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Touch Painting: An Art Therapy Intervention on Anxiety in Older Adults

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TOUCH PAINTING: AN ART THERAPY INTERVENTION ON ANXIETY IN OLDER ADULTS

A DISSERTATION

submitted by

CARRIE MAY EZELL

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

LESLEY UNIVERSITY
May 2016
Dissertation Approval Form

Lesley University
Graduate School of Arts & Social Sciences
Ph.D. in Expressive Therapies Program

DISSEMINATION APPROVAL FORM

Student's Name: Carrie May Ezell

Dissertation Title: Touch Painting: An Art Therapy Intervention on Anxiety in Older Adults

Approvals

In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

Dissertation Committee Chairperson: Michael Girard 4/13/16 (date)

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Final approval and acceptance of this dissertation is contingent upon the candidate’s submission of the final copy of the dissertation to the Graduate School of Arts and Social Sciences.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Dissertation Director

I hereby accept the recommendation of the Dissertation Committee and its Chairperson.

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SIGNED: Carrie May Zell
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ABSTRACT

This study investigated the use of two art therapy painting interventions with anxious older adults in long-term care or assisted living facilities in the Southeast. The control group used ‘traditional painting’ as defined by using a paintbrush and the intervention group used ‘touch painting’ as defined by using a foam core board with tissue paper. All participants in the study (n=44) were identified as having symptoms of anxiety as determined by their facility staff. Participants completed the Geriatric Anxiety Inventory (GAI) as a pre-test and post-test assessment. Both groups attended four art therapy sessions with the following themes: (1) Free painting, (2) Safety, (3) Belonging, and (4) Esteem. The themes were based on Maslow’s Hierarchy of Needs. Results showed both painting interventions reduced anxiety as evidenced by changes in GAI scores, with the touch painting reduction being slightly higher. There was a significant decrease in anxiety in both groups at pre and post study measurements, but no significant difference between the two painting interventions, indicating that both interventions were effective. The data from this study could be used to influence non-pharmacological methods of anxiety reduction in anxious older adults.
CHAPTER 1

Introduction

The next three decades will see a significant increase of older adults in the population as the first wave of ‘baby boomers’ transition into older adulthood (Yan, Silverstein, & Wilber, 2011). The American Psychological Association defines ‘older adults’ as those age 65 and older (American Psychological Association, 2014). Baby boomers are defined as those born between 1946 and 1964 and there will be necessity and demand for increased attention and services to meet the needs of this diverse population (Yan, Silverstein, & Wilber, 2011). In 1990, 1.6 million older adults lived in a long-term care setting (Burwell & Jackson, 1994). In 2008, the number doubled to 3.2 million (National Center on Elder Abuse, 2015). The number of older adults needing long-term care services in any setting (including home health, residential care, day service, hospice, and long-term care facilities) is expected to rise to 27 million by the year 2050 (Family Caregiver Alliance, 2015). The United States Department of Health and Human Services predicts that by 2020, older adults will make up 22% of the total population, in comparison to 16% in 2000 (United States Department of Health and Human Services, 2013). This generation of older adults has been called the silver tsunami and will change the landscape of successful aging (Lehning & Austin, 2009).

Anxiety disorders including panic disorder, social anxiety, and generalized anxiety are the most common among the general population (Clifford, Duncan, Heinrich, & Shaw, 2015). Anxiety disorders are common among older adults and generalized anxiety afflicts an estimated 52% of this population (Therrien & Hunsley, 2012). As many as 80% of residents in long-term care facilities are burdened with anxiety and depression, but as few as 30% are likely to seek out treatment (Clifford, et al., 2015; Vacha-Hasse, Archibald, Brescian, Martin, & Fitzpatrick, 2009).
Generalized Anxiety Disorder (GAD) is often accompanied by reduced quality of life satisfaction, increased disability, depression, sleep disturbances, and memory difficulty (Clifford et al., 2015; Stanley, Wilson, Amspoker, Kraus-Schuman, Wagener, Calleo, Cully, Teng, Rhoades, Williams, Masozera, Horsfield, & Kunik, 2014). There is a need to address anxiety in older adults proactively as it is often underdiagnosed and undertreated in this population (Bassil, 2011; Clifford et al., 2015; Sweeney, Greene, & Lawlor, 2013). Improved diagnosis and treatment is likely to lead to a better quality of life (Clifford et al., 2015).

Past studies have shown that creativity later in life has been associated with feelings of well-being and can be useful in adapting to changes which occur with aging (Flood & Philips, 2007). The expressive therapies field in general, and art therapy in particular, can offer mind-body connection, self-expression, and life review for the older adult (Kim, 2013). Art therapy groups with older adults have been shown to increase quality of life satisfaction and social connectedness, encourage reminiscing, regulate feelings of physical and cognitive decline, reduce anxiety, alleviate loneliness, and offer mental and physical stimulation (Lowman, 1992; Magniant, 2004; Wayman, 2011; Zeller, 2005). Specifically, art therapy groups are fitting for clients with anxiety due to the nature of the modality, in that it allows the client to creatively express a feeling that may be hard to articulate verbally, and can allow the client means of sublimation for these feelings (Chambala, 2008).

**Problem Statement**

Previous art therapy research has examined depression, social participation, stress level, well-being, and quality of life satisfaction in groups using materials such as clay, collage, paint, and scrapbooking (Levasseur, Desrosiers, & Whiteneck, 2010; Magniant, 2004; Stallings, 2010). There is a lack of research regarding the specific art therapy directive of touch painting as an
effective intervention for anxiety. The spontaneous imagery and ease of use for participants makes touch painting an accessible intervention, specifically for those who may not feel successful using other art making techniques. Touch painting uses aspects of finger painting, sensory stimulation, and the single image technique of printmaking called monoprinting (a method where only one print is created from a block form). As there is a need for further research addressing anxiety in older adults, the directive of touch painting may be fitting as a non-pharmacological intervention (Therrien & Hunsley, 2012).

Touch painting is not well known as an art therapy technique but it applies a simple methodology that allows expression in a unique way. It combines movement, touch, and offers the space for creativity to manifest. It is a very inclusive process requiring little dexterity or fine motor skills. Participants are not required to hold tools such as paintbrushes and can instead focus on the tactile experience of creating. Since the paint is on the underside of the paper there is no cleanup for those who may not want to get their hands dirty or who may have a tactile aversion to touching paint. Like other art therapy interventions, there is no artistic ability required to complete a touch painting. For these reasons, touch painting may be an effective means to reduce anxiety in older adults.

Touch painting uses a large sheet of porous lightweight paper (such as regular tissue paper) placed over wet paint on a smooth, non-absorbent surface (such as hardboard) where participants use their hands and fingers as the ‘brush’ to create an image. Participants’ hands never touch the paint and their hand and finger movements create imagery by lightly pressing the paper into the paint. After an image is complete, the sheet of paper is gently pulled off the board and put aside to dry and then the process can begin again. The paint is spread thin enough on the board so that the colors don’t generally mix or muddle, and therefore may need to be reapplied
throughout the process depending on how hard or soft the participant’s touch is, and how much paint they use up creating a touch painting.

**Purpose**

This study aimed to quantify the effect touch painting has on anxiety for older adults. Due to the characteristics of touch painting as an art therapy intervention, it is hypothesized that it will decrease anxiety levels in participants.

This research will address the following questions:

1. Do older adults report changes in levels of anxiety after a touch painting intervention?
2. Is there a difference in participants’ level of anxiety utilizing traditional painting materials versus touch painting in art therapy sessions?
3. Is there a difference in participants’ level of anxiety utilizing traditional painting materials versus touch painting when they are asked to create paintings with specific themes (such as safety, belonging, esteem) in mind?

This research attempted to fill gaps in the literature: (a) It addressed anxiety levels of older adults, and (b) It addressed touch painting as an art therapy intervention, and (c) It determined if specific creative themes elicited different results on the anxiety measurement.
CHAPTER 2

Literature Review

This literature review will examine (1) Facts and projections about aging in America, (2) Accommodation options for older adults, (3) Anxiety within this population, (4) Art therapy with older adults, and (5) Limitations of art therapy.

Aging America

The term ‘older adult’ as used in this literature review is in compliance with American Psychological Association terminology and identifies those 65 and older (American Psychological Association, 2014). Due to the American Social Security Act of 1965, those age 65 or older are colloquially considered to be older adults (Barba, Tesh, Cowen, Hancock, & Moore, 2010). It is important to remember, regardless of terminology, that the cohort called ‘older adults’ includes an incredibly diverse and varied group of people with a huge range of ability, vigor, and activity interests (Barba et al., 2010).

It is estimated that by the year 2050, racial and ethnic minorities will form half of the U.S. population (Yan, Silverstein, & Wilber, 2011). As the first of the baby boomers began to turn 65 in 2011, it is important to note America will see the number of ethnic minorities grow the fastest among those 65 and older (Solway, Estes, Goldberg, & Berry, 2010; Yan, Silverstein, & Wilber, 2011). Minority groups such as African Americans, Hispanics, and Asians have been shown to express a lower prevalence of anxiety disorders compared to Whites (Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010). It is important to consider race and ethnicity in the context of anxiety due to this disparity (Asnaani et al., 2010).

A 2008 age-period-cohort analysis of data collected from 1972 to 2004 showed overall levels of well-being typically increase with age however, the baby boomer cohort was found to
have a lower than average level of happiness (Yang, 2008). This could be due to the relative status baby boomers were born into following world wars, their formative experiences from economic depression, and cultural social upheaval (Yang, 2008). Additionally, with a large cohort such as the baby boomers, there is more competition for education and jobs, which may limit achievement and personal well-being (Yang, 2008).

**Accommodation**

As Americans age into older adulthood, their accommodation and health care requirements may change. Options for older adults include housing choices such as independent and assisted living facilities, short term rehabilitation and long-term care facilities, and, depending on level of attention desired or needed, adult day centers, home health care, and hospice.

To provide quality services, counselors and mental health providers need to be aware of sensory changes that occur with age, adult development, and issues of concern specific for older adults (Ganote, 1990). Many losses can come with aging: loss of ability, loss of function, loss of expression, and loss of the sense of self (Serlin, 2011). As age related changes may limit independence, accommodation needs for older adults may change.

Mental health practitioners need to be aware of typical age related changes such as decline in strength, which can affect range of motion, and neurological changes which can affect motor skills, cognitive processing, and memory function (Boltz, Capezuti, Fulmer, & Zwicker, 2012). Nerve function controlling the sense of touch tends to decline with age which may lead to a slower reaction time when exposed to painful stimuli (Boltz et al., 2012). Vision issues affect up to 25% of those 80 and older and the leading cause of blindness for Whites is macular degeneration; for Blacks and Hispanics it is open-angle glaucoma (Boltz et al., 2012). The most
common form of hearing loss for older adults is sensorineural hearing loss that affects the inner ear (Boltz et al., 2012). It is imperative that mental health care providers have an understanding of the normal aging process in order to provide the most effective approaches to care (Boltz et al., 2012).

**Housing**

Housing needs for the older adult may change depending on care required. A housing option that includes independent living, assisted living, and nursing home care is called a Continuing Care Retirement Community or CCRC (Eckert, Carder, Morgan, Frankowski, & Roth, 2009). These communities house a range of older adults from those with minimal assistance needs to those necessitating 24 hour care, and often share medical staff and food services (Eckert et al., 2009). On average, independent living and assisted living facilities care for older adults over longer time frames (22 months or more) than other healthcare settings (Katzmann, Breneman, & Byrne, 2015). An independent living facility often becomes the first choice of older adults who desire the flexibility to enjoy a home environment but no longer want the responsibility of upkeep and maintenance (Robinson, Saisan, & Russell, 2015). Typically older adults who move to an independent living arrangement downsize from their family home and choose independent living because they enjoy social connections with others, as well as the amenities available from the independent living community, which often include transportation, activities, and services such as meals and medication administration (Robinson, Saisan, & Russell, 2015).

Assisted living is an option between independent living and long-term care (Williams & Warren, 2008). An assisted living facility denotes a need for medical care and assistance such as medication dispensing, but not round the clock medical care such as that found in a long-term
care facility (Eckert et al., 2009). Residents in assisted living may need aid with activities of daily living (ADLs) such as bathing and eating, and rooms may offer a small kitchenette for residents to prepare snacks but not cook meals (Eckert et al., 2009). Many assisted living facilities also have specialty quarters for those with dementia or Alzheimer’s disease which are often housed in separate units with locked doors for resident safety (Eckert et al., 2009). While there is not an exact definition of what constitutes assisted living care, there is a general understanding that assisted living is a middle ground between living at home with visiting caregivers and admission to a nursing home for long-term care (Eckert et al., 2009).

Lehning and Austin (2009) classified long-term care as a patchwork of various services including the long-term care institution, material supports, and assistive devices such as wheelchairs, and the unofficial assistance of family and friends of the resident. Long-term care residents typically require coordinated nursing care due to ongoing medical issues and/or disabilities (Molinari & Edelstein, 2011). Long-term care institutions are known commonly as the ‘nursing home’ and in layman’s terms has come to mean caring for a resident until his or her death.

Although more older adults receive in-home care than care at long-term or residential care facilities, many still find the cost of in-home care prohibitive, and it may become necessary to choose a facility that has costs offset by insurance and/or Medicare or Medicaid programs (Family Caregiver Alliance, 2015). Because of the increased need for medical care or rehabilitation following a hospitalization, many residents often require the more intense attention and supervision of the long-term care environment (Fischer, 2010). Older adults who have physical and mental challenges along with low income are at greater risk for neglect and frequently require long-term care (Choi, Kim, & Asseff, 2009).
The majority of long-term care facilities are designed under the medical model of care, similar in style and procedure to a hospital. However, there is a growing trend towards a more home like environment focusing on person-centered care (Eckert et al., 2009). There is an enduring stigma and dissatisfaction with long-term care facilities from residents, families, and society in general (Eckert et al., 2009; Tse, Leung, & Ho, 2011).

**Other options**

Other wellness and support options for older adults include day centers, home health, and hospice care. Adult day programs can offer a range of services including cognitive stimulation, exercise, socialization, and reminiscence (Cohen-Mansfield & Wirtz, 2007). The availability of adult day centers can broaden services for older adults who may be resistant to pursuing mental health care (Solway, Estes, Goldberg, & Berry, 2010). Adult day service programs can also offer respite for caregivers as well as professional care and attention families may be unable to provide (Liu, Kim, Almeida, & Zarit, 2015; Marson & Powell, 2014). Participation in adult day programs has been shown to ease family members or caregivers into the idea or transition of relinquishing care to service providers such as long-term care facilities (Cohen-Mansfield & Wirtz, 2007).

Older adults who continue to live at home are considered to be ‘aging in place’ (Riley, Burgener, & Buckwalter, 2014). Due to a variety of factors including decreased mobility and social network, many older adults who live at home may spend a large portion of their day in their home environment (Oswald, Jopp, Rott, & Wahl, 2010). A significant number of older adults who live alone at home do not have an identified caregiver and may be vulnerable to additional risks which would make aging in place an unsafe option (Riley et al., 2014). Those older adults who require services such as personal care, transportation, and meal planning, can
usually receive them at a fraction of long-term care costs and thus delay or avoid moving to a long-term care facility (Riley et al., 2014). There are ongoing developments within the city planning, home building, and health care fields to create more accessible and barrier-free homes and communities to increase future possibilities for older adults to age in place (Oswald et al., 2010).

Hospice care primarily occurs in the home; however, there is an increasing number of older adults who require an inpatient hospice facility (Hurley, Strumpf, Barg, & Ersek, 2014). Older adults with acute medical crises, uncontrolable symptoms, or a lack of caregiver ability to provide proper attention at home, may be transferred to a hospice facility or under hospice care in a hospital or long-term care facility (Hurley et al., 2014). Hospice patients and their families or caregivers often have expectations for their placement and care that may change as their medical condition fluctuates (Hurley et al., 2014).

Anxiety

Anxiety in the older adult population is usually combined with other medical issues and depression (Bassil, 2011; Clifford et al., 2015). Primary health issues can be aggravated by anxiety and it is more prevalent in those with underlying medical conditions (Pachana & Byrne, 2012). Three out of four older adults have multiple chronic health conditions (Royer, 2015). Anxiety in older adults is less researched than other ailments such as depression or dementia however, Generalized Anxiety Disorder (GAD) is the most prevalent anxiety disorder for older adults (Bassil, 2011; Clifford et al., 2015; Pachana, Byrne, Siddle, Koloski, Harley, & Arnold, 2007; Therrien & Hunsley, 2012). Those who develop GAD at an early age are more vulnerable to relapse as they age into older adults (Goncalves & Byrne, 2012).
The percentage of community dwelling older adults with anxious symptoms that do not satisfy requirements to be diagnosed with an anxiety disorder is estimated to be up to 56% (Therrien & Hunsley, 2012). For those who are hospitalized or living in long-term care facilities, the percentage of those afflicted with anxiety ranges from 43% - 80% (Powers, 2008; Therrien & Hunsley, 2012; Vacha-Hasse, Archibald, Brescia, Martin, & Fitzpatrick, 2009).

It can be a challenge to properly diagnose older adults with an anxiety disorder because symptoms can be easily confused with other medical complaints, mental health disorders, and/or normal aging (Therrien & Hunsley, 2012). Up to 86% of people age 65 and older have one major health condition, and physical symptoms may be ascribed to this instead of anxiety (Therrien & Hunsley, 2012). Medication can also produce side effects that can mimic anxious symptoms (Clifford et al., 2015; Therrien & Hunsley, 2012). For this reason it is suggested medication history, previous medical complaints, and current medications are addressed and taken into account before a diagnosis of GAD (Clifford et al., 2015).

Anxiety may be under diagnosed or improperly treated in older adults due to ageism and negative beliefs from society about the aging process (Yan, Silverstein, & Wilber, 2011). Older adults in minority groups may encounter ageism as well as negative stereotypes and discrimination that can hinder a proper diagnosis (Yan, et al., 2011). Young and older adults frequently present anxious symptoms differently which can lead to an incorrect diagnosis for the older adult (Clifford et al., 2015; Therrien & Hunsley, 2012).

Baby boomers have expressed more willingness than their predecessors to seek out professional help for emotional issues such as anxiety (Mohlman, 2012). Although older adults typically see their primary health provider as the first line of defense for both physical and mental health issues, most primary care offices do not offer counseling or therapy services on
site (Mohlman, 2012). By the year 2030 it is estimated that up to 14 million older adults will require mental health care (Stanley, Wilson, Amspoker, Kraus-Schuman, Wagener, Calleo, Cully, Teng, Rhoades, Williams, Masozera, Horsfield, & Kunik, 2014). A 2011 study of older adults age 65-97 found that most (76%) preferred counseling services instead of medication to help ease their anxiety (Mohlman, 2012). Research suggests older adults could benefit mentally when health practitioners look for and treat symptoms of anxiety prior to any formal diagnosis (Rozzini & Trabucchi, 2013). The Geriatric Anxiety Inventory, Short-form (GAI-SF) was selected for use as a screen for generalized anxiety disorder in a study of 402 older adults with a mean age of 69 years (Rozzini & Trabucchi, 2013). The prevalence of general anxiety symptoms prior to this study was 3% but raised to 17% upon completion (Rozzini & Trabucchi, 2013). As participants met criteria through the GAI-SF they were presented with options such as anxiety-management groups (Rozzini & Trabucchi, 2013). Since older adults may experience medication toxicity and/or dangerous drug interactions by taking a variety of medications for other health difficulties, most prefer a non-pharmacologic intervention to treat anxiety (Riley, Burgener, & Buckwalter, 2014).

**Art therapy with older adults**

The cultural movement of positive aging is that which includes creative engagement and hands-on participation in the arts by older adults, not the mere passive viewing of artwork (Abrahms, 2011; Gorman, 2006). Many older adults are physically inactive, however, the brain has plasticity which means they can continue to learn and accomplish tasks (Chen, 2010; Safar & Press, 2011). Being an active participant in the creation of art gives the older adult an opportunity to socialize, learn, enhance life skills and well-being, reminisce, and express in an imaginative way (Ehresman, 2014; Gorman, 2006; Weisberg, 2001).
Creative expression facilitated by an art therapist can offer different benefits than verbal therapy alone, due in part to the relationship between therapist, client, and the artwork, and the art therapy technique which may meet the emotional and psychological needs of the older adults (Zeller, 2005). Client participation in art therapy is a different experience than talk therapy in that art therapy can allow for empowerment through symbolism and imagination of personal narrative, and a unique therapeutic environment (Geller, 2013; Kapitan, 2010). For instance, the client artwork can promote active imagination, sublimation of feelings, and physical evidence of emotional growth (Geller, 2013). The use of art therapy with a skilled art therapist can validate and stabilize client feelings and reactions and can create a compassionate and safe environment to express emotion (Geller, 2013; Kapitan, 2010). Although occupational or activity therapists may offer art making to their clients, their focus is primarily on performance, skill, and functionality (Orellano, Colon, & Arbesman, 2012). Kapitan (2010) noted art therapy can assist other care professionals in seeing their patient in a more holistic manner, as more than their disease. Art therapy with older adults can offer benefits through the creative expression and group interaction, and research continues to measure its efficacy.

*Creative expression*

Creative expression has no age limit and can enhance the aging process (Hickson & Housley, 1997). It can also be a means of active treatment for continued quality of life improvement (Fuss, 2010). Creativity requires problem solving abilities, open mindedness, and an accumulation of skills to express a unique concept (Flood & Phillips, 2007). Creativity can be an asset for older adults in the midst of health limitations (Flood & Phillips, 2007). Creative expression can enable older adults to successfully adapt to the social, physical, and psychological changes that occur in this later stage of life (Flood & Phillips, 2007). Many older adults are
reluctant to participate in creative activities, citing a lack of creative talent; however, creativity can offer benefits such as problem solving, improved neuronal connections in the brain, and relaxation (Flood & Phillips, 2007). Many older adults may not have used art materials for several decades, and the use of art may feel like learning a new skill. Thus, it is important to allow for time and practice to increase chance of success and confidence (Barba et al., 2010; Geller, 2013).

Limitations due to physical impairment are an oft cited reason older adults decline to participate in activities (Chen, 2010). The expressive arts therapies are inclusive of those with physical constraints and impairments (Abrahms, 2011). Art therapy can become both an outlet and an invitation for older adults to tell their stories and share their value with others (Geller, 2013). Life review in the form of a memory book or similar creative avenue can be a means for older adult clients to reevaluate unresolved conflicts, construct their life stories, and leave a tangible legacy for their families (Caldwell, 2005). Touch drawing has also been previously used by an expressive art therapist in a hospice group to assist patients with their grief (Rogers, 2007).

Self-exploration and self-concept activities can enhance participant self-esteem and confidence and become a means of empowerment (Ehresman, 2014; Ramage, 2006). Self-exploration through art making often allows a participant to define themselves and their personal history; sometimes working through previous life events of significance (Stallings, 2010).

Creative expression can promote emotional wellbeing and exploration for those suffering a health crisis (Stuckey & Nobel, 2010). A 2006 study with 39 women diagnosed with breast cancer found that participation in four art therapy sessions enhanced their overall feelings of well being (Stuckey & Nobel, 2010).
Displaying art created in an art therapy session can lend gravitas to the creative process and send the message that creative expression is valid, while also honoring the participant (Lanza, 1997; Wickland & Basting, 2009). Art therapy displays can also help advocate for the field and educate others about its benefit (Weisberg & Wilder, 2001).

**Group interaction**

Older adults can have limited social or activity choices due to cognitive or physical decline, access to transportation, and accommodation options (Barret, 1993; Levasseur, Desrosiers, & Whiteneck, 2010). A study by Levasseur, et al. (2010) showed that social participation, such as that in an activity group, offers companionship and engagement, which can boost quality of life satisfaction. This study had a sample size of 155 older adults with a mean age of 74 and normal cognitive function. Interviews were utilized to collect data regarding participants’ level of satisfaction in groups, stress levels, activity levels and impairment. Measurements included the General Well-Being Schedule, the International Classification of Diseases, the Charlson Index, a visual analog scale, and self-reporting from the participants. For data collection, the participants were interviewed at their homes for approximately 90 minutes by a therapist qualified to do so. This study found that social participation satisfaction is higher for younger participants who have a high activity level and feeling of well-being, no recent stressful events and fewer amount of obstacles in their physical environment. Participants reported a mean score of 25 (6.5SD) out of 35 on the Satisfaction with Life Scale (SWLS). Their satisfaction with participation had a mean score of 4 out of 5. This study shows that social interaction is an important element in older adults’ overall quality of life enjoyment (Levasseur, et al., 2010).
It is predicted that with person centered care trends, activity groups are becoming smaller and more specialized, focusing on individual needs (Richman, 2012; Oberst, 2015). The group therapy format can allow members to aid each other as they receive support at the same time (Vacha-Haase, Archibald, Brescian, Martin, & Fitzpatrick, 2009). Art therapy groups for older adults are being utilized in a variety of settings in conjunction with traditional medical treatment (Beauchet, Remondiere, Mahe, Repussard, Decavel, & Annweiler, 2012).

An art therapy group can assist older adults with memory preservation of a long life history, promote life review, reassessment of physical and mental potential and be a space for managing feelings of loss and decline (Magniant, 2004; Zeller, 2005). Art therapy groups can also offer the opportunity for self-expression by the creation of a tangible object, which can then serve as a conduit for emotion (Stewart, 2004). Alders and Levine-Madori (2010) asserted art therapy groups enhance participants’ self-perception as well as cognitive performance.

Participation in group activities has been shown to offer older adults benefits such as opportunity, inclusion, feelings of well-being and meaningful engagement (Karges-Bone, 2012; Levasseur, et al., 2010). Social connectedness is an important component of successful aging and the impact of friendship has a profound impact on a person’s well-being and overall health (Buettner, 2008; Karges-Bone, 2012; Martini, et al., 2002). Furthermore, art therapy groups for older adults promote well-being by incorporating socialization, mental and physical stimulation, the sense of control through the choice of art materials, and creation by participants (Cohen, Perlstein, Chapline, Kelly, Firth, & Simmens, 2006; Lowman, 1992). In addition to the positive experience of participating in a group art therapy, groups can also offer positive components of Haptics, or, therapeutic touch (Levasseur, et al., 2010; Ramage, 2006).
Lanza (1997) stated that an art therapy group must be facilitated by an art therapist who is appropriately credentialed due to the therapeutic nature of the group. Art therapists should be patient and organized and have the experience to be flexible when the situation demands it (Weisberg & Wilder, 2001). Additionally, art therapists should be able to engage participants who may feel uneasy with art making as well as be able to therapeutically contain the feelings and emotions of their participants (Weisberg & Wilder, 2001).

The Therapeutic Thematic Arts Programming for Older Adults Method (TTAP Method) is a nine step structured group which engages and stimulates the brain using a multimodal approach (Madori, 2013). The TTAP Method reinforces strengths of the older adult using the creative arts such as music, movement, art making, poetry, and guided imagery (Madori, 2013). A 2010 study used TTAP as a structured intervention to assess cognitive performance on Hispanic/Latino older adults (Alders & Levine-Madori, 2010). The 12 week study had 24 Hispanic/Latino older adult participants with an average age of 75. These participants completed the neurological Clock Drawing Test (CDT) and the Cognitive Failures Questionnaire (CFQ) as pre-test (at week one) and post-test measurements (at week 12). Participants attended 10 weeks of art therapy sessions which were structured by TTAP to engage various regions of the brain. Results showed 77% of the CDT scores and 69% of the CFQ scores improved after the 10 weeks of art therapy. This study showed cognitive performance was higher on participants who engaged in art therapy sessions compared to those who did not (Alders & Levine-Madori, 2010).

Additional Research

Additional outcome research is essential to identify the benefits of art therapy in the reduction of anxiety in older adults. Research will help determine the effectiveness of art therapy as a treatment modality and assist in perfecting the quality of services offered to the
public; however, traditionally art therapists have been reluctant to take on the role of researcher (Deaver, 2002; Reynolds, Nabors, & Quinlan, 2000). There is a need for outcome studies in the art therapy profession to evaluate current practices and specific interventions and approaches (Kaplan, 2001). The following is a sample of research studies examining art therapy with a variety of older adult populations. Due to small sample size or concrete population, many of these studies may have limited generalizability, but these data can be used to inform the therapeutic approach.

Kim (2013) examined the role of art therapy in promoting an attitude of healthy aging for Korean American older adults. This study randomly assigned the 50 participants into a control group or art therapy intervention group. Both groups received pre-test and post-test measurements. The control group had an average age of 78, while the art therapy intervention group had an average age of 77. This study utilized three measurements for the intervention group: the Positive and Negative Affect Schedule (PANAS), the State-Trait Anxiety Inventory (STAI), and the Rosenberg Self-Esteem Scale (RSES). The art therapy intervention group participated in three one hour sessions per week for four weeks total. The art therapy sessions allowed participants to work on one piece for the entire study, or a new piece each session. The control group participated in other activities such as games, reading, and watching television. Results from this study showed no statistical difference in the two groups at the pre-test measurement; however, participants in the art therapy intervention group reported greater positive change on two measurements, the PANAS and the RSES. The art therapy intervention group mean pre-test score on the PANAS was 63, while the mean post-test score was 83. Conversely, the PANAS score for the control group was 62 for the pre-test and 57 for the post-test. The RSES mean pre-test score for the art therapy intervention group was 16, and 20 for the
post-test. For the control group the RSES mean score was 16, and 15 for the post-test. The art therapy intervention group had an 85% positive change in affect and 71% positive change in their state of anxiety. This study did show art therapy sessions are effective in promoting healthy aging among Korean American older adults, and stated there is a need for art therapy sessions designed specifically for older adult participants.

An art therapy study by Doric-Henry found that 20 nursing home residents with an average age of 84 years utilized pottery with positive results (Doric-Henry, 1997; Magniant, 2004; Stallings, 2012). Participants in the art therapy intervention group (n=20) attended eight pottery sessions and were given pre and post-tests at each session. The control group (n=20) had an average age of 86 years and did not participate in artmaking but completed the same assessments. These tests consisted of the Coopersmith Self-Esteem Inventory, State-Trait Anxiety Inventory, Beck Depression Inventory as well as qualitative measurements such as an open-ended questionnaire. The study found that the art therapy intervention did reduce depression and anxiety as well as increase self-esteem for those in the intervention group compared to the control group. The pre-test depression score for the art therapy intervention group was 4.6 and declined to 2.1 on the post-test. The control group pre-test depression score was 5.9 and declined to 5.0 post-test. The pre-test trait anxiety score was 29.1 for the intervention group and was 25.1 post-test. For the control group, the trait anxiety score was 36.6 pre-test and 33.7 post-test. Those participants whose pre-tests showed low self-esteem showed considerable improvement after the art therapy intervention. The self-esteem score for the intervention group was 72 pre-test and 81.6 post-test. For the control group, the self-esteem score was 70.8 pre-test and declined to 69.8 post-test. This finding led the researchers to deduce this particular subset of the participant group may be best helped by art therapy interventions.
Qualitative data showed participants felt the art therapy group was an enjoyable experience and improved their sense of well-being. While the number of participants was small, the results were promising and larger scale studies will help determine if these results can be generalized to the overall population.

Stallings (2010) conducted a qualitative research study that utilized the practice of collage making with three older adults who had dementia, two women and one man. The study used the Landgarten Magazine Photo Collage assessment, clinical observations, and case notes. The study found that self-empowerment, self-expression, and a sense of dignity can come from partaking in the arts. The study found positive results in only two sessions, so further research including more than two sessions may provide even more positive effects. Also, one of the participants only participated in one session, not two. The directive promoted communication, interaction, and positive reminiscence between the participants who worked together during each of the sessions. This study had a small sample size, but the results prove promising for a larger population.

Cohen, Perlstein, Chapline, Kelly, Firth, and Simmens (2006) reported positive results from a therapeutic group for older adults led by professional artists in a widely cited research study. Cohen, et al. (2006) conducted a longitudinal study with 166 older adult participants 65 years and older, with a mean age of 80. The participants were divided into either a control group which participated in their usual activity or an experimental group which was involved in diverse programs led by professional artists in a wide range of disciplines including painting, music, writing, and jewelry making. The study participants were given questionnaires such as a depression scale, loneliness scale and health scale. They also gave self-reported measures regarding their habits. Noteworthy differences were found in the two groups regarding overall
health (intervention group rated health on a scale of 0-10 at 7.97 compared to 7.25 in the control group), doctor visits (6.73 for intervention group compared to 10.84 in control group), and number of medications (2.61 for intervention group and 4.25 in control group). The groups were found to have a positive impact on quality of life, mood, feelings and ability for the older adult. Participants also reported a lowered instance of depression and loneliness as well as lowered medication and falls. A significant finding was that falls decreased from 0.40 to 0.23 per person for the intervention group and increased from 0.36 to 0.55 per person for the control group over a year’s time. Although this study found that the participatory group had an overall positive experience from the art experience, the groups were led by professional artists and not expressive therapists. This suggests that art making in and of itself can provide therapeutic benefits. A limitation of this study is that the majority of both groups were white and mostly female, therefore not representing a wide range of diversity.

A 2012 quasi-experimental French study examined the role of a geriatric inclusive art (GIA) program on in-hospital mortality among older adults in a geriatric acute care unit. The participants (n=55) were diagnosed with dementia and participated in an art therapy group of up to four people where they painted a picture (Beauchet, Launay, Annweiler, Remondiere, & Decker, 2014). Compared to the control group, the GIA group participants were less likely to die while on the acute care unit (Beauchet, et al., 2014). The researchers hypothesized the painting directive created a positive affect on the participants that may improve general mobility and lead to successful rehabilitation. The study found advanced age of the participants, regardless of their group, increased the risk of death while on the acute care unit. A limitation to this study is that the participants were not randomized and completed only one group session.
However, this study indicates positive results can occur in just one session and these results could be used to inform the design of a larger study.

**Limitations of Art Therapy**

Participation in art therapy and groups has been shown to improve self-esteem, reduce depression and anxiety, increase attention span, offer greater social inclusion with others, and increase cognitive performance (Alders & Levine-Madori, 2010; Doric-Henry, 1997; Karges-Bone, 2012; Lanza, 1997; Magniant, 2004); however, there are limitations to this treatment modality.

A possible hindrance to an art therapy approach could be the clients’ belief that they lack skills in the modality. This is most common with adults (Lobban, 2016; Lowman, 1992; Magniant, 2004). Factors such as this apprehension regarding artistic skill, the fear of failure or being judged, and feeling vulnerable can be barriers to client participation in art therapy (Lobban, 2016). While an art intervention may be anxiety provoking, one role of an art therapist is to help participants decrease anxiety when engaging in the creative process (Weisberg & Wilder, 2001). The therapist can use basic terms instead of art specific language to encourage older adults creatively in the art therapy group (Weisberg & Wilder, 2001).

Older adults may be resistant to creative offerings if their previous life experience and work did not include familiarity with the arts (Lowman, 1992; Magniant, 2004; Martini, Weeks & Wirth, 2002). Art therapists conducting groups in long-term care settings often find residents are hesitant to join an art group citing their perceived lack of artistic ability (Lanza, 1997; Magniant, 2004; Martini et al., 2002; Weisberg & Wilder, 2001). For many older adults, artistic expression can be hindered by “…limited spontaneity in expression” (Lanza, 1997, p. 142). Even as far back as 40 years ago an art therapist noted the helpfulness of ‘assignments’ and
instruction for older adults as open ended creative freedom may be too overwhelming and confusing for this population (Crosson, 1976).

Maslow’s Hierarchy of Needs can help art therapists understand the divide between creative art making and the hesitancy of many older adults to join a social group (Lanza, 1997). It will be hard for residents to participate in an art therapy group if their current basic needs such as hunger or pain management have not been met to their satisfaction or they are uncomfortable with the group premise (Lanza, 1997; Magniant, 2004).

Older adult males may need extra encouragement to join art therapy groups as they may not be accustomed to expressing themselves creatively (Hayes & Povey, 2011; Lowman, 1992; Weisberg & Wilder, 2001). It is important to keep art therapy groups gender neutral in order to attract participants of either sex (Weisberg & Wilder, 2001). Although not as common, another limitation to art therapy is that clients who are skilled arts practitioners will rely on learned talents and can have trouble letting go of their artistic training in order to participate fully in the therapy session (Malchiodi, 2005).

The current workforce is inadequately staffed to meet the mental health needs of older adults (Lehning & Austin, 2009; Stone, 2012). As the population continues to age this may become a limitation of care for the older adult. Another drawback to the art therapy approach can be therapist’s lack of experience. Newer clinicians may treat art therapy sessions as a blanket approach and utilize routine directives of their choice instead of what the client or group needs or desires (Malchiodi, 2005). Additionally, a professional artist, nurse, or non-art therapist could easily make the mistake of drawing his or her own conclusions to client art, which could be vastly different from the client’s intent.
Long-term care facilities are understaffed with qualified counselors, psychologists, and gerontologists to meet the specific complex physical and mental health needs of older adults in the institutional setting (Ganote, 1990; Molinari & Edelstein, 2011; Solway, Estes, Goldberg & Berry, 2010). Stone (2012) expressed a need for caregivers trained and competent to deal with mental health and as well as substance use in the geriatric population.

Working with the older adult population can be challenging for art therapists who find the work stressful or sad (Geller, 2013). Magniant (2004) projected an increased need of qualified therapists to work with the older adult population as the baby boomers continue to age. Currently there is a lack of adequate resources and funding for art therapists to work directly with older adults in need (Mihailidis, Blunsden, Boger, Richards, Zutis, Young, & Hoey, 2010). Art therapists have limited funding sources such as federal agencies or foundations to which they can apply (Kaimal & Blank, 2015). Often facilities that house older adults lack adequate funding or are unable to pay for art therapy services and research (Hayes & Povey, 2011; Weisberg & Wilder, 2001). Additionally, some facilities are reluctant to allow researchers in to conduct studies even if participants are willing (Kaldy, 2016). Fewer art therapists specializing in older adults translates to a decline in qualified practitioners providing services which will impact care and research opportunities (Elkins & Deaver, 2015). Due to the lack of racial, cultural, and gender diversity among professional art therapists, there is a need to enhance diversity in the field (Elkins & Deaver, 2013). While there is a need for more evidence based and peer reviewed art therapy research, the modality has been demonstrated to be a statistically significant means of treatment for a variety of issues in various age groups (Slayton, D’Archer, & Kaplan, 2010).

Therapists working with older adults often encounter initial client resistance to art therapy and may be apprehensive working with an older adults’ health issues or limitations
Art therapists who work with older adults must enjoy the population and be aware that it can be harder to engage them in activity (Magniant, 2004; Weisberg & Wilder, 2001). Involving resistant clients in art therapy can take additional ingenuity and skill for the therapist (Doric-Henry, 1997; Magniant, 2004; Weisberg & Wilder, 2001). Art therapists working with older adults in communal living situations may also encounter skeptical or resistant staff which creates difficulty if they are needed to assist the therapist in gathering participants for group (Doric-Henry, 1997; Weisberg & Wilder, 2001).

Therapists who may feel comfortable with their education and skill set may be lacking in experience adapting activities for those with physical limitations or communicating effectively with someone who has cognitive impairment or a form of dementia (Rollins, 2013). An Australian study assessed the comfort level of students and faculty in psychology and social work educational programs and found a correlation between positive contact with older adults and positive views on aging (Chonody, Webb, Ranzign, & Bryan, 2014). There was also a correlation between negative contact with older adults and an overall negative attitude towards working with this population (Chonody, et al., 2014).

According to the most recent American Art Therapy Association Membership Survey Report (for the year 2013), there is a slight increase of art therapists working in a geriatric facility (4%) compared to 3.75% in 2011 (Elkins & Deaver, 2015). The 2009 survey reports 38% worked with those age 65-74, 25% worked with those age 75-89, and 13% worked with those age 90 and above. The numbers in each of those age groups had declined in the 2011 survey (32% worked with those age 65-74, 17% worked with those age 75-89, and 10% worked with those 90 and above). These results may be skewed since respondents had the option to select all age groups that they work with, so if a respondent works with 65-74 year olds, odds are...
good they also work with 75-89 year olds and their selection would have been duplicated in the survey results. Because of this, it is also very likely if respondents work with those age 90 and above, that they may select all three age categories. Respondents identifying their area of specialization as ‘Gerontology’ was highest in the 2007 survey with 8%. In the 2009 survey the number dropped to 7.5%, in 2011 it fell to a low of 4.9%, and in the 2013 was on the rise again with 6.25%. Although the number of respondents specializing in gerontology is on the rise, it is still below 2007 numbers (Elkins & Deaver, 2013).

Ageism is another factor that can impact work with older adults (Durost, 2011; Fuss, 2010; Stewart, 2004; Weisberg & Wilder, 2001). Ageism can occur when an older adult is stereotyped, excluded, demeaned, or overlooked (Durost, 2011; Stone & McMinn, 2012). Mental health professionals have been shown to hold bias against older adults, citing them as less likely to benefit from treatment (Helmes & Gee, 2003). These negative attitudes by health care providers can affect the quality of care given to the older adult, who is often underserved by the mental healthcare profession (Fuss, 2010; Stone & McMinn, 2012).

Art therapy can be especially beneficial by giving older adult populations the means to explore non-verbal narratives through art materials (Durost, 2011). It is important that the art materials are chosen carefully for older adult clients because the line between ageist and appropriate is often vague and up to the discretion of the therapist to make the correct choice (Stewart, 2004). Materials that may be considered child like, such as crayons or finger paint, can be successfully utilized by older adults (Stewart, 2004). Durost (2011) encouraged therapists to focus on the needs of each client, not their age.

An additional limitation which can impact art therapy groups as well as other interactions with older adults is the behavioral pattern of infantilization (Marson & Powell, 2014).
Infantilization occurs when a service provider or a person in power deals with an older adult as though they were a child (Marson & Powell, 2014). This can occur through direct verbal interactions with the older adult by using pet names, a ‘baby voice’ with high pitch, or simple, child-like vocabulary words (Marson & Powell, 2014). Other means of infantilizing an older adult could be openly discussing their mental and physical health concerns and information, or providing age inappropriate leisure activities (Marson & Powell, 2014). Infantilizing older adults is disrespectful and can actually hinder their mental and physical competence as well as discourage their independence (Marson & Powell, 2014; Whitbourne & Cassidy, 1994). It is important to avoid this condescending manner of interaction and provide age appropriate art materials and directives for this population (Stewart, 2004).

Summary

With the aging of the baby boomers, older adults are quickly becoming the biggest population in the health care industry (Wickland & Basting, 2009). Accommodation options for older adults vary widely depending on need and desire. Housing options include independent living, assisted living, and long-term care. Other options for older adults include adult day programs, ‘aging in place’ in the home, and hospice care. The need for person centered care is great and encompasses holistic experiences, interactions, and individualized, purposeful care of older adults (Porock, 2013). Creative aging practices include new and diverse programming, such as the inclusion of art therapy (Abrahms, 2011; Sole, Mercadal-Brotons, Gallego & Riera, 2010).

As anxiety affects up to 56% of the older adult population, there is a need to address this dilemma (Therrien & Hunsley, 2012). There are challenges in properly diagnosing older adults with anxiety disorders due to symptom confusion with other medical complaints (Clifford et al., 2015; Therrien & Hunsley, 2012). Additionally, older adults may encounter ageism or
stereotypes which can impede a clear conclusion (Yan, et al., 2011). Baby boomers have been more willing to seek out professional care when dealing with mental health issues such as anxiety (Mohlman, 2012). Research has shown older adults prefer counseling services or other non-pharmacological interventions to treat anxiety (Mohlman, 2012; Riley, Burgener, & Buckwalter, 2014).

Art therapy with older adults offers a different experience than verbal therapy alone and may meet emotional and psychological needs of this population (Zeller, 2005). Art therapy offers creative expression and is inclusive for those who have physical or mental limitations (Abrahms, 2011; Flood & Phillips, 2007). Art therapy can allow the older adult a means of self-expression which promotes well-being and empowerment (Ehresman, 2014). Participation in art therapy groups can aid the older adult socially, cognitively, and physically (Alders & Levine-Madori, 2010; Magniant, 2004; Zeller, 2005).

Research examining the role of art therapy on specific populations such as older adults is essential to providing quality services (Deaver, 2002; Reynolds, Nabors, & Quinlan, 2000). While there have not been a great deal of research studies regarding the effectiveness of art therapy as a healing modality with older adult populations, the studies which have been done indicate effectiveness (Alders & Levine-Madori, 2010; Chambala, 2008; Kim, 2013; Stallings, 2010).

Limitations of art therapy were found to include client hesitation to participate because of perceived lack of artistic talent or skill, therapist inexperience, and participant motivation (Sole, Mercadal-Brotons, Gallego & Riera, 2010). Another shortcoming to art therapy can be a lack of therapist experience and familiarity with the older adult population (Magniant, 2004; Malchiodi, 2005). Older adults are sometimes less spontaneous and less willing to participate in a group
environment, such as that found in an art therapy group (Lanza, 1997; Lowman, 1992; Weisberg & Wilder, 2001).
CHAPTER 3

Methods

Research Question

The purpose of this study was to ascertain the effects of two painting interventions (traditional and touch painting) for older adults with anxiety. The GAI (Geriatric Anxiety Inventory) was utilized as a pre and post-test measurement. It is hypothesized that touch painting will decrease anxiety levels in participants.

This study researched the difference in levels of anxiety after a traditional painting intervention versus touch painting intervention as well as any difference in participants’ level of anxiety when they are asked to create paintings regarding specific themes such as safety, belonging, or esteem in mind.

This research addressed the following questions:

1. Do older adults report changes in levels of anxiety after a touch painting intervention?
2. Is there a difference in participants’ level of anxiety utilizing traditional painting materials versus touch painting in art therapy sessions?
3. Is there a difference in participants’ level of anxiety utilizing traditional painting materials versus touch painting when they are asked to create paintings with specific themes (such as safety, belonging, esteem) in mind?

This research will begin to fill gaps in the literature: (a) It addressed touch painting as an art therapy intervention, and, (b) It addressed anxiety levels of older adults, and (c) It determined if specific creative themes elicit different results on the anxiety measurement.
As touch painting has not been researched prior to this study, there is an opening to further the field of art therapy with this specific intervention and to provide an effective treatment option to address the anxiety of older adults in community care settings.

**Research Design**

This research study used quantitative methodology assessed by the Geriatric Anxiety Inventory. The Geriatric Anxiety Inventory (GAI) has been validated to have sound psychometric properties for use with typical older adults as well as those diagnosed with Generalized Anxiety Disorder (Pachana, Byrne, Siddle, Koloski, Harley, & Arnold, 2007). The test was created for the population of older adults. It is also appropriate for the typical range of anxiety found in older adults living in a communal situation (such as an assisted living or long-term care facility). The GAI has been shown to have excellent internal consistency and has been determined to be an effective measurement for detecting anxiety in older adults (Therrien & Hunsley, 2012).

This study examined the effect of art therapy sessions utilizing the directive of traditional painting or touch painting on older adults with anxiety. Deborah Koff-Chapin, an artist, popularized the technique of ‘Touch Drawing.’ On Koff-Chapin’s website, www.touchdrawing.com, she discussed her discovery of the process and application of it for professionals. Koff-Chapin asserted that the technique has not been researched and it is open for professionals in any field to customize the method (personal communication, November 6, 2014).

As touch painting utilizes aspects of finger painting, haptics, sensory stimulation, and monoprinting, it is important to note how these elements combine to create the foundation for touch painting. Finger painting is an informal and spontaneous technique that uses simple steps
to accomplish (Fleming, 2006; Kovach, 2012). The lack of materials needed for finger painting and touch painting, such as brushes to hold, may be helpful for older adults with limited grasping ability or fine motor skills. Finger painting is a basic form of sensory engagement and can provide cognitive stimulation as well as information processing (Schoenwald, 2012). Haptics, or communication and perception through touch, has been shown to be most powerful when using both hands (bimanual exploration), as opposed to just one hand (unimanual exploration) (Wijntjes, Lienen, Verstijnen, & Kappers, 2008). Touch has an impact on emotion and the experience of touching smooth materials has been found to elicit a pleasing emotional experience (Mammarella, Fairfield, & Domenico, 2012). Printmaking has long been used with older adults as a creative modality (Barret, 1993; Magniant, 2004). The setup of the touch painting directive is well suited for older adults in that touch interaction is a familiar means to manipulate the world around us (Piper, Campbell, & Hollan, 2010). Additionally, a large surface area (such as that used for touch painting) has been reported as being less intimidating and frustrating than a smaller space for older adults (Piper, Campbell, & Hollan, 2010).

It is predicted that touch painting may be a way for older adults to enjoy the experience of painting and reduce both the anxiety related to artistic skill as well as reduce symptoms of anxiety overall since it is a more unstructured means of creating. Touch painting may also be looked at as a means of creative play which could facilitate continued self-actualization in older adults (Fuss, 2010). Painting in the traditional method, with a paintbrush, may increase anxiety for those who have problems such as decreased eyesight, lack of pincer grasp or limited hand strength or coordination. The unstructured format of touch painting could increase feelings of success for the participant, however it could overwhelm the participant who may feel lost without structure. The layer of paper between the paint and hands offers distance and structure
between the participant and the art piece. Tissue paper was selected for this study after trial runs
with a heavier paper medium. Drawing paper was not see through after application on the touch
painting board, which limits the immediate act of creation. Tissue paper is thin enough for
participants to see what they are creating, as they create it.

This study had 44 total participants divided into two groups; a control group and an
intervention group. The statistics only include GAI scores from the 36 participants who
completed all four sessions. The control group participants attended up to four half hour art
therapy sessions conducted using traditional or typical painting materials such as acrylic paint in
primary colors of red, blue, and yellow, brushes, and paper. The intervention group participants
attended up to four half hour art therapy sessions conducted with touch painting materials of
foam core boards, water based oil paint in primary colors of red, blue, and yellow, brayers (paint
rollers), and tissue paper. The water-based oil paint was preferred for this study because it does
not dry out as fast as acrylic paint.

The participants were provided with the themes for the art therapy sessions in the
following progression: (1) Free painting, (2) Safety, (3) Belonging, and, (4) Esteem. This
progression is partially based on acquainting the participant with the art materials (session one)
and partially based on Maslow’s Hierarchy of Needs (sessions two through four). The
motivation for this sequence was that participants have their basic physical needs (food, clothing,
medication, etc.) met by their facility staff but their higher needs may be unmet. The basic needs
are the foundation of Maslow’s Hierarchy and once those are satisfied the participant can focus
on the higher order needs (Herbst, 2006). It is up to the therapist to try to engage the older adult
participant with the art materials regardless of where they fall on Maslow’s hierarchy (Crosson,
1976).
With approval from the Lesley University Institutional Review Board (number 15-028) and permission granted from facilities, data were collected pre and post each art therapy session. Participants were given the GAI to assess if there is a difference in the anxiety levels between the two groups after the art therapy intervention of traditional painting or touch painting. Due to the age, health, and possible decline of the participants, it was thought a pre and post session measurement (instead of a pre and post study measurement) would provide the most accurate data. In an assisted living or long-term care setting, participants are more likely to decline in health and may become unavailable to the research study therefore the data were collected immediately before and after each art therapy session.

The data collection for this study occurred over a three-month period in five assisted living or long-term care facilities in the Southeast. The quantitative data was analyzed by staff at the Biostatistics, Epidemiology, and Research Design group at the University of Alabama at Birmingham.

**Participants**

Participants in this study were recruited from five assisted living or long-term care facilities in the Southeast. With assistance from each facility’s Chief Executive Officer, Social Services Director, Activities Department, and/or Director of Nursing, participants who exhibited anxiety or anxious symptoms were recruited for the study. Participants were recruited for the study via facility staff, or self reported as having anxious symptoms, and did not have to be clinically anxious to enroll in the research study. However, participants did need to express anxious symptoms as determined by the facility staff. Parameters for the study required participants who were physically able to paint, were cognizant and aware of themselves and others, were able to follow directions, and had the verbal ability to answer questions.
Participants signed a consent form and retained a blank copy of the form. Participants had the choice to not participate in the research and had no negative consequences if they declined to participate or chose to leave the study before it was complete. Only data from subjects that completed all four sessions were included in the statistical analysis. Participants were divided into either touch painting or traditional painting groups. As the study progressed, prior participants helped spread the word and recruit others in their facility.

This study entailed 44 total participants aged 55-100. All participants lived in long-term care or assisted living facilities in the Southeast. Participant demographics are below in Table 1:

Table 1

Demographics of Participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Traditional Group</th>
<th>Touch Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (SD)</td>
<td>78.5 (10.0)</td>
<td>80 (13.3)</td>
</tr>
<tr>
<td>Male (%)</td>
<td>6 (27.3%)</td>
<td>1 (4.6%)</td>
</tr>
<tr>
<td>Female (%)</td>
<td>16 (72.7%)</td>
<td>21 (95.4%)</td>
</tr>
<tr>
<td>Black</td>
<td>9 (40.9%)</td>
<td>4 (18.2%)</td>
</tr>
<tr>
<td>White</td>
<td>13 (59.1%)</td>
<td>18 (81.8%)</td>
</tr>
</tbody>
</table>

Procedure

This study divided the 44 participants into either a control group (n=22) or an intervention group (n=22). Each group attended up to four half-hour art therapy sessions facilitated by an art therapist. The control group was the traditional painting group and was instructed to use materials such as acrylic paint in primary colors of blue, red, and yellow, with white taklon (synthetic brush fiber) flat size six long handled brushes, and 12”x18” white paper. The intervention group was the touch painting group and was instructed to use 20”x30” white foam core boards, brayers (paint rollers), water based oil paint in primary colors of blue, red, and
yellow, and tissue paper. All groups were instructed by an art therapist at each session on how to utilize materials and the therapist ensured all participants understood the process and the directive. To avoid any confounds that might arise from the group leader administering the assessment tool, every effort was made to locate facility staff members to administer the Geriatric Anxiety Inventory assessment pre and post each session. In those instances no facility staff members could be located, the art therapist administered the assessments.

The Geriatric Anxiety Inventory (GAI) asks the participant if they agree or disagree with the following statements:

1. I worry a lot of the time.
2. I find it difficult to make a decision.
3. I often feel jumpy.
4. I find it hard to relax.
5. I often cannot enjoy things because of my worries.
6. Little things bother me a lot.
7. I often feel like I have butterflies in my stomach.
8. I think of myself as a worrier.
9. I can’t help worrying about even trivial things.
10. I often feel nervous.
11. My own thoughts often make me anxious.
12. I get an upset stomach due to my worrying.
13. I think of myself as a nervous person.
14. I always anticipate the worst will happen.
15. I often feel shaky inside.
16. I think that my worries interfere with my life.
17. My worries often overwhelm me.
18. I sometimes feel a great knot in my stomach.
19. I miss out on things because I worry too much.
20. I often feel upset.

The GAI is a self-report measurement for older adults and a score of zero to eight ‘agree’ responses indicate an absence of clinically significant anxiety, while a score of nine and above ‘agree’ responses indicate the presence of clinically significant anxiety.

Both the control and intervention groups had the same directives for the four art therapy sessions. The directives were centered on the following themes: (1) Free painting, (2) Safety, (3)
Belonging, and, (4) Esteem. The therapist used the same language in both the control and intervention group. For example, in the second session, to introduce the theme of ‘safety’, the therapist would say, “Today we’re going to create a painting with the theme of ‘safety.’” Think about what this word means to you and how you can express it. What comes to mind when you think of ‘safety’? With this in mind, create a painting around the theme of ‘safety.’”

Session one offered free painting for creative expression and experimentation. The order of the four sessions is important in that the first session in both groups was ‘free painting’, which acclimated the participants to the sensation of painting and allowed them to experiment with the materials. In her years of leading touch drawing sessions, Deborah Koff-Chapin stated she often has the first session be pure experience to introduce the technique (personal communication July 21, 2015). Sessions two, three, and four are based on Maslow’s hierarchy of needs. The rationale for inclusion of Maslow’s hierarchy is that historically, medical needs (physical needs, the foundation of Maslow’s hierarchy) of older adults have been the primary focus of care, but there is a need for more complete care that encompasses psychological issues (Herbst, 2006).

Equipment and Materials

The control group, using traditional painting materials, was provided: 12”x18” white paper, acrylic paints in primary colors of blue, red, and yellow. White synthetic fiber flat size six long handled brushes, water containers, and paper towels were also provided. The intervention group, using touch painting materials, was provided: 20”x30” white foam core boards, brayers (paint rollers), water based oil paint in primary colors of blue, red, and yellow, and tissue paper.

The white foam core boards are incredibly lightweight and also have a smooth surface. Due to the nature of working with older adults the boards for this researcher determined white
foam core boards would be easiest for older adult participants to successfully maneuver. All materials were provided by the researcher.

The space where the art therapy sessions took place varied by facility. Ideally the groups were facilitated in a private area with minimal distractions. Realistically, long-term care and assisted living facilities are busy, and often loud places. Some groups were able to meet in a private space, such as an open room with tables set up and closed doors, a meeting room, a quiet end of a living area, an activity room, or similar. However, some spaces were dual purpose. One group took place at one end of a busy room where a birthday party was wrapping up. After finding the previous meeting space locked with no staff in sight, another group took place in the dining room just after lunch while staff were cleaning and other residents were waiting for assistance. Two groups took place in a resident’s room when she was unable to leave her bed. The resident was unable to leave her room however, she was willing to participate and engage in the art therapy activity from her bed. Other group members agreed to participate in the group in this resident’s room. Using the lightweight white foam core board allowed the bed bound participant to hold the board easily in her lap.

Data Collection

After confirming participants had signed a consent form and given assent to join the art therapy group, a staff member of the facility asked participants the 20 question Geriatric Anxiety Inventory questions before the group began and the facility staff member noted the responses. At times no facility staff were available or could be located, so the researcher gathered participants for group and completed the GAI assessment. A total of two art therapists facilitated groups in two different states, one conducted groups in Tennessee, and one conducted groups in Alabama. The art therapist began each session by introducing herself and the theme for the
group session. Participants were then given instructions on either traditional painting or touch painting by the art therapist facilitator, depending on their group, and discussed the theme for the session as they painted. At the end of the session, the staff member would again give the 20 question Geriatric Anxiety Inventory assessment. As participants were leaving group and the facilitator was cleaning the space, the discussion often continued. The facilitator made notes of participants’ comments and included these comments in the research as anecdotal evidence in support.

**Method of Analysis**

SAS software, version 9.4 (SAS Institute, Cary, NC) was used to perform the statistical analyses. The mixed model was used to examine the treatment effects as well as the group effects, taking the repeated measures into account. Other tests used were the Fisher’s exact test for demographics, the Wilcoxon Rank Sum Test, and the Wilcoxon Signed Rank Sum Test. The Wilcoxon Signed Rank Sum Test was used in this study to compare the sample means of age and baseline GAIIs between groups because of the small sample size and non-normality distribution.

The Fisher’s exact test is traditionally used for small sample sizes but is valid for all sample sizes. For this study the Fisher’s exact test was used to compare the frequencies of gender and ethnicity between groups. Only participants with complete data (participants who successfully completed all four art therapy sessions) were used in the descriptive analysis. In this study 36 of the 44 participants completed all four art therapy sessions. No adjustments were made for multiple comparisons.
This study asked the following questions:

1. Do older adults report changes in levels of anxiety after a touch painting intervention?
2. Is there a difference in participants’ level of anxiety utilizing traditional painting materials versus touch painting in art therapy sessions?
3. Is there a difference in participants’ level of anxiety utilizing traditional painting materials versus touch painting when they are asked to create paintings with specific themes (such as safety, belonging, esteem) in mind?

Out of 44 total participants, 36 finished all four sessions. The data from these 36 is represented in the results.

The table below shows the baseline GAI pre-test score for both traditional and touch painting groups (Session 1) and the GAI pre and post-test scores for the other three sessions (Sessions 2,3,4). These data indicate there were no significant differences between the groups at the outset of the study.
Table 2

*Participant scores pre and post each session*

<table>
<thead>
<tr>
<th>GAIs</th>
<th>Traditional (N=22)</th>
<th>Touch (N=22)</th>
<th>P values (group difference)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-treatment</td>
<td>6.8 (4.7)</td>
<td>6.1 (2.9)</td>
<td>0.95</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>4.1 (3.6)</td>
<td>2.7 (2.3)</td>
<td>0.25</td>
</tr>
<tr>
<td>Change</td>
<td>2.7 (2.0)</td>
<td>3.4 (1.9)</td>
<td>0.16</td>
</tr>
<tr>
<td>P values (pre vs post)</td>
<td>&lt;.0001</td>
<td>&lt;.0001</td>
<td></td>
</tr>
<tr>
<td><strong>Session 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-treatment</td>
<td>6.3 (4.5)</td>
<td>5.0 (2.9)</td>
<td>0.35</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>3.5 (3.6)</td>
<td>2.2 (1.6)</td>
<td>0.20</td>
</tr>
<tr>
<td>Change</td>
<td>2.9 (2.7)</td>
<td>2.8 (2.1)</td>
<td>0.63</td>
</tr>
<tr>
<td>P values (pre vs post)</td>
<td>&lt;.0001</td>
<td>&lt;.0001</td>
<td></td>
</tr>
<tr>
<td><strong>Session 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-treatment</td>
<td>5.7 (4.2)</td>
<td>3.9 (3.4)</td>
<td>0.10</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>3.4 (4.1)</td>
<td>1.8 (1.9)</td>
<td>0.13</td>
</tr>
<tr>
<td>Change</td>
<td>2.3 (2.0)</td>
<td>2.2 (2.4)</td>
<td>0.45</td>
</tr>
<tr>
<td>P values (pre vs post)</td>
<td>&lt;.0001</td>
<td>0.0001</td>
<td></td>
</tr>
<tr>
<td><strong>Session 4</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-treatment</td>
<td>5.0 (4.0)</td>
<td>3.4 (2.6)</td>
<td>0.15</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>3.0 (3.9)</td>
<td>1.6 (1.7)</td>
<td>0.18</td>
</tr>
<tr>
<td>Change</td>
<td>2.0 (2.0)</td>
<td>1.8 (2.0)</td>
<td>0.60</td>
</tr>
<tr>
<td>P values (pre vs post)</td>
<td>&lt;.0001</td>
<td>0.0001</td>
<td></td>
</tr>
</tbody>
</table>
As Table 2 shows, there were no statistical differences between the traditional painting or touch painting group. The decreases in anxiety scores between pre and post-test and across sessions are shown in Figures 1-4.

Higher scores on the Geriatric Anxiety Inventory (GAI) indicate greater anxiety. Out of 20 items, a participant has to score a nine or above to indicate clinically significant anxiety. As Table 2 shows, prior to the first session, the average GAI scores were below clinical significance and there were no significant differences between the two groups (p = 0.95). However, the pre-test GAI score is decreased at each subsequent art therapy session; session two p = 0.35, session three p = 0.10, session four p = 0.15. The traditional painting group overall exhibits a higher level of anxiety than the touch painting group at each session. The first session (baseline) with the theme of ‘free painting’ in which the participants were encouraged to experiment with the materials, shows the highest level of anxiety for both groups (6.8 for the traditional group and 6.1 for the touch painting group). As this was the first meeting of each group there may have been factors such as increased anxiety regarding goals of the group, completing the GAI measurement, or uncertainty concerning confidence in working with art materials. As the sessions progressed the pre-test score consistently declined.

Anxiety levels for sessions two (‘safety’), three (‘belonging’), and four (‘esteem’), have a lower pre-test score than session one (‘free painting’). The pre-test score for session two was 6.3 for the traditional group and 5.0 for the touch group. Session three pre-test score was 5.7 for the traditional group and 3.9 for the touch group. Session four pre-test score with the theme of ‘esteem’ shows the least level of anxiety with 5.0 for the traditional group and 3.4 for the touch group. This continuous decreasing score on the pre-test measurement may be due to participants’ sense of familiarity with the study process as sessions progressed, familiarity with
the GAI measurement, increased confidence with materials and their ability, or some combination of those factors.

Figure 1 shows the results of the GAI assessment score pre and post each traditional painting group.

Figure 1

*GAI results for traditional painting group*

Figure 1 error bars represent standard deviation of GAI scores and show a decline in anxiety as reported on the GAI assessment. This figure shows the significant decline in reported scores for session one pre-test to session three pre-test (p = 0.044), and session two pre-test to
session four pre-test (p = 0.005). Figure 1 also shows the significant decline between pre and post-test scores.

Figure 2 shows scores from Session 1 compared to Session 4 for the traditional painting group.

Figure 2

*GAI results for traditional painting session 1 compared to session 4*

Figure 2 shows the significant decline in the anxiety from the traditional painting group session one pre-test (6.8) to session four pre-test (5.0) p = 0.004, as well as the significant decline in sessions one and four pre and post-test measurements. The post treatment scores show a decline from 4.1 in session one to 3.0 in session four.
Figure 3 shows the results of the GAI assessment score pre and post each touch painting group.

Figure 3

*GAI results for touch painting group*

Figure 3 shows error bars represent standard deviation of GAI scores and show a decline in anxiety as reported on the GAI assessment. This figure shows the significant decrease in each session pre and post-test, session one pre-test to session two pre-test (p = 0.009), session one pre-test to session three pre-test (p = 0.0004), and session two pre-test to session three pre-test (p = 0.017), and session two pre-test to session four pre-test (p = 0.001).
Figure 4 shows Session 1 compared to Session 4 results for the touch painting group.

*GAI results for touch painting session 1 compared to session 4*

![Bar chart showing GAI results for touch painting session 1 compared to session 4.](image)

Figure 4 shows the significant decline in baseline anxiety from the touch painting group session one pre-test (6.1) to session four pre-test (3.4) (p < 0.0001). Sessions one and four also have a significant decline pre and post-test (p<0.0001 and p = 0.0001). The post treatment scores show a decline from 2.7 in session one to 1.6 in session four. As there is such a large drop in anxiety at the session one post-test, the touch painting results are limited by the floor effect meaning, anxiety doesn’t have much further to decline.

The results from all figures show there is an immediate effect directly after the art therapy group shown by the decrease in anxiety. There is a persistent decline in anxiety at each pre-test measurement. The trend of lessened anxiety at each pre-test measurement is known as the carryover effect. So, overall anxiety is lower at each subsequent art therapy session.
After the adjustment of baseline GAI, age, gender, and ethnicity, both painting interventions can decrease the GAI score. Specifically, the average decrease of the GAI in the traditional painting group is 2.37 (1.16, 3.58), \( p = 0.0003 \). The average decrease of the GAI in the touch painting group is 3.03 (1.83, 4.23), \( p < 0.0001 \). The results show the touch painting group had a greater level of anxiety reduction, but the result was not statistically significant (\( p=0.162 \)).

**Additional Benefits of the Study**

Anecdotal remarks were transcribed after both the traditional painting and touch painting art therapy sessions. These remarks showed participants expressed satisfaction in learning and participation with both styles of painting. The remarks often echoed themes of enjoyment due to the experience.

Comments regarding the touch painting group included: “You learn something new doing this,” “I always feel better after this group,” “This [touch painting method] is open to everyone, anyone can do it and be creative,” and “It’s been a type of experience I’ve never had.” A remark made from a 97 year old female was a poignant testimony to the power of art therapy. After her group she stated, “Some worries have been taken away from us [during the activity]. We’re at the last part of our journey and still have lots of positives built up in us to get out!”

Comments regarding the traditional painting group included: “This was an enjoyable experience,” “I enjoyed learning from others in the group. Learning makes you achieve things better. I enjoyed this and have kept all my papers [art from the sessions],” “This was very exhilarating for me!,” and “I felt like I learned to relax.”

These remarks weren’t part of the official research in the study, but are included because they are representational of every group interaction. This could be due to the social nature of the
group, investment in the creative process, the art itself, or some combination of these factors. The comments at the beginning of the study were some variation on the theme of “I’m not an artist, I can’t do this.” These anecdotal statements paint a fuller picture of the research study.

The discussion and stories that surfaced during the art therapy groups were not included in an official capacity however several staff members exclaimed surprised at the life history that emerged from their residents. For example, one participant while in the ‘safety’ traditional painting group (session two), recalled an incident when she helped a car accident victim hold her head up out of water until she could be safely evacuated. She was honored for her efforts by the Governor of Alabama. Sharing her story seemed to humanize the participant to the staff.

Interesting stylistic commonalities occurred between the groups. The session three theme of ‘belonging’ evoked several images of ‘home’ for the participants. There was discussion around homes they lived in prior to community living and discussion involving belonging to a family and a friend group.
Figure 5 shows a painting from the traditional painting group with the theme of ‘belonging.’

‘Belonging’ traditional painting

The participant stated this painting was of her home (image on right) and her daughter (image on left). While discussing this piece the participant was reflective and began to reminisce with group members. Staff witnessing stated the participant had never spoken of a daughter prior to this group.
Figure 6 shows a painting from the touch painting group with the theme of ‘belonging.’

‘Belonging’ touch painting

This participant stated this image is a house (center) with a fence protecting it. She discussed her farm growing up in Alabama and chores she and her family had to do each day. There was additional discussion of time bringing constant change in addition to theme of ‘belonging’ to the assisted living facility at this time.

**Contribution of the Study**

This study begins to fill a gap in the literature and aimed to identify specific interventions that might be used to decrease anxiety in the older adult population in community care settings. The predicted outcome of this study was that both traditional and touch painting would have an effect on the anxiety level of participants, but the extent of that effect was not known. Consistent with predictions based on previous literature and research, the painting interventions resulted in decreased anxious symptoms in older adults.

This study found that after both painting interventions anxiety significantly decreased over time in older adults. There was no statistical significance between anxiety levels between traditional and touch painting groups. However, by the end of the experimental protocol the touch painting group exhibited lower anxiety overall. There was a statistically significant
decrease in anxiety after the first touch painting intervention. This information can be helpful in planning and executing treatment for older adults. Additionally, results from this study could benefit the older adult population by offering treatment that is non pharmacological, which is an ideal first step for behavioral or psychological stressors (Mayfield & Holmes, 2012).

Prior to this research study there were no studies to be found on the efficacy of touch painting as an art therapy intervention or touch painting in comparison to traditional painting with older adults. Research on the intervention of touch painting with the specific population of older adults will contribute new knowledge to the field, specifically with this population.

This study encompassed a specific art therapy intervention (touch painting) on specific populations (older adults) who exhibited symptoms of anxiety. Furthermore, this study provided data regarding art therapy directives using a variety of themes, which could provide interesting and useful information for the field.

The art materials in this study were offered with best practices in mind. For example, touch drawing is traditionally done with a hard board. For this study it was determined a larger foam core board would be best suited to the population due to its lightness. Participants had no trouble arranging the board to their satisfaction on a table and one participant was able to join the group from her bed and create with the foam core board on her lap. The paint brushes used for the traditional painting session were long handled for easier gripping. Primary paint colors were selected for both groups because they have the brightest chroma and it was thought these would be easiest for older adults to distinguish.
CHAPTER 5

Discussion

This study examined the effect touch painting has on anxiety for older adults in communal living facilities. It compared four art therapy sessions using a traditional painting intervention to four using a touch painting intervention and determined if specific creative themes (such as safety, belonging, esteem) elicited different results on the anxiety measurement. This study addressed the following questions:

1. Do older adults report changes in levels of anxiety after a touch painting intervention?
2. Is there a difference in participants’ level of anxiety utilizing traditional painting materials versus touch painting in art therapy sessions?
3. Is there a difference in participants’ level of anxiety utilizing traditional painting materials versus touch painting when they are asked to create paintings with specific themes (such as safety, belonging, esteem) in mind?

It was hypothesized that touch painting would decrease anxiety levels in participants and this was found to be true. While the study found that touch painting provided greater anxiety reduction and both painting interventions decreased participant anxiety, there was no statistical difference between the two group interventions. However, there were statistically significant decreases in anxiety over the course of both art therapy interventions. All art therapy sessions had an immediate effect on anxiety however, there may be more long-term benefit to the touch painting group as the decline in anxiety happened faster with this group.

The study noted a common statement for both art therapy group members was, “I’m not an artist” which is consistent with previously published literature (Lobban, 2016; Lowman, 1992,
Magniant, 2004; Weisberg & Wilder, 2001). This study found using art therapy as a way to explore and reminisce (rather than simply create from a blank slate) through the various themes seemed to quiet these negative statements among participants. Allowing participants creative space with thematic boundaries encouraged them to experiment with materials and decreased negative or self-defeating comments. It seemed to be beneficial to allow the first session be all about exploration of art materials and technique. Literature stated an overlooked element of art therapy groups for older adults is the opportunity for choice of materials, which can elevate a sense of control (Stewart, 2004; Durost, 2011). This study offered choice to the participants through choice of paint colors and stressed the concept of experimentation rather than artistic finesse. This appeared to encourage those who were reluctant and provide a successful experience for participants to realize there truly is no ‘right’ or ‘wrong’ way to create. Past participants in the study were vocal to their peers in recommending they too join the study because it was an overall positive experience. As facility staff originally recruited participants who exhibited symptoms of anxiety for the study, or participants self-reported anxious symptoms, this peer recruitment was an unexpected positive development.

As the literature review referenced, community living accommodation for older adults such as assisted living and long-term care are designed along a medical model and art therapists may encounter barriers to serving older adults such as reluctant staff (Eckert et al., 2009; Doric-Henry, 1997; Weisberg & Wilder, 2001). This study indeed encountered this barrier several times when no staff could assist the therapist with either gathering participants for group or administering the testing assessment. This study also reflected the literature stating art therapy can create a more holistic image of the client with their caretakers (Kapitan, 2010). The staff members who interacted with study participants after the art therapy sessions often expressed
surprise and interest in the stories and discussion brought forth in the group. Learning more information about the participants seemed to humanize them to their caretakers. Some participants in this study stated a sense of pride displaying their artwork that is similar to the literature that noted art therapy participants can feel confidence from showcasing their artwork (Lanza, 1997; Wickland & Basting, 2009).

This study paralleled components of the anxiety research examined in the literature review such as; most participants had other medical complaints necessitating nursing care (Bassil, 2011; Clifford et al., 2015; Pachana & Byrne, 2012). Medication and physical complaints were often disclosed and referenced throughout the study. In one instance a participant was unable to get up from bed due to her medical condition but the group gathered around her and continued. Health concerns were frequently verbalized among the group members with apparent anxiety and were the most cited reason a participant could not join the group. Participants discussed medication as being both helpful and detrimental. The study echoed the literature in that the older adult participants stated a preference for counseling and art therapy to assist with their anxiety over medication (Mohlman, 2012). Several anecdotal remarks indicated enjoyment and enhanced quality of life through the art therapy experience.

As discussed in the literature review, older adults may be hesitant to participate in art therapy due to a perceived lack of talent in art making, fear of being judged, or fear of feeling vulnerable (Flood & Phillips, 2007; Lobban, 2016; Lowman, 1992; Magniant, 2004). Additionally, three out of four older adults have a chronic health condition (Royer, 2015). Even with these common limitations, this study had better than average participation, which may have been helped by positive word of mouth among participants. Out of 44 older adults in this study, 36 participated in all four art therapy sessions. While the results showed the highest level of
anxiety was session one (free painting), anxiety steadily decreased over the course of the study. This finding mirrors the literature which describes initial client resistance to art therapy can be overcome by a qualified art therapist who can manage it while creating a safe environment for creative exploration (Geller, 2013; Kapitan, 2010).

The literature regarding art therapy with older adults stated group interaction can offer companionship, socialization, life review, and meaningful engagement (Magniant, 2004; Zeller, 2005). This study found the various themes for the sessions were both a springboard and a focal point for discussion within the group. Often stories, memories, and connections between participants were discovered. The groups elicited both positive and negative emotions, laughter, and tears from the participants. Self-expression was honored and encouraged in the study and processing the artwork with clients seemed to aid in confidence, which may be a reason for lowered anxiety reported on the post-session assessment.

Literature showed past art therapy research studies offered groups in a timeframe from a half hour to one hour (Doric-Henry, 1997; Kim, 2013; Stallings, 2010). The groups for this study reserved a time of at least one hour for each art therapy session. The hour timeframe was helpful in that it gave leeway in gathering the group or making alternative preparations (such as offering a group in a resident’s room) but actual execution of the groups was found to take just about half an hour. This was a comfortable time limit that allowed for discussion, art making, and processing. A half hour group also seemed to be a timeframe to hold participant attention and concentration on the task at hand. After the group some participants needed to leave to receive their medication or use the restroom and some stayed behind to chat and continue discussion. The hour timeframe allowed for a successful group and accommodated other participant needs.
Limitations

Limitations of this study include a relative homogeneity of the participants, diminished power for the study due to small sample size, and group facilitation and space.

The participants for the study were all of American ethnicity, residents of the Southeast, and either black or white. The majority of participants were white females.

This study had diminished power due to the small sample size ($n=44$), of which only a subset was included in the statistical analysis. While both interventions led to decreased anxiety, the small sample size might have precluded the ability to detect between group differences. An increase in the sample size may improve the significance of the study and be better able to differentiate the effects of traditional or touch painting groups.

Not every participant in this study completed all four sessions, which reduced the power. This study had 44 total participants, with 36 who participated in all four sessions. The data from only those 36 participants is represented in this study. The absence of several participants was primarily due to their health issues. Working with an older adult population means health conditions may deteriorate rapidly as happened to several participants.

Since participants were recruited by facility staff or their own self-report of anxiety symptoms, it is not known if any participants had a formal diagnosis of an anxiety disorder. This may mean both painting interventions could be best utilized by older adults with a lower starting level of anxiety. Several obviously anxious older adults were brought in to participate but declined to sign the consent form so were not able to join. In fact, the discussion about the consent form seemed to cause more anxiety for these individuals. Since these are the very people who may benefit from this therapeutic activity, this component of the study could have been approached differently.
The group spaces were not always ideal. Some were quiet and private, which projected dignity and validity to the group. Some spaces were loud and had distractions, which seemed to devalue the group. In several instances, no facility staff were available or could be located, so the researcher gathered participants for group and completed the GAI assessment. The likelihood of bias is somewhat diminished however since the art therapy interventions were facilitated by different therapists in a variety of different locations. Because the majority of comments by participants were positive, any bias that might result would likely be positive and reduce the GAI further than the art intervention by itself. However, this may also indicate the value of the role of both the art modality and the art therapist in anxiety reduction with this population.

**Suggestions for Future Research**

To increase the power of the study, it could be executed with groups in a larger number of facilities. Additionally, it would be valuable to gather data from a wide variety of locales, with more ethnicities represented. As this study found participants in assisted living or long-term care facilities, it may be worthwhile to hold groups with older adults in other locations, such as day or community facilities.

Additional research could be conducted examining factors of the relationship between art therapist and the older adult population. Research could systematically look at the effect of relationship, art making, social connectedness, or some synergistic effect of all these factors. As discussed in the literature, there is a shortage of trained mental health providers adequately trained in issues regarding older adults and the older adult population poses unique challenges and opportunities for therapeutic work. The relationship between art therapist and older adult could be the basis for research that further examines this dynamic.
It may be interesting to explore this study with older adult populations, such as those with dementia and Alzheimer’s disease, specifically. Those with dementia tend to naturally explore their world through tactile stimulation, so an intervention with touch painting may be a good fit (Schoenwald, 2012).

It would also be beneficial to further examine the role of the various themes in this study (safety, belonging, esteem) and gather additional data on each of these topics. Qualitative data could be correlated and themes may emerge with valuable material. As shown in this study, the anecdotal remarks often gave a more holistic representation of the participants than just the GAI scores. Adding qualitative data may highlight specific areas of anxiety for the older adult, which would then allow art therapists insight into how to best meet their needs.

As the results from this study show a continued decline in anxiety levels as the sessions progressed, it may be worthwhile to expand on this research with additional sessions to see the saturation point, or where the anxiety levels cease to decline any further. A longitudinal study that follows participants would enrich this data. Utilizing a survey for secondary analysis could also provide beneficial information.

Other art therapist researchers may want to examine touch painting in regards to pain. Like anxiety, pain is related to depression, decreased quality of life enjoyment, and social withdrawal (Boltz, Capezuti, Fulmer, & Zwicker, 2012). As acute and persistent pain can be a common experience for older adults, it may be beneficial to examine the touch painting directive as a means of pain management (Boltz, et al., 2012). As the directive of touch painting requires use of the hands, it is important to note this directive may not be suitable for older adults with certain sensory loss. Some older adults, especially those with diabetes, have been shown to have decreased sensory perception in the hands (Jain, Muzzafarullah, Peri, Ellanti, Moorthy, & Nath,
However, it would be prudent to check in with the client before declaring this specific directive off limits.

**Conclusion**

Art therapy groups have often been described in imprecise terms as ‘helpful,’ ‘fun,’ or ‘good’ for participants. This study provided quantitative data that art therapy painting interventions actually created a decrease in anxiety for the older adult. Both traditional painting and touch painting decrease anxiety significantly and this study identifies touch painting as an art intervention that may be suitable for anxiety reduction in older adults with physical limitations that preclude the ability to hold a brush or create detailed paintings. This information can be used to support art therapy programming in assisted living and long-term care facilities. As the population continues to age it will be imperative to use non-pharmacological methods of anxiety reduction that are proven to assist this demographic.

This study addressed the changes in anxiety levels after a touch painting intervention, the difference in participants’ level of anxiety utilizing traditional painting versus touch painting, and the difference in anxiety levels when creating with specific themes in mind. Results were consistent with previous research literature which showed art therapy groups can decrease anxiety for the older adult. This study showed both pre and post-test changes as well as a decrease in anxiety over time.

The flexibility of touch painting as an art therapy directive was found to be helpful in allowing group participation in a variety of locations and situations. The statistics indicate anxiety decreased even when sessions took place in a variety of locations. Notably, the statistical results were similar when two different art therapists administered the interventions and several different people administered the GAI. As these are all sources of potential
variability, the fact that the results were still strong makes it more likely that it was due to the intervention rather than only to the relationship with the therapist.

As anecdotal information was gathered it became clear through participant quotes and discussion that creativity through painting enhanced the overall quality of life for participants. At the beginning of the study many participants expressed feelings of inadequacy through statements such as, “I’m not an artist, I can’t do this,” but these statements transitioned throughout the study to a more positive expression of enjoyment, experimentation, and confidence. This information and study data can assist art therapists in their treatment of older adults and may provide beneficial in creating specific directives and assessments for this population.

Touch painting was demonstrated to be an effective means of anxiety reduction in the older adult population. Offering participants a choice in materials and utilizing thematic boundaries proved to be helpful in transitioning the focus from artistic talent or skill to experimentation and creative expression. The relationship between art therapist and participant was found to be successful in creating a supportive environment for life review and social interaction. Touch painting should be considered by art therapists for use as a non-pharmacological means of anxiety reduction.
APPENDIX A

RESEARCH CONSENT FORM
Informed Consent Form for the study entitled:  
‘Touch Painting: An Art Therapy Intervention on Anxiety in Older Adults’

Principal Investigator:  
Carrie May Ezell, LPAT, ATR-BC, NCC  
423-653-8116  
cezell@lesley.edu

Co-researcher: Dr. Michele Forinash, MT-BC, LMHC  
Director, Division of Expressive Therapies PhD Program  
Lesley University  
617-868-9600  
forinas@lesley.edu

You are invited to participate in this study to assist in my doctoral research on touch painting as an intervention on anxiety with older adults. The purpose of the study is to examine the effect touch painting has on anxiety with older adults.

Your participation will entail four art therapy sessions that will last approximately one hour each and take place at your facility. You will be asked 20 ‘agree/disagree’ questions before and after each art therapy session. During the art therapy session you will be asked to paint imagery focusing on a theme, such as safety, belonging, or esteem in mind. Your paintings will be photographed but not identified by name in order to protect your privacy. All demographic and identifying details of participants will be kept confidential by the researcher. Data collected from the assessment will be kept confidential.

You will be personally interacting with only myself as the principal researcher. This research project is anticipated to be finished by approximately October, 2015.

I, ______________________________________, consent to participate in a study titled ‘Touch Painting: An Art Therapy Intervention on Anxiety in Older Adults’.

I understand that:

- I am free to choose not to participate in the research and may discontinue my participation in the research at any time with no negative consequences.
- Any and all of my questions regarding this research will be answered at any time and I am free to consult with anyone (i.e., friend, family) about my decision to participate in this research.
- My identity will be protected.
- I am volunteering for four, hour long art therapy sessions involving painting while focusing on a theme such as safety, belonging, or esteem in mind.
- The art therapy sessions will include verbal discussion about safety, belonging, and esteem.
- The art therapy sessions may bring up feelings, thoughts, memories, and physical sensations. Therefore, possible emotional reactions are to be expected, however, I am free to end the session at any time. If I find I have severe distress, I will be provided with resources and referrals to assist me, and will not lose any benefits that I might otherwise gain by staying in the study.
- This study will not necessarily provide any benefits to me. However, I may experience increased self-knowledge and other personal insights that I may be able to use in my daily
life. The results of the study may also help increase public and professional awareness of the needs and experiences of older adults.

- The researcher may present the outcomes of this study for academic purposes such as future articles, books, teaching materials, conference presentations, or in supervision.
- The therapist is ethically bound to report, to the appropriate party, any criminal intent or potential harm to self or others.

**Confidentiality, Privacy and Anonymity:**

You have the right to remain anonymous. If you elect to remain anonymous, we will keep your records private and confidential to the extent allowed by law. We will use pseudonym identifiers rather than your name on study records. Your name and other facts that might identify you will not appear when I present this study or publish its results.

If for some reason you do not wish to remain anonymous, you may specifically authorize the use of material that would identify you as a subject in the experiment. You can contact my advisor Dr. Michele Forinash at 617-868-9600 or forinasm@lesley.edu with any additional questions. You may also contact the Lesley University Human Subjects Committee Co-Chairs (see below)

You will be given a copy of this consent form to keep.

a) Investigator's Signature:

<table>
<thead>
<tr>
<th>Date</th>
<th>Investigator's Signature</th>
<th>Print Name</th>
</tr>
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</table>

b) Subject's Signature:

I am 18 years of age or older. The nature and purpose of this research have been satisfactorily explained to me and I agree to become a participant in the study as described above. I understand that I am free to discontinue participation at any time if I so choose, and that the investigator will gladly answer any questions that arise during the course of the research.

<table>
<thead>
<tr>
<th>Date</th>
<th>Subject's Signature</th>
<th>Print Name</th>
</tr>
</thead>
</table>

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Co-Chairs Drs. Terry Keeney tkeeney@lesley.edu or Robyn Cruz rcruz@lesley.edu at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138.
APPENDIX B

LIST OF ART MATERIALS USED IN SESSIONS

Traditional Painting Sessions:
White synthetic fiber flat size 6 long handled brushes
Acrylic paint in primary colors of blue, red, and yellow
12”x18” white paper

Touch Painting Sessions:
20”x30” white foam core boards
Water based oil paint in primary colors of blue, red, and yellow
Brayers (paint rollers)
White tissue paper
REFERENCES


Behavior Therapy in Long-Term Care Settings. *Behavior Therapy* 42. 59-65.


