consciousness of past experiences, especially the resurgence of unresolved conflict; simultaneously and normally, these revived experiences and conflicts are surveyed and integrated. It seems likely that in the majority of the elderly, a substantial reorganization of the personality does occur, and may account for the development of such qualities as wisdom and serenity noted in some old people. (Butler's judgement that "serenity" and "wisdom" are supremely appropriate for every person's old age is

his own bias, and not shared by everyone working with the old: I am one.)

Not all life review has constructive outcomes. The aged reviewer may experience varied behavioral and affective states, especially severe depression or intense guilt. The more affective consequences would appear to occur when the process proceeds in isolation in those whose lives have experienced notable discontinuities, increasing contraction, and psychosocial disruptions. (Butler, 1964)

Motivation and Age

"For obvious reasons, motives are an important aspect of human behavior, but we know very little about them. What evidence there is indicates that age changes in capacity for motivation are very slight." (Botwinick, 1959) Botwinick suggests that the role of motivation in the behavior of older people cannot be understood outside the specific situation in which it occurs. Energy and drive on the part of the elderly in an institutional setting are capable of turning into apathy and disinterest if activities which promote the aged residents' self-worth, usefulness and self-esteem are not provided. As Kuhlen has stated:

> A society or culture decrees in many subtle ways, and in some not so subtle, that certain types of stimulation will be brought to bear on certain age groups, and largely withheld from those of other ages . . . Moreover, since the motivational tendencies of people are very largely learned as a result of

> the reward and punishment systems to which they are exposed during the course of early development, it is reasonable to expect that motives may be changed during adulthood if the individual is exposed to a new set of punishment and reward patterns.

Kuhlen has also advanced the notion that in early adult years, growth-expansion motives predominate, while changes related to work and family structure may cause anxiety to dominate the later adult years. "This anxiety . . . is especially important as a generator of handicapping behavior patterns . . . conservatism, intolerance of ambiguity, and rigidity . . . utilized to control the anxiety." (1964)

Studies of adult personality, with emphasis on the effects of age, are reported in Neugarten's Personality in Middle and Late Life. With increasing age, the ability of a certain number of the old to relate emotionally to people or objects tends to decline. Along with increased interiority there seems to go decreased complexity of the personality, as well as increased separation from the environment. Self concept tends to remain stable in later life because former roles in life can still be used to enhance the ego. However, self-esteem is more volatile as persons age, and defense mechanisms such as selective perception--for example, avoidance or downgrading of people apt to give negative feedback, or as in one study in which the majority of people over seventy were found to identify with "middle-aged" rather than "old" (Kuhlen, 1964)--can be used by older persons to control the influence of social interaction on self-esteem.

Sociological Aspects of Old Age

Retirement

Retirement probably requires the most adaptation of the older person and brings the most crucial changes, whether retirement was forced or voluntary. Work usually provides the person with a meaningful group and social situation. With removal from the working environment, a social void not easily filled may occur. But reaction to retirement varies with the individual, depending on whether there has been planning for it, on health, and especially on economic factors. Most persons have less than half of their former income after retirement. With the accelerating rate of inflation and so few of the elderly having assets in addition to the Social Security, 60 percent of the aged in America are poor.

The majority of all women over 65 are widows. Widowhood in our society severely curtails their former social involvements. Since there are 134 women to every 100 men over 65, remarriage and social companionship with men are also limited.

Dependency

Dependency is probably the role most dreaded by the old. Self-sufficiency is a deeply ingrained value for most persons; the aged especially fear the necessity for dependence on their adult children, yet about a third of older Americans find themselves having to ask children for some kind of help at one point or another. (Riley & Foner, 1968)

Another role the older person is likely to experience is disability, which occurs in varying degrees but when extreme, results in dependency. A third of the old have some disability serious enough to limit their ability to engage in normal activities or work. As mentioned earlier, 5 percent of the older population reside in nursing homes or homes for the aged. Most of the old have an extremely negative attitude toward institutionalized living; opportunities for contacts in the former community and useful activities markedly decline, and may contribute to lowered morale and depression. Kahana (1971) points out that individuals in institutions are less likely to have a living spouse or children and are more likely to have lived alone than comparable aged living in the community. Half of the persons in institutions are on public assistance, although this is true of only 12 percent in the general population of aged. Only a minority of the impaired elderly move to institutions, but those who do tend to have both mental and phsyical disabilities.

Retirement, widowhood, dependency, disability and institutional living are negative changes that many elderly face. Singly or in combination they stand as barriers to role stability as the person grows older. Although the trend for long-term care of the aged in the past decade has shifted in orientation from custodial to therapeutic, with its aim to decentralize the services and facilities dealing with social problems of the old (Zibit, 1971), there will continue to be those living in institutions who can no longer manage to live in the community. Lieberman (1969) points out that depersonalization results from

institutional living. As will be noted later, these changes contribute to the extreme difficulty an art therapist experiences in starting new therapeutic groups, or even in doing individual art therapy with residents: many become dependent and apathetic once the freedom to make choices about everyday living conditions is gone.

Disengagement Theory

At present there are two main, contrasting theories of successful aging, the activity theory and the disengagement theory. (Cumming & Henry, 1961) Briefly, the disengagement theory proposes that in the absence of pathology, normal aging is a mutual withdrawal or "disengagement" between the aging person and others in the social system to which he belongs--a withdrawal initiated by the individual himself, or by others in the system. When disengagment is complete, the equilibrium that existed in middle life between the individual and society has given way to a new equilibrium characterized by greater distance and changed interests.

Activity Theory

The activity theory proposes that except for changes in biology and health, older people have the same psychological and social needs as when they were middle-aged. In this view, the decreased social interaction characteristic of many old people results from society's withdrawal from the aging person; the withdrawal is said to be counter to the wishes of the old. The older person who ages optimally actively

resists the shrinking of the social milieu, maintains the activities of middle age as long as possible, and find substitutes for work lost in retirement and for losses of friends and loved ones by death. Havighurst and associates (1964) did a six-year study to test the activity and disengagement theories for life satisfaction and successful aging. Havighurst states that data on the activity, satisfaction, and personality dimensions of aging show that personality is the pivotal dimension in predicting relationships between level of activity and life satisfaction.

Neugarten (1964) did a study of personality variables that presumably reflect the aged individual's readiness to meet and anticipate society's response, sensitivity to the expectations of others, and other characteristics reinforced by social interaction. The findings were that eccentricity and egocentricity develop not merely in response to relative social isolation, but also in response to processes of change in the individual.

Recreation and Leisure

With departure of the last child and upon retirement from work, people gradually expand time spent in leisure. The problem is whether the leisure activities are capable of giving the person the self-respect and identity that the job or homemaking role provided. People who have worked at manual labor or relatively unskilled kinds of jobs welcome retirement. Middle-status people whose jobs have been oriented around people and have required considerable interpersonal

skills seem to adjust most successfully to the post-retirement phase, since there are more opportunities to use these skills with increased leisure. (Simpson, Back & McKinney, 1966)

Some of the elderly are hamstrung with an ethic that does not allow "play" without work; this fact makes particularly difficult the involvement of the elderly in purely esthetic activities, and doubly so in cases where the old are depressed from the effects of institutionalization. The less well-educated tend to feel incompetent about engaging in autonomous activities such as reading, listening to music, painting, sculpting, or writing. (Atchley, 1972) But for the minority of persons who have developed consistent reading habits over the years, books become "friends" to replace the loss of loved ones.

Television watching is the major leisure pursuit among all people in American society. Only a small proportion of older persons occupy themselves with crafts, hobbies, or artistic activities. Atchley (1972) points out that the learning necessary for a full-blown leisure lifestyle must begin early, due to the extreme stability of earlier activity patterns. Many gerontologists are pessimistic about the possibility of resocializing older people into a life of leisure, based on the slow-down in learning speed and the reluctance of most older people to attempt anything entirely new.

DeBeauvoir, in speaking of the lack of meaningful goals that occurs in the lives of many persons in late age, explains:

> The greatest good fortune, even greater than health, for the old person is to have his world still inhabited by

> projects: then, busy and useful, he escapes both from boredom and decay . . . he is not compelled to adopt the defensive or aggressive forms of behavior that are so often characteristic of the final years. (1972)

Principles of Art Therapy

There has not been a great deal written about art therapy with the elderly population. As the proportion of old persons grows ever larger the need for opportunities for artistic expression, which can be a natural and vital aspect of life for persons of all ages, grows also. Because the aged are part of a general population which does not express itself by artistic means, Durkee (1964) suggests, there are inhibiting factors more specific to the aged themselves which help to further explain their non-participation in art activity. When today's aged were in school, art was chiefly copy-work; those who could not copy well were targets for criticism. Deteriorating ego strength makes the aged particularly reluctant to undertake activities as visible as the graphic arts or sculpture, which could leave them vulnerable to criticism.

"On the brighter side is the fact that some aging persons do participate in creative art activity. Those who do are aware of its values." (1964) Durkee attributes this expansion of creative activity to the need for expanded meaning to parallel medicine's extension of life itself.

Dynamically Oriented Art Therapy

The earliest research in dynamically oriented art therapy dates back to 1941, when Margaret Naumburg, its recognized parent/founder, began her work with behavior problem children at the New York Psychiatric Institute. Years of directing free, spontaneous art expression at Walden School had convinced her that it constitutes a symbolic form of speech. After working with both children and adults in psychiatric hospitals in New York and Philadelphia, Naumburg developed training seminars in art therapy. In 1958 she established the first graduate program in art therapy at New York University. It dealt with a psychoanalytic understanding of the creative process:

> The process of dynamically oriented art therapy is based on the recognition that man's fundamental thoughts and feelings are derived from the unconscious and often reach expression in images rather than words . . . By means of pictorial projection, art therapy encourages a method of symbolic communication between patient and therapist. (Naumburg, 1966)

Dynamically oriented art therapy is useful to all patients capable of insight. The therapist helps the patient uncover the inner meaning of his symbolic designs by the use of free association and recovery of the mood of his drawings. This process often leads to a speeding up of verbalization about the patient's conflicts, frustrations or problems. Visual forms of expression have been basic to societies

throughout history. Art critics and psychologists have observed that "the kind of symbolism chosen by man in his visual productions from pre-history to the present has certain strikingly similar elements." (1966)

In general, insight therapy is not applicable to elderly institutionalized patients. Exercises with art media that allow the patient to experience some immediate success can help maintain a tenuous self-esteem. Art activities in which the therapist gives assignments that encourage organized thinking help those patients who are fast losing reality orientation. An example of the former is sponge-painting: small cellulose sponges dipped in bright poster paints yield quick abstract compositions when printed on manila paper. A cardboard stencil of circles, a square, and a triangle makes it easy to produce colorful designs, using colored felt tip pens to trace and color shapes.

"Art therapy" is currently used to describe widely varying uses of art in both educational and therapeutic settings. Its practitioners range from workers in special schools, psychiatrists who use patients' graphic projections in psychiatric practice, to persons whose training has been according to guidelines set by the American Art Therapy Association. "Possibly the only thing common to all their activities," says Elinor Ulman (Ulman & Dachinger, 1975), "is that the materials of the visual arts are used in some attempt to assist integration or reintegration of personality."

Psychoanalytic Mode

Numerous modifications of method have been developed by art therapists according to their own preference as well as the particular needs of the institution in which they work. Individual art therapy is usually limited to circumstances where long-term psychotherapy is possible. Art therapy in this psychoanalytic mode is generally interpretive, and art productions are encouraged primarily for their immediate communicative use. Whether individual therapy is the primary mode of treatment or supplements conventional psychotherapy the art therapist must have psychotherapy skills or be adequately supervised. (Valletutti & Christoplos, 1977) In institutions for the aged, individual art therapy, when it can be arranged, is very helpful in providing for ventilation of personal frustrations and problems, for the expression of emotional conflicts through art media, and especially in connection with the life review process.

Use in Family Evaluation and Therapy

Similar to psychiatric trends of the 1960's and 1970's, methods of family evaluation and therapy were developed by Hanna Y. Kwiatowska in 1958. These formal art therapy groups begun at the National Institute of Mental Health were especially designed for young hospitalized patients and members of their families; all were at the same time receiving intensive family therapy. The art productions serve as a springboard for group discussion, especially where there are difficulties with verbal communication between family members. (Kwiatowska, 1967b)

Psycho-educational Mode

In psycho-educational modes of art therapy informal groups of patients work in the same room at the same time, but each working on individual art productions, working at his or her own level, encouraged by the art therapist to use art materials expressively. Informal groups will vary in size according to circumstance and the kind and degree of patient disability. The therapeutically oriented art class is appropriate in working with older persons where the use of words and emphasis on insight is subordinated to creative activity that gives social returns and satisfactions.

Gestalt Art Therapy

There now exists a large body of art therapy practice which synthesizes psychoanalytic principles and the principles of humanistic psychology, focusing on individual creativity. Fully acknowledging their debt to Freud, these therapists have enriched and broadened the field by incorporating many of the contributions of the human potential movement into their art therapy. Janie Rhyne is representative of this group. Rhyne, in the book The Gestalt Art Experience (1973), puts emphasis on using art as a tool in the process of life-enrichment and self-perception for persons who are not suffering severe mental or emotional impairment. There is less importance placed on verbalizing the conflicts than in some art therapy modalities; the immediate experience of making art works is the essence of the

therapeutic process. Although there may be a few protective cases of the elderly in institutional settings who would be greatly benefitted by this modality, the fact that most nursing home residents are quite elderly and usually have one or more chronic disabilities would probably contraindicate its widespread appropriateness.

Some Basic Requirements for an Art Therapy Program

It is important that art therapy should be separated from other activities for which art materials are used -- a room of its own. There should be running water and storage space for art supplies and finished work. Wall space that can be used to display pictures is necessary. If possible there should be shelves for display of sculpture, and a kiln for firing clay pieces. Plentiful supplies of basic media should be available, including rolls of brown paper, paper of various sizes, poster paints, sturdy brushes and sculptor's clay. (Valletutti & Christoplos, 1977) These simple-sounding requirements are actually difficult to be found in institutions for the aged. The art therapist often finds it necessary to function in conjunction with recreation or occupational therapy departments; an attitude of cooperation and respect between each group who uses art in their practice should enable them to share peacefully their common ground. (But not simultaneously, as I found myself doing during my practicum.)

As a practicum student in an Orthodox Jewish institution for the elderly I felt it would be helpful to me to do some research into Jewish values and perspectives on aging. With this in mind I reviewed a paper that Dr. Robert L. Katz presented in 1974 to a workshop of theologians from Protestant, Catholic and Jewish seminaries. Their purpose for convening was to examine theological implications for the aging process. The Orthodox Jewish perspective includes a traditional view of the use of leisure in old age. The workshop was in response to needs expressed by many religious leaders for fundamental theological reflection on their programs, actual and potential, for older person.

Katz, a professor of Religion, Ethics, and Human Relations at Hebrew Union College - Jewish Institute of Religion, noted that the Bible contains many statements mandating respect for the aged, and quoted sources in Leviticus ("Thou shalt rise up before the hoary head and honor the face of the old man." 19:32), Proverbs ("the hoary head is a crown of glory." 16:31), and Job ("Wisdom is with the aged, and understanding is the length of days." 12:12). In the post-biblical Mishnah we are informed that learning from the aged is like drinking old wine, and a Talmudic source goes so far as to maintain that as scholars grow older, they grow wiser. (Hiltner, 1979)

The Jewish community has historically demonstrated exemplary care for the aged and expressed this concern with institutions meeting their needs. Katz states, "In the Jewish religious system, it was the elders who interpreted the Torah, who transmitted it to successive generations,

and who, in terms of family structure and in the value-set of Judaism, commanded a loving authority and respect . . . the tradition-directed, as contrasted with the 'inner- and other-directed' (Riesman, 1950) could be taken as a paradigm for the role of the mature, if not the aged, in the Jewish family system." As the custodians of tradition, the aged enjoyed preferential and revered status.

Much like Erikson's (1950) modern social science model of the life cycle, the Eight Stages of Man, and the ancient reference by Hippocrates (357 B.C.) to the Seven Ages of Man, there is in Jewish culture the concept of the stages of life, with the sense of a change in status with chronological aging, each age having particular functions. The most familiar description is found in the Mishnah, Ethics of the Fathers, with role-descriptions for the stages of life catalogued for the ages of 5, 10, 13, 15, 18, 20, 30, 40, 50, 60, 70, 80, 90, and 100!

Intergenerational conflict, a recurrent theme in all cultures relating to the competition for power and status, appears in Jewish biblical tradition as the fifth commandment, "Honor thy father and thy mother", given to Moses presumably because such honor was not consistently bestowed. Reconciliation between the generations is envisioned. Katz quotes the Biblical prophet Joel:

> And it shall come to pass afterward,
> that I will pour out my spirit on all flesh;
> your sons and daughters shall prophesy
> your old men shall dream dreams,
> and your young men shall see visions.

We in contemporary America need, Katz says, to recognize the economic basis of our ideology of aging. A philosophy that esteems individual worth in terms of productivity, and yields to a lifestyle of consumerism with the pervasive stress of upward striving is especially uncongenial to the elderly. It is middle-class bias that makes one assume that the age of retirement calls for restructuring lives and redefining relationships; actually, these changes are functions of socioeconomic position, not of chronological age. The wealthy aged still enjoy privileged status, nor do they suffer rolelessness. Katz calls for a changed value orientation toward aging that would allow old age to be a time when the meaning of each day is relished. No longer pressured by guilt (of unproductivity), the old would be free to enjoy leisure and savor the remainder of life.

The main thrust, Katz concludes, in Jewish tradition having reference to aging is toward a belief that the universe is not hostile to man's hope for fulfillment. Therefore there is no reason for a person or group to compromise their expectation for a life lived to the fullest until its end.

> Life becomes an unending Sabbath for the individual attaining the years of maturity; . . . Nothing captures the essence of the theology of aging in Judaism as does the concept of aging as the Sabbath of the soul with its rich possibilities for self-realization. (Lamm, 1971)

Vital to the understanding of that which Jewish sources contribute to the issue of aging is the distinct difference from other religious

traditions in the meaning of work. He comments that the work ethic of the Western world makes an individual's work his primary source of self-image, self-esteem and identity. The lack of role or disengagement from work is dreaded because loss of status in the community results, often leading to isolation. In the Messianic thought of Judaism, old age is not abased but is honored. The cessation of work, rather than leading to idleness, offers the elderly leisure in which to cultivate one's soul and its potentialities. In Judaism we encounter a magnificent defense of leisure, and a perspective that can be stimulating to those seeking new values for the aging and for those who would serve their needs.

Description of Agency

For the past six months I have been doing an art therapy internship at a Jewish center for the elderly in a midwestern city. Although located in its newer quarters only five years, this center was organized nearly 75 years ago by the Orthodox Jewish community for its aged, and began with ten residents. Now it is a 288-bed facility, with a large board of directors who serve voluntarily to establish policy, determine the budget and through its committees maintains liaison with various community agencies who provide services.

In 1957 a study by the Jewish Federation on development of a coordinated plan of services for the old and chronically ill resulted in a change in the agency's admissions policy. Consistent with more recent concepts is care of the aged with emphasis upon helping persons to remain in the community as long as possible. With institutionalization considered a last resort, only those elderly persons who could no longer be maintained in the community, the chronically ill, were to be admitted. The facilities were greatly enlarged and this policy for entrance and type of care provided has been in effect up to the present. Now the residents are older and have more serious illnesses than in many homes for aged and retirement communities. At present the average age of the residents is 84. (Seventy percent of all persons in Old-Age Institutions, according to Manard, Kart & van Gils [1975] are over 75 years old.) About two-thirds are nursing type patients and a third protective type cases. At the time this change took place it was recognized that adequate social work services

should be provided by the agency for all persons for whom it accepts responsibility. The main thrust of this particular agency's philosophy is stated thus in its Operations Manual:

> The philosophy of _____ is that we can help people to adjust to their later years so that they can derive all the joys and pleasures possible. We believe that older people can be helped to maintain or improve their physical, psychological, and social adjustments and we try to help people live up to their greatest potentialities within their limitations. The way in which our philosophy is carried out is by providing a wide variety of programs and services including the technical skills of Food Service, Medicine, Therapeutic Services, and Social Services (including Religious Services).

As a practicum student I was assigned to work in the recreation therapy department. My schedule consisted of Monday, Wednesday and Friday mornings with residents in an activity called Workshop. Tuesday and Thursday afternoons were spent getting acquainted with individual residents in their rooms in an effort to remotivate them to participate. The majority do not attend Workshop. The central recreation program consists of a recreation therapist who supervises and two aides. The workshop session is from 9:00 - 10:30 a.m. three mornings a week.

The internship agreement included the following: 1) working with residents in Workshop on whatever projects the recreation staff had planned, 2) attending planning sessions for the central Workshop activities, 3) working with residents during Workshop with whatever art media I chose (although there was not a separate room nor a separate part of the large room in which to do art therapy), 4) doing art therapy with any interested residents in their own rooms, 5) attending designated meetings regarding the interdisciplinary plan of care for residents, 6) making weekly process notes for the director, 7) an oral presentation on Art Therapy to the Therapeutic Services staff meeting early in the internship and a written and oral presentation at the end. I carried out the assignments according to these guidelines.

This particular center for the elderly is considered a pioneer in the progressive care concept of treatment and rehabilitation of the individual resident. The residents are housed in six divisions

according to their specific needs, as determined by an interdisciplinary team of staff physicians, nurses, and social workers. The aim is to enable them to reclaim or maintain as much self-sufficiency as possible. After spending six months observing its residents in many circumstances, I feel it is, indeed, a caring agency.

In view of the high goals the institution has set for itself in the rehabilitation of aged persons, I feel there is evidence that the failure to motivate more than a minimal few residents to participate in recreational activity (except for Bingo!) is at least in part a failure to understand complex psychological factors involved in the aging process which affect motivation, as well as the stress caused by severe physical disabilities. The interdisciplinary teams which set goals for care understand these factors, but the failure occurs at the point of inadequate detailed planning and in-service training for staff responsible for carrying them out. For instance, if the resident's plan of care calls for taking part in recreational activities two or three times a week in the large central recreation area, it takes less persuasion on the part of the staff to get residents to attend a passive form of entertainment by a visiting group than to attend morning Workshop sessions where residents work on art or crafts. Ambulatory residents come to Workshop activities less often than residents in wheel chairs. Either the ambulatory patients have not been motivated by what was offered, and/or some encouragement by staff persons and better scheduling publicity is required to interest them in seeking stimulation from the arts and crafts program.

As mentioned earlier in this paper, investigators have found that the recent memory loss suffered by many of the very old is minimized in those persons who exercised their memories and took part in activities that call for mental involvement. The myths about the abilities and capacities for continued emotional and mental involvement into old age are not only believed by some of the young, but have been accepted as fact by many of the old themselves. One hears older persons saying things like, "I'm beyond all that; you're wasting time with me," or "I'm just an old lady that never could draw," etc. Maslow in Motivation and Personality (1954) states:

> The chief principle of organization in human motivational life is the arrangement of basic needs in a hierarchy of less or greater priority or potency . . . The physiological needs, when unsatisfied, dominate the organism . . . Relative gratification submerges them and allows the next higher sets of needs in the hierarchy to emerge, dominate, and organize the personality, . . .i.e., love, esteem, and self-actualization.

In the nursing home setting the basic physical needs of its residents are met, and met very well in the particular home in which I interned. In a broad sense, the "safety" needs are not met satisfactorily, due to the multiple physical and emotional losses the residents have already sustained. The sure knowledge of the shortness of life remaining for the very old, and threat of approaching death are constant reminders of insecurity for geriatric residents. Love needs are difficult to gratify, because the majority of nursing home

patients are in the institution because of the death of a spouse, because they were never married, have no children to help meet their needs, or have lived alone most of their lives and can no longer do so. Self-esteem is difficult to maintain in persons who have become dependent due to institutional care and physical limitation. So it should not be surprising that I found it difficult to begin art therapy with elderly residents, many of whom are brain-damaged and most of whom show signs of minimal to severe depression. Crosson, an art therapist with geriatric patients says regarding these phenomena, "Depression is so pervasive among nursing home residents, whether or not they are stroke victims, its effects in impeding spontaneity are so strong that an art therapist working in a nursing home must think about how to deal with it." (1976)

Art therapy is a human service profession. As such, it is an expression of human relationship. At the core of such relationship is the therapist's affirmation of a common humanity out of which grows the right of one person to help another, as well as the right of the receiver, in this case the older person in an institution, to be approached as a unique individual. Thorough grounding in the principles of developmental psychology and art therapy is necessary in order for a beginning art therapist to believe in whatever therapeutic measures are being offered to a certain population. In my practicum, I have learned that I must show sincere enthusiasm (and not simply "peppy" persuasion) for whatever changes in mood, for instance, that I feel a certain art activity may mediate in depressed

persons. By knowing from records some of the individual resident's past life, I can show respect in a real way for past accomplishments in conversation. I have done this in several instances, to witness pleasure in the older persons who then began to talk about former roles, professions and past capabilities. It is possible to be hopeful and still realistic about what art therapy can do for the old if the therapy is based on the individual's potential strength and appeals to the person's highest level of functioning.

Much of the recreational activity that I have observed appeals to the lowest common denominator of the audience or participants. (The fact that Bingo draws the largest participation simply reflects a dearth of anything more meaningful.) In the agency where I have been working, in striking contrast to its stated goals for the residents, there is notable incongruity between the quality of physical care given its residents and the attention given to their psychosocial needs.

Before citing details about some of the residents with whom I did art therapy at the Jewish center it may be helpful to mention a few facts about this population, in a general way, and about the kinds of lives they lived before moving into the institution. As in all institutions for the aged, women outnumber men about 3 to 1 and of women near the same median age (84) as in the general population, over 70% are widows. (Manard, 1975) Bureau of Census figures for 1970 showed the median years of education completed in the population over 65 to be 8.7 years. (1975) A large number of this

agency's residents completed very few years of schooling, due in large measure to their own or their parents' immigration to the United States from eastern Europe and Russia. In conversations and in records I found that quite a few of the women went to work in factories in St. Louis as soon as they had finished three or four years (less in some cases) of school and had mastered English. Because of their economic needs, time for schooling was hard to come by for all immigrants, but education was felt to be more important for the men.

Most of the women were housewives with families, some in addition helped husbands with their business, and some few I have met, widowed early, raised and educated one or more children with income from unskilled factory jobs. There are quite a few women who never married, and whose work did not provide pensions for their old age. Manard's Old-Age Institutions (1975) states that over 28% of all women over 65 in the United States had no living children in 1970; this includes 8% who never married. There is a sizeable number from this group living in this agency.

It was explained to me by one of the institution's administrators that its male population is somewhat higher than it might otherwise be due to the need of Orthodox Jewish men to be within walking distance of the Synagogue. There is a Synagogue within the facilities of the agency, and services are held every day except Sunday.

I have mentioned earlier that only 5% of the nation's population over 65 reside in institutions. Institutionalization is a last resort for most persons, and usually only comes about due to the

inability of the person to live independently. This may be the result of increasing physical or psychological disability, no relatives or children upon whom to depnd, lack of economic resources sufficient for independence, or a combination of all of these.

These factors, plus an admissions policy under which only those old persons who cannot live independently are accepted for residency, have contributed to the characteristically older and more chronically ill makeup of residents with whom I have been dealing. In keeping with theory emphasizing the importance of flexibility of approach to therapy and allowing for adaptibility of material and techniques to the specific population, I learned quite early in Workshop sessions that art media in general and being asked to draw, particularly, is extremely threatening for older adults. Most of them did not encounter any art appreciation or training in their formal schooling. Abstract concepts are not only more difficult as persons age, but are impossible for depressed residents with varying amounts of brain damage. So, after two attempts at what I thought were very simple ways to involve a few residents in art therapy exercises that were neither abstract nor symbolic, I realized that I would need to make another start on the more familiar arts and crafts level. We made several laprobes for wheelchair use, involving a few persons who could still see to do hemming; several others simply tied the polyester stuffing between both sides of the laprobe with pieces of yarn. Cutting yarn and tying it is slow, tedious work for arthritic hands. There is time for involving the residents in conversation, along with

many words of encouragement and reassurance. I was regularly asked to make posters and decorations for the Recreation area that celebrated the various national and Jewish holidays. Since half of the persons who come to Workshop are in wheelchairs the projects could not involve much range of motion. Although it is far faster to letter posters with magic markers or ink, I used a lot of construction paper letters to allow persons to cut them out, and made the letters to be drawn around from cardboard for tactile sensation and to aid in drawing around them for vision-impaired people.

I was surprised that there is very little conversation between the residents. If I asked someone a direct question, I usually got an answer. Residents who have several disabilities get so accustomed to having physical therapists, nurses and aides take care of all their needs of daily living that, left with very little personal choice, they withdraw into their own shell. In addition, the loss of many friends and loved ones contributes to the feeling many have of, "What's the use? (for reaching out and making new contacts) I'll only lose new friends also." This often leads to further withdrawal. But there remains the need for closeness and caring human relationships. Therefore I felt that my first hurdle in working with these residents was to establish myself as a friendly face that was going to be on hand regularly to be interested in them, and secondly to work with them on crafts and with art media.

In an attempt at a simplified explanation of art therapy I often repeat to the residents in Workshop that what is produced is

not as important as how they feel while they are doing it. This does not seem to take away from their pleasure of seeing whatever they do displayed for their peers to see, and the explanation has seemed to lessen the fears of a few who have consented to draw, paint or model with clay. Ulman (1975) says that after unsuccessful attempts to explain the potentialities of art to some hospital patients, she used the following simple definition for art: "Art is the meeting ground of the world inside and the world outside." Suddenly things began to fall into place and the patients began to find personal meaning in what they were doing. She concluded from experiences such as this that there was a way to bridge the gap between middle-class therapy and working class patients. In like manner there must be adaptation made in classic methods and techniques of art psychotherapy to suit the needs of the very old institutionalized resident. When one considers various physical changes in the elderly mentioned earlier in this paper it is easy to understand the underlying causes of their lack of spontaneity, so valuable in forms of art therapy seeking to contact unconscious motivation. In trying to contact the former higher-functioning part of regressed elderly patients it is first necessary to establish good interpersonal relationships. Maslow (1954) says:

> It will also be pointed out that these basic needs are mostly satisfiable only by other human beings, and that therefore therapy must take place mostly on an interpersonal basis. The sets of basic needs whose gratifications constitute the

basic therapeutic medications, e.g., safety, belongingness, love, and respect, can be obtained only from other people.

Some Individual Examples of Art Therapy

Jerry B. is an 80 year old man who has been living at the Jewish Center for six years. He was born in Russia and brought to this country, along with one brother, by his parents at age 3. Brain-damaged by scarlet fever at three years of age, Jerry was well cared for by his immigrant parents. He only attended kindergarten and writes only his name. Upon their death he lived with an aunt 23 years until her death in 1974, when he moved to this Center. He has a small pension from working as a porter for 30 years. His aunt was fond of Jerry but treated him like a child and thus he is quite dependent and lacks many ordinary adult skills. The brother lives in a nearby state but takes no responsibility and does not visit Jerry. His speech is very hard to understand but he is pleasant and always comes to Workshop three days a week. The only thing I had ever seen him do was make the coffee in the Recreation area each morning.

The big highlight of his week is going every Wednesday to Jewish Community Centers Association where he gets his lunch free of charge for helping, as he has told me each Wednesday as he leaves to go there. Jerry likes to be where there is activity going on, even though, partly because of his speech problem, he only observes. When some of the residents were tacking laprobes with yarn ties one

day, I interested him in winding skeins of yarn into balls after he declined joining in the tacking. He spent a couple of sessions doing that and as he worked I was able to get better acquainted with him by having him tell me how long he had been helping at JCCA, etc. Later I was able to get him to work with plasticine. He worked two hours the first time, making a very recognizable dog (and drawing surprised and complimentary comments from two persons at the same table) and then a sea lion and an elephant. Jerry was willing to try to talk some about what he had made and was extremely pleased to have his work displayed for a week. The next Workshop day, after making a long snake of plasticine, Jerry was pleased to discover that he could put texture on its skin with his fingernails. On a recent Wednesday he had gotten his overcoat and hat on two hours too early for his weekly trip to JCCA and was pacing up and down the hall in front of the Recreation area. An Occupational Therapist acquainted with Jerry told me that he gets very nervous about riding in the Center's van to the JCCA each week, and worries about being in an accident. I invited him in to work with clay for a while, explaining that he had quite a long time to wait, that I knew he was a little nervous about the ride and that working with the clay might make him feel calmer and better about it. He seemed to understand it when I told him that other people sometimes do clay modeling to make them feel better about their problems, and he continued to soften hard plasticine for twenty minutes or so. He returned next Workshop and made five fish in graduated sizes, lined them up on

the worktable and brought a couple of staff persons in from the hall to see his work. They were put with his other animals for display. About the only other remarks I had heard made to Jerry by the residents in Workshop had to do with whether they liked the coffee that day or whether it was ready. Jerry's childlikeness makes obvious his pleasure at the attention his clay work received as well as his satisfaction in using a media he had never before experienced.

Wanda F. is a 65 year old resident whose hemiparesis is due to a stroke suffered three years ago. Her husband died a few years before her stroke. Wanda has two sons, one a physician with a wife and three young children, the other a businessman who recently married. The sons see their mother at the Center nearly every weekend and take her out for breakfast when they come. Her only sister lives here but is unsympathetic on her infrequent visits. Her speech is minimally affected, and she can be understood quite well. Her alertness seems entirely normal; she walks with a quad cane and can use her good arm and hand very well. Fortunately, Wanda enjoys reading a great deal. She recieved therapy as an outpatient for two years before moving to the Center last year. After her children were grown Wanda worked several years as a bookkeeper in a downtown office and "loved every minute of it," she says. She was still employed when her stroke occurred. Her main complaint is that she doesn't have much in common with many of the residents that she knows and that most of her friends that she saw socially before her stroke no longer keep in touch with her. Since I have become well

acquainted with Wanda I have learned that she does have friends who telephone but not many who take her away from the Center, which is "the only time I feel normal," she explains.

Although Wanda is not usually very interested in crafts she has made two quilted-cloth purses of the type that can be carried on her quad cane. She cut and glued felt menorahs on Chanukkah banners that we made in Workshop and with some assistance, appliqued Raggedy Ann and Raggedy Andy figures on pillows that she gave two grandchildren. Most sewing she prefers finishing in her room after starting it in Workshop, because she says the way she has worked out to hold her work while sewing with the one good hand is more comfortable in her room. She got a great deal of satisfaction from giving the toss pillows to her grandchildren. She does not see them but every three or four months, since they do not usually come with their father to visit. Very frustrated with a completely deaf roommate she can't talk to, being 15 or 20 years younger than most of the patients and with more mental agility than most, this resident needs ventilation of her anger about the stroke, giving up her nice apartment with "at least a little privacy" and her living conditions in general. What she enjoys most is being taken away from the Center for lunch, and so I have taken her four or five times. During lunch she has a chance to vent her frustrations privately. She agreed to be a part of a small art therapy group that I tried to get started, and which met twice, but I will talk about that a little later.

Sophie B. carefully watercolored the reproduction of the Bible story character from the story of Queen Esther, Haman (Figure 1). This was done in connection with celebration of the Jewish festival of Purim. Sophie said it was her first attempt to use paints since she was a child. She was very pleased when I mounted and placed Haman in the hall where she lives. Sophie is 81 years old and has lived in the Center for two and a half years. She came to the United States from Odessa, Russia, at age twelve with her parents, a sister and a brother. She attended grammar school and then had secretarial training. The judge for whom she worked many years was made a federal judge and Sophie went to Washington, D.C., to work for him there for several years. She returned to her hometown when her parents became ill and lived with them until their deaths in 1961. The married sister with whom she made her home after the parents' deaths became resentful of having to care for Sophie after she broke her hip in 1977, and arrangements were made for transfer to the Jewish Center. Still friendly and cooperative when she came here, Sophie had become so forgetful and confused that she was afraid to leave her room because of being unable to find her way back. At first she walked with a cane but is now confined to her wheelchair. She is often brought to the Workshop sessions but used to be willing only to observe others. In the past few months she has seemed less frightened about attempting projects, and has done some copper tooling, stuffed pillows with polyester for a bazaar, and asked to watercolor a second Purim figure after her pleasure and success with

Haman. Sophie hardly ever speaks, and answers questions in nearly inaudible tones; but her manner is more assured and the staff persons say that she no longer resists being brought to Workshop because she realizes that someone will take her back to her room if she gets lost. She was here for over two years before she seemed to feel this trust, I was told. She still gets confused nearly every day about where her room is, but now she is no longer overwhelmed by this.

Stephen K. is a very straight, tall 85 year old man who moved to the Jewish Center a year and a half ago from an apartment in the city where he had been living alone. His only child, a daughter, and one of her two sons lives here. Stephen was born in Upper Hungary, which is now Czechoslovakia, and served in World War I as a general in the army. Before being drafted he attended law school. During World War II he was sent to a Nazi labor camp, but he managed to have his wife, daughter and mother sent to Budapest. In 1949 Stephen and his wife arranged for the daughter to emigrate to Israel. There she married, two years later the parents went to Israel, and in 1959 the daughter, her husband and two sons, and parents came to the United States. The daughter, now divorced, works and cannot oversee her father's medications as is necessary and fears that he may fall again as he did just prior to admission to the Center. Stephen's wife was an accomplished painter and died in 1968. He is alert and courtly, has mild angina and walks with a cane. He worked until age 80 (his passport said he was 70) at rather menial jobs after coming to the United States because his English is poor, although comprehension is good. He speaks German and Yiddish.

I had been told by the staff that Stephen enjoys painting, but he always works on woodworking projects supervised by an Occupational Therapist during the time I work with residents in Workshop in the same room. A few times he brought pen and ink sketches that he had done in his room. His work is excellent but quite small. One day I brought in a larger sketchbook to give him but he refused it politely, saying that he had a larger one in his room. (He did ask for some white paint to finish a picture.) I invited him on several occasions to join in when we were working with clay or other art media, but he never did so. I don't speak German or Yiddish but knowing that he understands English fairly well, I encouraged him to continue to sketch and paint and to bring work in to share with the group. The week that my internship was to be finished, I told Stephen that I would not be coming to Workshop regularly after that but would visit occasionally and hoped that he would continue to work with his art. The last day he brought me the little watercolor landscape in Figure 2 as a gift. Here is another resident who rarely carries on a conversation with anyone, probably due to his uncertain English. There should be an attempt made to find another resident who could converse with him in German occasionally, even though the staff is attempting to reinforce his use of English. His aloof or shy demeanor changed markedly during the times that I talked with him about his sketches. The fact that his wife was a professional may bring back fond reminiscences during this kind of conversation, as well.

After spending my first trimester interning at the Jewish Center I concluded that among the needs of residents that I could identify are more activities for small groups that would enable them to enter into closer interpersonal relationships. Some of the residents that I have worked with in Workshop who are withdrawn or depressed are admittedly there specifically to help with these particular problems; but it is not only these persons but a good number of others that I checked with who know very few names of other residents, or know only first names. This is true of persons living on the same hall for as long as a year or two. Thus I designed a series of four simple art therapy exercises and hoped to get two small groups of residents to meet four times, do the exercises and then talk about their work with each other.

After an hour's delay when the small Library room I had permission to use (and had art materials in readiness) was pre-empted for another meeting, the first group met in a corner of the big dining room. Four of the five persons who had agreed to participate waited during the delay and did drawings: Figure 3 is by Fannie A., Figure 4 by Wanda F., Figure 5 by James S., and Figure 6 by Edith S.

At the beginning of the session I tried to explain in very simple terms that one important understanding of art therapy is the use of various art materials to express feelings unique to that person, and to enjoy the process of creating. This is understated, of course, but all four persons were so intimidated by the idea of drawing that I felt simplicity was necessary. Each person was

given an 8½ X 11" piece of drawing paper which was divided into quarters. I asked them to spend about twenty minutes drawing anything they chose that showed some important aspect of their lives, past, present, or future. I further explained that we would spend the remainder of the hour discussing the drawings, and that one of the main purposes of the exercise was to get to know each other better.

Fannie A. is an 83 year old resident and has lived at this Center for a little over four years. She came to the United States from Odessa, Russia, at six years of age with her parents, a brother and a sister. Her father was a junk dealer after coming here. Fannie reads and writes English although she only went to second grade. She was a clerk in a downtown department store and worked in a factory during World War II. She and her husband of 54 years moved here after she had cared for him at home for two years following a stroke. They have no children and only two nephews survive. She is ambulatory without a walker at the Center but uses it when residents occasionally are taken on outings. With the exception of hearing loss, arthritis, and surgery for cataracts, her health is reasonably sound.

Figure 3 shows Fannie's four-part drawing. She explained that it pictured, left to right, her late husband, herself, the little house that they had before his illness, and her room at present in the Center. Before this group met I had never heard Fannie speak more than three or four sentences during Workshop sessions, although she always attends. She prefers coming in quietly and assuming her

same chair each time and crocheting on different projects she chooses. Once when I had asked her to join others on some painting, she told me that she makes afghans for the Center to sell at its bazaar and prefers crochet to other forms of crafts. So it was really surprising when she started talking about this drawing. With a great deal of emotion, a few tears and in great detail she told about her very happy marriage. She and her husband were not lonely because they spent all their time together when he wasn't working. She told how satisfying it was to finally own their own small home and how difficult it was to make the joint decision to take the $10,000 saved for their old age and make application to enter the Jewish Center. Her husband had been a cap maker in a factory.

Figure 4 was done by Wanda F., mentioned earlier, and focuses on the weddings of her two sons and the annual trip to the horse races in Chicago that Wanda and her husband took for many years. The upper left drawing shows the race track, horses getting ready to run, and a betting slip. Below it are more slips, Wanda pointed out, showing that "win", "place", and "show" paid that day. She said they only gambled once a year but "always won enough to pay for our trip, which we could not have afforded otherwise." Over each bride and groom figure of the sons and wives Wanda drew a wedding canopy. In the lower right there are figures in Las Vegas playing blackjack ("BJ") and slot machines ("SM"). Wanda said these represented memories of a vacation spent there after her husband's death when she had accompanied friends. "It's a good thing I went because

I liked it and will never do anything like it again; it was the year before my stroke." Because she has very ambiguous feelings about living here, Wanda remarked that she has a lot of angry feelings bottled up inside all the time. She very much misses her former social life and associations with friends. She is disappointed that some former friends no longer come to see her and feels stigmatized.

The other two persons in the group are a married couple who had only moved to the Center two months previously, James and Edith S. He is 78 and she is 74. They both grew up in this city, and have a married son and married daughter. He has a high school education and retired as manager of a small office; Edith has an 8th grade education, some secretarial training and worked briefly at a local department store. They are attractive, function independently and are quite capable. The reason they decided to move here is Edith's increasing depression and inability to take care of their apartment. She had carotid artery ligation and broke her right hand a year ago; it was after this that her depressive episodes began. Edith uses the hand for an excuse not to participate in activities, to dress late in the morning, and to stay in their room much of the time. James is having chemotherapy for a recent malignancy (but has never mentioned it) and functions very well in spite of considerable hearing loss.

James S. did the drawing shown in Figure 5. The upper left shows James and Edith, smiling and holding hands. He explained that

the Jefferson Expansion Memorial represented the city where they had always lived. Inclusion of the brightly shining sun is typical of his pleasant disposition. James told us that the lower left drawing in Figure 5 is a sketch of the little round garden, round table, benches and landscaping which was directly outside the windows of the dining room where we were having the art therapy group. The last drawing on the right is of the art therapist. He and Edith were quite empathetic as Fannie described her long marriage. When James discussed his drawings he mentioned that both couples had been married the same year, 1919. Since most of the residents who are mentally intact experience some regret and depression at moving to a home for the aged, I noted that all his drawings are in the present tense, perhaps indicating that he is more comfortable with his present life. In the three months since the drawings were done, he <u>is</u> this kind of person.

Edith's drawings, Figure 6, were done left and then lower left. Next she looked around at her husband's drawing and copied the Arch in the lower right section, and did not finish the upper right portion of her paper. Edith's picture of the couple shows her with her flowers and veil at the time of their wedding; she told us the little house is a picture of their apartment just before moving to the Jewish Center. Her husband has approached me privately twice since this session to ask if I would try to interest her in some kind of activity. He is concerned that she spends more and

more time in bed and although they have a telephone in their room, she seldom calls friends. I was able to interest her in making a purse for herself out of quilted fabric, but after that she has claimed that she can't work anymore as a result of the hand injury last year.

I met individually with Fannie A. and James S. to do figure drawings, based on Machover's (1949) projective Draw-a-Person test.

Fannie drew her husband first, then herself in a bridal gown. We worked in her room (lacking another private place to work) where there were photographs very much like the rigid drawings that she did. James and I did have the small Library in which to work without interruption, but he protested so much about being unable to draw people that I felt he drew hastily, simply to get through with the exercise. He drew himself in front of their old apartment first, then drew his wife.

Hammer (1958) cautions therapists and other researchers (in discussing the use of projective drawing techniques as a method of personality evaluation) that "no single technique will in itself provide a complete and meaningful picture of the subject's personality. Consequently, experiments designed to test a single technique's ability to do this are unrealistic." Nevertheless, he goes on to say that projective drawings have a specific use at the start, in the middle, and at the end of courses

of therapy. They serve as an aid in identifying suppressed conflicts and may be used as springboards for fruitful associations during the process of therapy.

With Hammer's approach in mind, I was able to draw the following limited and tentative conclusions from the Draw-a-Person drawings of Fannie A. (Figures 7 and 8) and James S. (Figures 9 and 10).

Hammer (1958) stated that of the 5,500 adult subjects he examined, 89 per cent drew (using the D-A-P technique) their own sex first. "These 5,500 include drawings secured from college students, from high school students, from clinic patients, neuropsychiatric hospital patients, and patients in psychoanalytic and psychotherapy practice." He further says that most of the research reported in the literature verifies that the great majority of people draw their own sex first. The finding among the several that Hammer suggests as explanations for the deviation of drawing the opposite sex first (Figure 7) in a D-A-P test is that the person has a strong attachment to or dependence on some other individual of the opposite sex. In Fannie's case it was already known that she spent all of his leisure time with her husband, and took great pride in catering to his wishes. Records indicate that the first time she spent a night away from him in over 50 years was when he became ill. Hammer also makes the suggestion that button emphasis in D-A-P

drawings is usually an indicator of a dependent, infantile, inadequate personality. The felt inadequacy in Fannie's instance had to do with her chosen subservient role in the marriage: she remarked that her husband was "perfect." The second figure drawn (Figure 8) was of herself in her wedding gown, but she drew herself without arms, although she included the wedding bouquet. Suggestions of insecurity and inadequacy are present here also. She spent about 15 minutes doing each of the drawings. In asking her about them she replied with some sadness that she never expected to live this long after such a good marriage had ended. Then she expressed disappointment that her remaining relatives, nephews, seldom visit her.

In Figure 9 James S. drew himself in front of the apartment building where he and Edith had lived until two months before. It was hastily done because he feels he has no drawing ability, saying, "My youngest grandchild could do better!" But because he agreed to the session and did not want to be uncooperative with the therapist (compliance is very much a part of his personality), he quickly drew himself first, and then in Figure 10, a picture of Edith, his wife. Figure 9 shows a tiny James, less than two inches tall in the horizontal dimension of an 8½ X 11 inch piece piece of drawing paper. When compared with his second drawing of his wife, Figure 10, whom he drew 8 inches high on the vertical dimension of the same size paper (and that did not include her figure from the hips down), one might conclude that James tends to feel overpowered by his wife.

There could be overtones of inadequacy and futility suggested by the size discrepancy of the figures. The noticeable sexual characteristics in the hair, dimples, suggestions of breasts, wasp-waist and hips, combined with the omission of the bottom of her torso probably had to do with the fact that James at that time was living in a different room from his wife and while they were in separate rooms there was no chance for intimacy or privacy, or as the drawing states, "incomplete" access to his spouse. The Center has since put them in a room together once one became available. In actuality, James does usually accede to his wife's wishes as to whether they take certain outings offered by the Center, attend presentations for the residents, or take a more active part in the Residents' Council.

The next day Fannie brought in the two drawings, Figures 11 and 12. Figure 11 shows Fannie and her husband in their wedding clothes. The lower left she described as an artificial bouquet and the lower right a pewter cup; all three objects, including a photograph of the wedding couple are sitting on her dresser in her room where she did the drawings "while waiting to go to supper." Figure 12 shows her father and her nephew's son, taken from a photograph she has, and on the right a picture of her mother done from memory. Fannie said that she had surprised herself with doing the drawings. "I

never drew before; I didn't know I could draw until I tried it, and now I can't quit." In the next six weeks Fannie brought me over fifty drawings, all done in her room. She liked to tell me what they were about, whether she had had difficulty with getting the effect she wanted, etc. She said she draws while waiting to go to meals and in the mornings after getting dressed, because she explained that she does not eat breakfast and so has time before anything else begins. Fannie is very concrete and so I did not attempt to interpret the drawings in a symbolic way to her. She enjoys drawing for its own sake. I brought her a sketchbook, pencils and eraser and tried to get her to use felt markers. She did one drawing with the felt tip pens and decided it was too messy. After that experience I got her some colored pencils which she has used a great deal.

In the course of talking about her drawings Fannie had an opportunity to ventilate a lot of repressed emotions concerning her present living situation, particularly having a roommate who she says has disliked her from the first day she came over a year ago. She speaks with a lot of emotion about the two nephews who she said were always in her home for the Jewish holidays before she moved to the Center, but who now seldom contact or come to see her although they live in town. She, as well as others, mentioned that there is a stigma to living in "a Home" and friends no longer keep in touch.

I have regularly mounted and put up drawings she has done so that Fannie can share them with all of the other

residents. Her social worker told me that having various staff persons and peers seek her out to comment on her drawings has given her confidence and enhanced her sense of self a great deal. Fannie did a series of ten drawings of the members of the cast of a favorite television program. When they were put up in the hall on her division there were many persons who commented to her about them. Recently she told me that one person she named had not liked the TV drawings. There was a time no too long ago that this kind of comment would have crushed her, but she is assured enough now that she simply concluded, "It's all right, though, because she's always cranky!"

Figure 13 showing a donkey's head and Figure 14 illustrating a birthday party are included because they are the last two drawings that Fannie did during my practicum. When she began to draw animals and was not satisfied with her efforts I got her a simple book about animal drawing. Although not an exact copy, the donkey is similar to some of the book's examples; in Fannie's case it is an adventurous step to try something this different from anything attempted before. The birthday party group of persons in Figure 14 is her most complicated composition thus far and the detail indicates that she is much more observant than when she first began to draw. Occasionally when she gave me several drawings at once she would remark, "I need a rest from all this hard work (drawing)! I used to take naps but now I can't quit drawing and I'm tired!" I suggested that perhaps she grant herself a day off. But the

next day she came in with more drawings, and thus I decided what my "third ear" was hearing from this 83 year old: a newly discovered excitement and sometimes amazement with her involvement in the creative process.

Summary and Discussion

From a personal standpoint, the most valuable thing I learned from the six-month practicum spent at the Jewish center is that I enjoy working with the aged. The multiple disabilities in some cases are of such overriding significance in the life the older person lives in the institution that therapy using art materials may be impossible. There remains, however, the need for human caring on a one-to-one basis, beyond what is required in the physical care of institutionalized people.

The rehabilitation of the elderly nursing home resident is hard work for those responsible for it. A high percentage of turnover in auxiliary persons who assist the therapists and nurses makes in-service training for this group an ongoing necessity; at present it is inadequate. This center for aging has high ethical standards for rehabilitating the old and it does well in the area of nursing, but the mental stimulation of and re-education of its residents falls far short of this standard.

Necessary routines for treating physical ills in large institutions unintentionally foster depersonalization. The aged resident who is not treated as an individual, but instead receives all necessary care in the presence of large groups of other residents, loses a sense of individual worth. Two-thirds of this center's residents are seriously disabled and require intensive nursing home care. But not all of these persons have mental impairments, and could

greatly benefit from activities and programs that have as their goal the stimulation of the person's highest remaining level of functioning. This stimulation also benefits the old who have suffered mental decline, and still need activities that are ego-building and encourage social interaction between residents.

I believe that art therapy could provide emotionally supportive experiences for many residents here if it were given adequate support in the form of public announcements, scheduling on the center's weekly calendar of activities, the encouragement of residents to participate from other members of the therapeutic staff, and a private space for a small group of 8 to 10 residents to work 45 minutes at a time.

Residents have told me that they feel much of the activity planned for them is infantile. Art therapy exercises such as drawing while familiar music is played, or making tape recordings of persons telling whatever they remember about their first home, are simple yet allow wide participation without seeming like "kindergarten". The discussions generated by the drawings, the music, or descriptions on the tape recorder, encourage group interaction and the enjoyment of remembering former lives.

Staying in touch even in small ways with the community at large helps lessen depression in the elderly. I will suggest an art therapy exercise that serves this purpose: Five or six Jewish nursery school children occasionally visit this center. The exercise requires the older person to draw around a child who is standing against a wall on which long brown paper is taped, or, if easier, the

child can lie on the paper on the worktable top). After the outline is drawn, the older person and child color it in any way they wish and talk to each other as they do it. Music to "Fiddler on the Roof" can be playing while the drawing is done to promote a lively atmosphere. I am sure children have plenty to say during this exercise (and this starts the conversations!).

I often observe patients in wheelchairs sitting in the halls, waiting for linens to be changed or to go to physical therapy sessions. When these residents are passed in the halls by other persons, whether fellow residents or staff, they are not spoken to, but are passed by as if they are invisible. Referring to a resident as if the person were not present is a common occurrence. Another example is when staff persons answer simple questions which are addressed to a resident who is present. In each of these instances I have described, the residents were capable of responding when spoken to, and might have known the answer to the questions directed to them. I believe this lack of courtesy contributes to existing depression and is the source of further depersonalization and withdrawal.

A few other residents who understand the problem of "invisible" patients mutely sitting in wheelchairs could perhaps make nametags shaped like flowers, or birds, or whatever they choose, then ask the wheelchair patients on one division their first and last names, write the names on with felt tip markers, and pin them on the people for a

day. Colored construction paper, scissors, felt tip markers and common pins are the materials needed. The goal is to encourage people to call residents by name.

An art therapy exercise to aid elderly residents in remembering earlier roles played in life concerns associations with family members. Materials needed are 8½ X 11" white paper, five-inch careboard circles, cut out, and pencils or pens for writing names. Members of the group draw around the circle to make a wheel with hub at center. Residents write their own name in the center of the hub. Spokes radiating out from the hub are drawn and family members' names are written on lines. Focusing on present and former ties helps residents with self awareness and centering. Group discussion after drawing the wheel facilitates group interaction.

A final suggestion for appropriate art therapy with a geriatric population is an exercise designed to stimulate and reactiviate sensory awareness, particularly the sense of smell. The materials needed are colored felt markers, 12 X 17" drawing paper, pieces of lemon and orange peel, a few vanilla beans, fresh spearmint leaves, and cinnamon sticks. (cotton balls saturated with a few drops of lemon, orange and vanilla extract plus oil of cinnamon may be substituted if the actual articles are unavailable, but the tactile parts of the exercise are missing). The therapist explains that the group is to close their eyes, after which they will be smelling some familiar scients. The therapist allows each person to feel the object they have just smelled. After each item is passed, the older person draws anything that came to mind connected

with each scent. It may be a slash of color, an abstract design, or realistic sketch. About five minutes should be allowed for drawing each article, and participants are told this before the exercise starts. A discussion of whatever the residents want to say about the experience ends the activity. Often the sense of smell diminishes in the aged. This art therapy exercise briefly compensates for some of this loss and results in heightened awareness of the individual's immediate environment. The more vividly one communicates with the immediate surroundings, the more fertile are the person's resources for personal interpretation of experience. The opportunities for helping elderly residents recall experiences in which their emotional involvement is strong enough to create a desire to tell the therapist and others about it are present in abundance through the creative use of paper, paint, clay, colored chalk and other simple art materials. The other essential resource for institutionalized aged in interpreting their own experience is the trained art therapist, whose knowledge of psychotherapy and art helps the elderly integrate the past and find new avenues for emotional outlet through involvement in the creative process.

Appendix

The basic procedure for the Draw-a-Person test based on Machover's Projective Drawing (1949) consists of presenting the person with a moderately soft pencil and a blank piece of 8½ X 11" drawing paper. The therapist says: "Will you please draw a person." If the person protests about artistic ineptitude, the therapist should limit comments to a general statement, such as, "Draw whatever you like in any way you like." About competence, the person should be reassured that how well the drawing is done is not important as long as a person is drawn. If an incomplete drawing is done, the person is asked to take another sheet and do a complete one. The same is true if a cartoon or abstract figure is drawn. When the first complete drawing is finished, the instruction is to draw a person of the opposite sex. Verbal and behavioral orientation of the person is noted during drawing.

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Fig.1

Fig. 2

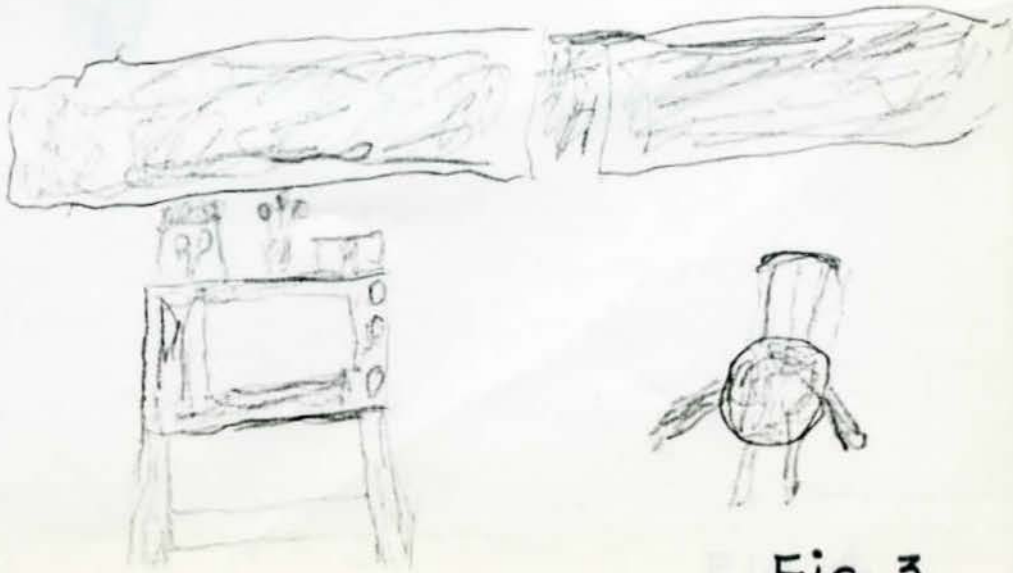

Fig. 3

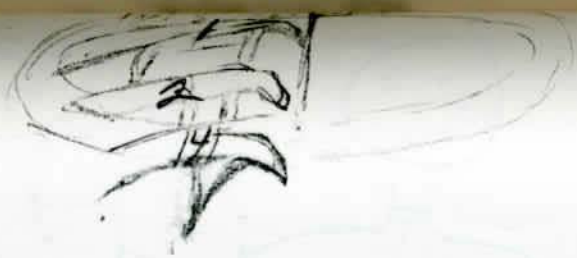

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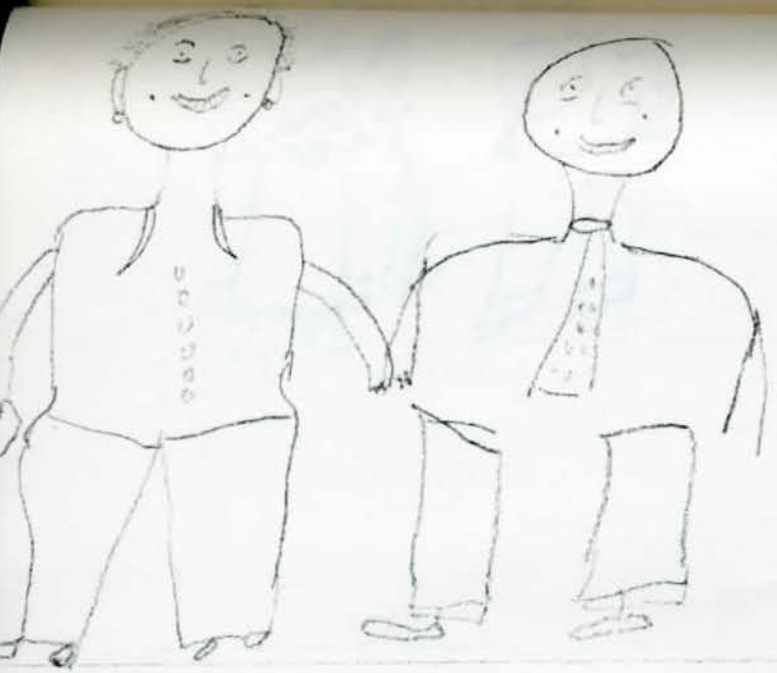
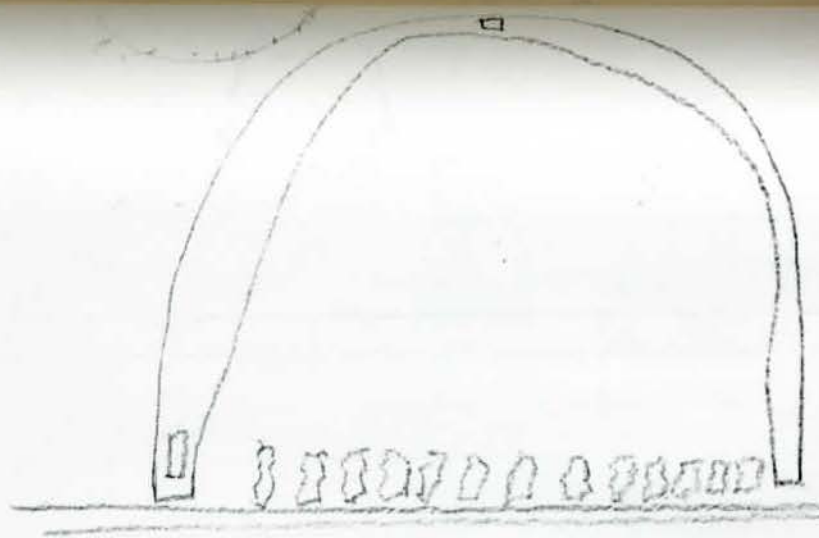
Fig. 4





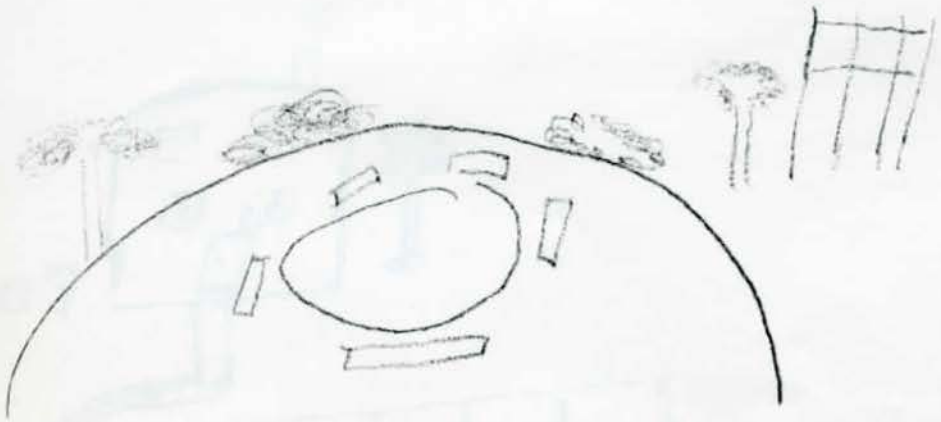
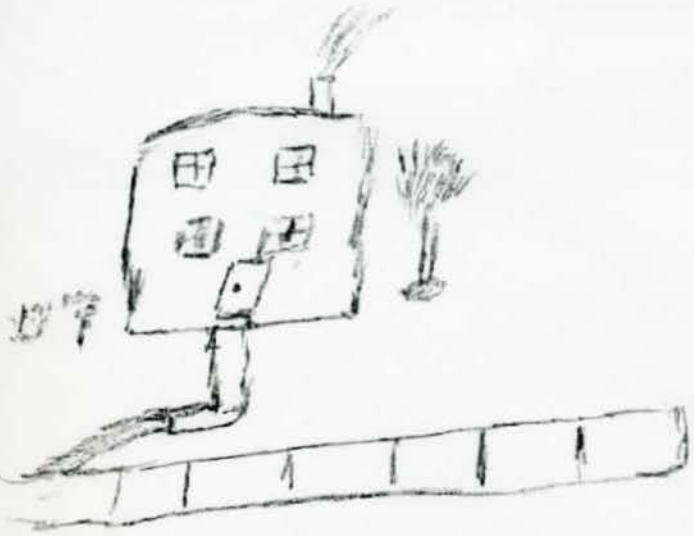


Fig 5



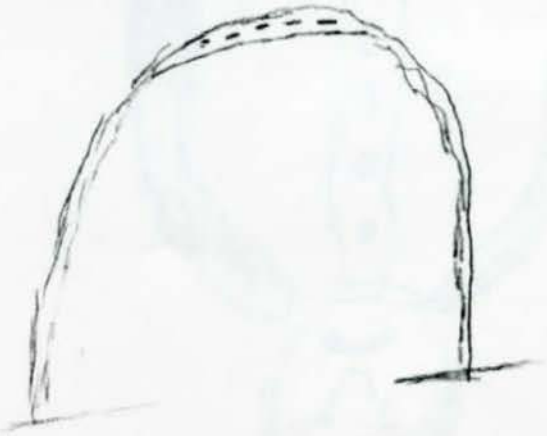
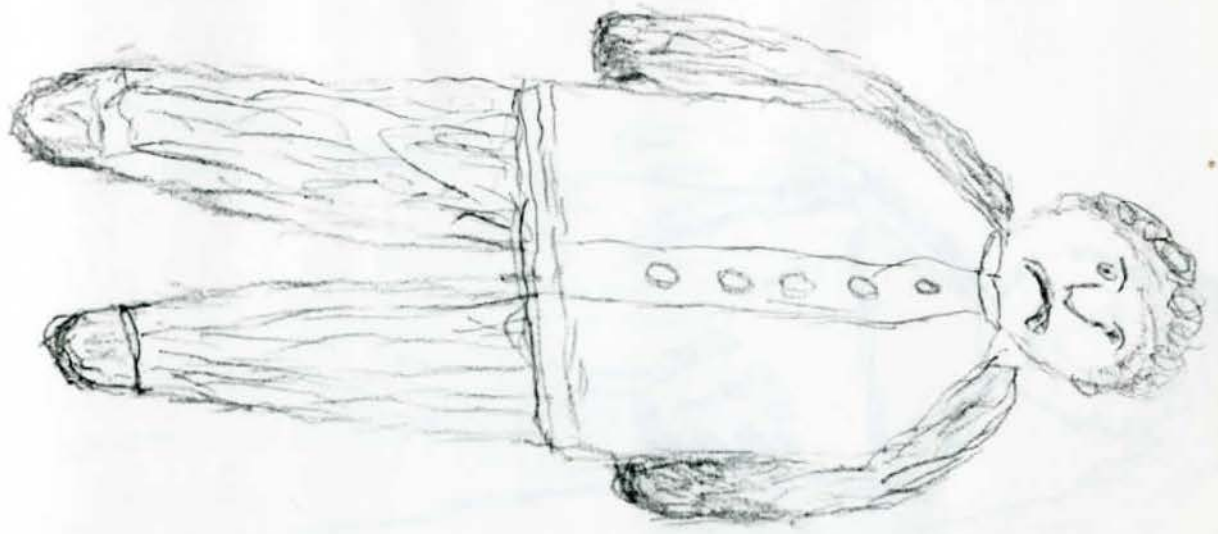
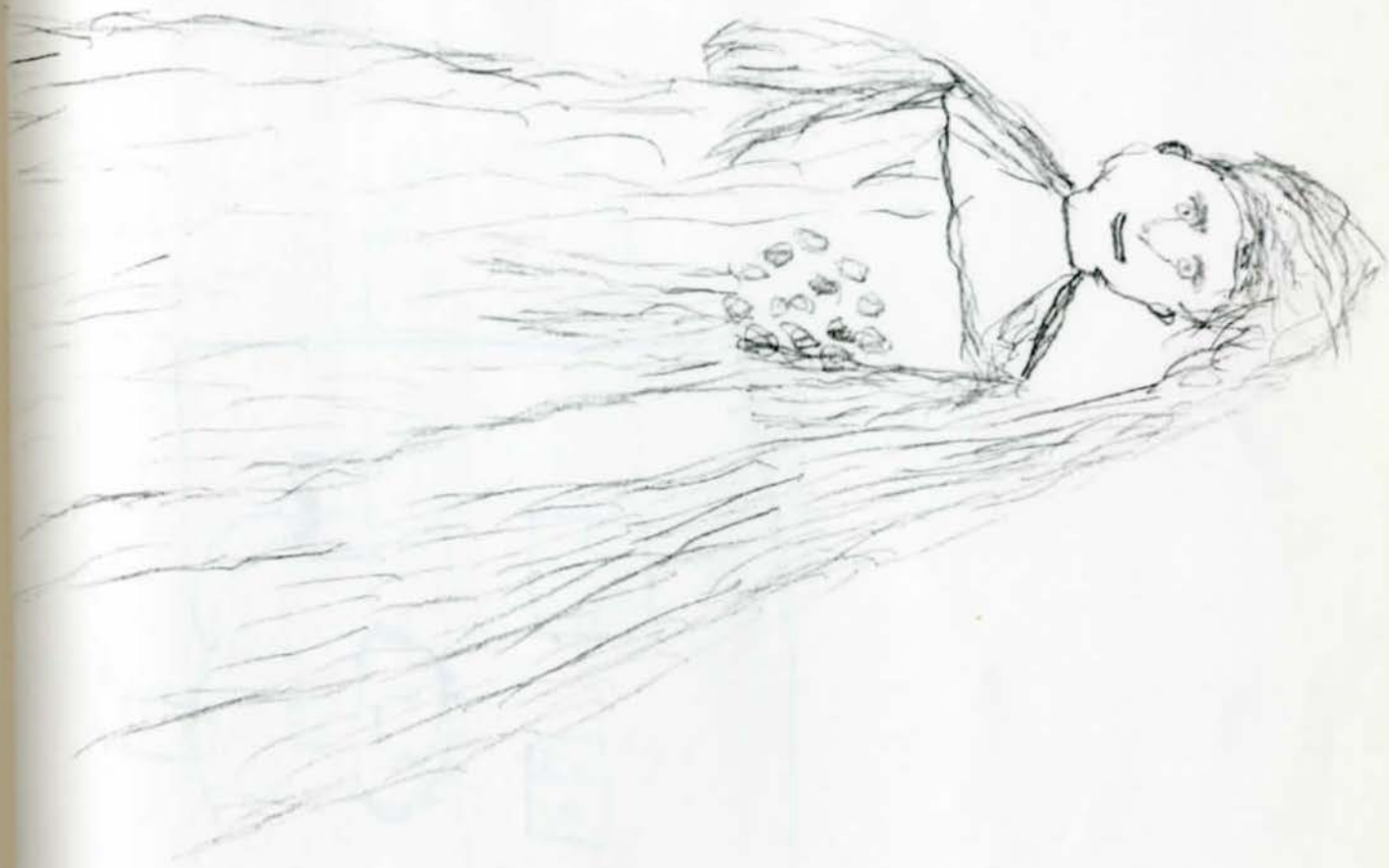


Fig. 6





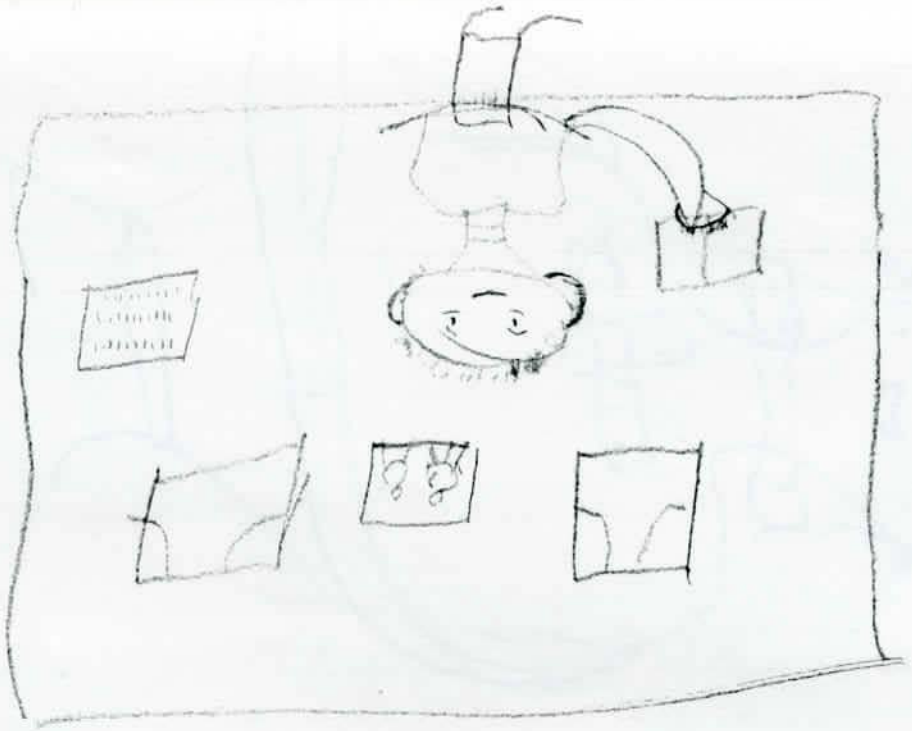


Fig. 10

FIG. 11

FIG. 12

Fig. 13

Fig. 14