Eternal Age: Art Therapy as a Means of Improving Quality of Life

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ABSTRACT

This human-subject study used a mixed methods research design to identify if participation in individual, group, and open studio art therapy sessions would improve the quality of life for older adults. Person centered care was used as a framework for the art therapy programming. The Brunnsviken Brief Quality of life scale (BBQ) was used as a pre and mid test intervention and provided a baseline measure of quality of life. It was hypothesized that there would be an increase in the BBQ scores after participation in a 16-week art therapy program. The average difference of individuals pre and mid BBQ scores were used to identify if a change in quality of life had occurred in the life areas of leisure, creativity, and learning through the art making process. This study assessed creativity and learning through art making and leisure as the time spent in the process. The results showed that the overall BBQ scores were not representative of the gains demonstrated, although there were notable increases in leisure, creativity, and learning. Additionally, companionship was found to be a key factor in quality of life. These findings provided support for the use of a person-centered approach to art therapy which may lead to an increase in quality of life for older adults. Future implications of this study include continuing to explore the correlations between art therapy and quality of life as a means of engaging older adults in meaningful and productive activities that foster self-esteem, autonomy, empowerment, and problem-solving skills.

Keywords: Art therapy, older adults, quality of life, BBQ, person-centered, creativity, leisure, learning

DEDICATION

This work is dedicated the guests and elders who graciously participated in the study making it all possible. Working with each one of you was tremendously rewarding watching your growth from the beginning of the study to the very end. I have gained experience and memories that I will never forget.

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CHAPTER I

INTRODUCTION

Many have gone in search of the magical, restorative waters of the fountain of youth, however few have found it. Sophia Loren states, "There is a fountain of youth: it is your mind, your talents, the creativity you bring to your life and the lives of people you love. When you learn to tap this source, you will truly have defeated age" (as cited in Emling, 2015).

As individuals age, decline usually happens. The decline can occur physically, mentally, or both. As individuals decline, they usually have to give up on things that they once enjoyed such as relationship, hobbies, work, and other leisure activities. Along with the decline, individuals may begin to have feelings of depression, isolation, and low self-worth (Hutchinson, Hersch, Davidson, Chu, & Mastel-Smith, 2011). As the aging population grows, the more they become marginalized (Hutchinson, Hersch, Davidson, Chu, & Mastel-Smith, 2011).

Development in older adulthood becomes a time for meaning making. They have time to do what they please, for some, as a result of retirement. They tend to spend time reminiscing on one's accomplishments and often pass on knowledge to future generations (Cohen, 2006; Broderick & Blewitt, 2015; Peck, 1956). There is a desire to live well to the very end of life.

Creativity allows older adults to gain a sense of control and mastery (Cohen, 2006). It promotes a sense of social engagement, which may be lacking for many older adults. Creativity, like person-centered theory has states that include psychological safety (judgment free zone and empathy), and psychological freedom (freedom to express ideas freely) (Rogers, 1954).

The purpose of this grant funded study was the development of art therapy programming and the use of rating measurements to identify an increase in quality of life for older adults. This thesis focused on the theoretical foundation for program development, themes that emerge for

participants, and the quantitative data from the Brunnsviken Brief Quality of life scale (BBQ). The art therapy program included individual, group, and open studio art therapy sessions. During the art therapy programming, a person-centered approach focused on the understanding of the participants from within their own frames of reference; and their individual ways of experiencing and promoting growth and development. The BBQ was administered pre and mid study and provided a baseline and midpoint report on the perceptions of quality of life. The difference between the pre and mid BBQ scores were compared to identify a difference in quality of life scores occurred from pre to mid study. It was hypothesized that there would be an increase in the BBQ scores from pre to mid assessment.

Operational Definitions

Adult day center: "professional care setting in which older adults, adults living with dementia, or adults living with disabilities receive individualized therapeutic, social, and health services for some part of the day" ("Adult Day Centers," n.d., para. 1).

Aging population: ages 65 and older (Erikson, 1950).

Art therapy: "an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship" (American Art Therapy Association, 2017, para. 2).

Brunnsviken Brief Quality of life scale (BBQ): "brief, easy-to-use and freely accessible self-rating scale of QoL concordant with the overall life satisfaction conceptualization thereof" (Lindner et. al, 2016, p. 189).

Creativity: "the emergence in action of a novel relational product, growing out of the uniqueness of the individual on the one hand, and the materials, events, people, or circumstances of his life on the other" (Rogers, 1954, p. 251).

Discretionary activities: "optional activities usually chosen by the respondent" (Pruchno & Rose, 2002, p. 10).

Formal learning program: "intentional, organized, and structured" (Wang et al., 2018, p.379).

Informal learning program: "unstructured and experiential in nature, resulting from everyday activities related to family or leisure such as discussions with family members or reading books and newspapers" (Wang et al., 2018, p. 379).

Nonformal learning program: "might not be institution-led, but instead managed by local authorities, enterprises, and voluntary organizations" (Wang et al., 2018, p.379).

Obligatory activities: "Activities whose performance is necessary to the conduct of every day life" (Pruchno & Rose, 2002, p. 10).

Person-centered theory: counseling approach that requires the client to take an active role in his or her treatment with the therapist being nondirective and supportive (Rogers, 1949).

Sense of coherence: "general orientation to life indicating the extent to which individuals perceive arising issues as structured, predictable, and explicable, feel confident that they have the resources to deal with these issues, and are motivated and willing to do so" (Slootjes, Keuzenkamp, & Saharso, 2017, p. 571).

Skilled nursing care facility: "aids individuals in need of procedures that must be done by a licensed professional. They are state-licensed and provide nursing and rehabilitative care under the direction of a skilled medical professional 24 hours/day" (Caregiver Foundation, 2019, para. 8).

Successful aging: "low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life" (Price & Tinker, 2014, p. 282)

CHAPTER II

LITERATURE REVIEW

According to the United States Census Bureau, there are 47.8 million adults aged 65 and older living in the United States (Census Bureau, 2018). It is predicted that there will be 98.2 million adults aged 65 and older living in the United States by the year 2060. That is an increase of 50.4 million adults over 43 years.

Studies involving older adults has increased as a result of the ever-growing population. These studies have focused on the use of time, health, and functioning (Hutchinson et al., 2011); Pruchno & Rose, 2002). Researchers have found that the more that is known about the older adult population, the better off they will be able to help them in the long run (Hutchinson et al., 2011).

Health and functional ability are strong determinants of activity patterns (Pruchno & Rose, 2002). A study conducted on time use for older adults by Pruchno and Rose (2002) found that most older adults spend their days at home and alone. "Obligatory activities accounted for a little more than a third of the waking day, with discretionary activities accounting for approximately two-thirds of the day" (Pruchno & Rose, 2002, p. 19). Obligatory activities were defined as "activities whose performance is necessary to the conduct of everyday life" (Pruchno & Rose, 2002, p. 10). Examples of obligatory activities include eating, housework, shopping, and personal/sick care. The study found that the most common obligatory activities were eating and personal/sick care (Pruchno & Rose, 2002). Discretionary activities were defined as "optional activities usually chosen by the respondent" (Pruchno & Rose, 2002, p. 10). Examples of discretionary activities include watching television, listening to the radio, reading, prayer, and

resting. The study found that the most common discretionary activities included watching television and resting (Pruchno & Rose, 2002).

Mental health studies reviewed below on older adults focus on religion, coping mechanisms, achievements, and living situations (Hutchinson et al., 2011). The exploration of these topics have led into insight in the mental health needs of older adults.

Hutchinson, Hersch, Davidson, Chu, & Mastel-Smith (2011) did a qualitative study and reported that older adults emphasize their religion and their attempts to live according to the rules of their belief system (Hutchinson et al., 2011). They noted that resignation, hard work, and prayer are the most common coping mechanisms that older adults use as a way to get through the hard times (Hutchinson et al., 2011). Along with hard work and resignation, comes achievements. Achievements are often expressed in terms of "educational attainment, living a long time, working one's way through college, service in the military, successful careers, successful parenting, and hard work and survival" (Hutchinson et al., 2011, p. 401). Achievements are often seen as a positive which in turn may increase quality of life.

Older adults prefer to live in their own homes for as long as possible with long term care being a last resort (Hutchinson et al., 2011). Older adults living in nursing homes are "immersed in a new environment, which places demand on the individual to develop the skills needed to be successful in that environment" (Hutchinson, et al., 2011, p. 398). The individuals, who are not able to develop the needed skills may suffer from depression, loneliness, or feelings of abandonment (Hutchinson et al., 2011). According to a study by Choi, Ransom, and Wyllie (2008), "psychiatric services were needed by more than one third of nursing home residents, however three fourths of the nursing homes were unable to access even consultation or educational services for behavioral intervention" (p. 536). Late-life depression contributes to

further deterioration of physical and functional health and also a decline in the quality of life among older adults (Choi et al., 2008). Most of the information in older adult research is gathered through self-reports (Knauper et al., 2016). Older adults may demonstrate difficulty with "question or response option comprehension and memory retrieval can lead to erroneous conclusions" (Knauper et al., 2016, p. 186).

Developmental Theorists and Theories of Creativity

Of the theorists who created developmental theories of lifespan development, although few have explored the development of older adults. For the purpose of this thesis, the following late stage theorists will be discussed: Erik Erikson, Robert Peck, James Fowler, and Gene Cohen (Kelley, 2017). Additionally, theorists who explored development of creativity will be reviewed, and include Gene Cohen, Abraham Maslow, and Carl Rogers.

Erik Erikson. Erick Erickson created the eight psychosocial stages which focused on conflicts and resolutions through one's lifespan (Broderick & Blewitt, 2015). The stages that coincide with older adults are generativity versus stagnation and ego integrity versus despair (Broderick & Blewitt, 2015). In generativity versus stagnation, the older adult wants to contribute to the next generation and create something of lasting value (Broderick & Blewitt, 2015). Examples of this are child rearing and community service. If the resolution is not met for this stage, then the older adults may be faced with self-absorption (Broderick & Blewitt, 2015).

In ego integrity versus despair, the older adult "comes to terms with life's successes, failures, and missed opportunities and realizes the dignity of one's life" (Broderick & Blewitt, 2015, table 1.2). This conflict is primarily met by looking back and reminiscing on one's life. If the resolution of wisdom is not met, then the older adult may be faced with regret (Broderick & Blewitt, 2015).

Robert Peck. Robert Peck's first stage of old age is ego differentiation versus work-role preoccupation (Peck, 1956). During this stage, there is a "crucial shift in the value system by which the retiring individual can reappraise and redefine his worth and can take satisfaction in a broader range of role activities than just his long-time, specific work role" (Peck, 1956, p. 46-47). Within this stage often comes retirement, which can mean a reduction of income leading to a reduced standard of living. This stage brings about ego differentiation among varied role activities and different qualities of personality and interpersonal relationships (Peck, 1956).

The second stage of old age is body transcendence versus body preoccupation (Peck, 1956). During this stage, "social and mental sources of pleasure and self-respect may transcend physical comfort, alone" (Peck, 1956, p. 47). This stage recognizes physical decline, but mental and social powers may increase with age (Peck, 1956).

The third stage of old age is ego transcendence versus ego preoccupation (Peck, 1956). During this stage, one must "live so generously and unselfishly that the prospect of personal death looks and feels less important than the secure knowledge that one has built for a broader, longer future than any one ego ever could encompass" (Peck, 1956, p. 48). The importance of this stage is for one to pass on knowledge through children, contributions to culture, and friendships. Wherein older adults can achieve significance for their actions (Peck, 1956).

James Fowler. James Fowler looked at the development of faith consciousness across lifespan. The stage of faith consciousness for aging adults is universalizing faith (Fowler, 1991). During this stage, the individual is thoroughly engaged in the power of being or God (Fowler, 1991). Individuals in this stage have "identified with or they participate in the perspective of god. They begin to see and value through God rather than from the self" (Fowler, 1991, p. 41). This

leads to an individual's universalization of their capacity for care, love, and justice (Fowler, 1991).

Gene Cohen. Cohen believed that development in the second part of life could be divided in four stages. The first stage is midlife evaluation, which occurs between age 40 and 50 (Cohen, 2006). During this stage, "plans and actions are shaped by a sense of crisis or quest" (Cohen, 2006, p. 8). There is a strong desire and capacity to create meaning in life (Cohen, 2006).

The second stage is liberation, which occurs between ages 50 to 70. During this stage, "plans and actions are shaped by a mounting sense of personal freedom to speak one's mind and to do what needs to be done" (Cohen, 2006, p. 8). Also, during this stage is the feeling of having time to experiment with something different (Cohen, 2006).

The third stage is summing up, which occurs between ages 60 to 80 (Cohen, 2006). During this stage "plans or actions are shaped by the desire to find larger meaning in the story of one's life as one looks back, reexamines, and sums up what has happened" (Cohen, 2006, p. 9). This can motivate people to share their accrued wisdom through many different outlets such as storytelling, volunteering, and philanthropy (Cohen, 2006). This stage is also a time to deal with unresolved conflicts and unfinished business through creative new strategies (Cohen, 2006).

The last stage is encore, which can occur at any time between ages 70 to the end of life (Cohen, 2006). During this stage, "plans and actions are shaped by the desire to restate and reaffirm major themes in one's life but also by the desire to explore novel variations on those themes and to further attend to unfinished business or unresolved conflicts" (Cohen, 2006, p. 9). Also, there is a desire to live well until the very end, which can have a positive impact on families and the community (Cohen, 2006).

Creativity. Cohen's theory of creativity focused on creative expression and how it promotes health in the aging population. Cohen believed that a sense-of-control and mastery were important components of creativity for older adults (Cohen, 2006). The feeling of mastery can lead to feelings of empowerment (Cohen, 2006). Cohen (2006) believed that a sense of control can increase the level of comfort with exploring new challenges (Cohen, 2006).

Brain plasticity is affected by the creative expression of aging adults. The brain, when challenged through activities and surroundings, forms new synapses (Cohen, 2006). Cohen (2006) states, "art activities are especially good because they are more likely to be sustained, and just like the impact of physical exercise over the long term, the benefits of challenges for the brain increase when they are ongoing" (p. 10). Almost every art form provides ideal utilization of the left and right brain capacities (Cohen, 2006).

Social engagement plays an important role in an aging adults' creative expression. Cohen (2006) found that social engagement has a positive influence on general health and can reduce mortality. The health systems found to benefit from social engagement included cardiovascular, endocrinological, and immunological (Cohen, 2006).

Abraham Maslow. Abraham Maslow discussed creativity in self-actualizing people. Maslow applied the word creative to more than just products, but also to "people in a characterological way, and to activities, processes, and attitudes" (Maslow, 1962, p. 129). As a result, Maslow (1962) believed that there were two types of creativeness: special talent creativeness and self-actualizing (SA) creativeness (Maslow, 1962). SA creativeness comes from an individual's personality and therefore appears in everyday tasks, such as housekeeping or teaching (Maslow, 1962). Maslow believed that the individuals with SA creativeness could "see the fresh, the raw, the concrete, the ideographic, as well as the generic, the abstract, the

rubricized, the categorized and the classified" (Maslow, 1962, p. 129). An important aspect of SA creativeness is the ability to express ideas freely without fear of ridicule (Maslow, 1962). Another important aspect is being free from stereotypes and clichés, as well the creative act feeling spontaneous and effortless (Maslow, 1962).

Carl Rogers. Carl Rogers, the creator of person-centered theory, had a theory of creativity as well. Rogers described a social need for creativity because leisure time often includes "passive entertainment and regimented group action" (Rogers, 1954, p. 249).

Rogers believed that there were various components that defined creativity. The first was that there must be something observable. This means that the creative act must be seen. The second was that products must be original constructions (Rogers, 1954). The originality comes from the individual through their interactions with the materials and experience. The third component is that creativity is not restricted to particular content (Rogers, 1954). After looking at all three components, Rogers (1954) defined creativity as "the emergence in action of a novel relational product, growing out of the uniqueness of the individual on the one hand, and the materials, events, people, or circumstances of his life on the other" (p. 251).

Rogers (1954) theorized that creativity came from an individual's tendency to want to become the best that they can be. The tendency to actualize is often buried under psychological defenses, but Rogers stated that it exists in every individual and can be released through stages (Rogers, 1954). The first stage was seeing the novel creation as "erroneous, bad, or foolish" (Rogers, 1954, p. 252). The second stage was seeing the creation as "obvious, something self-evident to all" (Rogers, 1954, p. 252). The third and last stage was seeing the creation as a "creative contribution" (Rogers, 1954, p. 252). The last stage happens when the individual is open to all experiences (Rogers, 1954).

Rogers describes the conditions of constructive creativity. The first condition is "openness to experience extensionality" (Rogers, 1954, p. 254). Rogers stated that this is the opposite of psychological defenses. Psychological defenses serve as a way to protect individuals in which certain experiences are prevented from coming into awareness except through distorted fashion (Rogers, 1954). Individuals who are open to experience allow creative stimuli to flow freely without distortion from defenses (Rogers, 1954). The second condition of constructive creativity is an "internal locus of evaluation" (Rogers, 1954, p. 254). The value of the novel creation is not established by the praise or criticism of others, but instead by the individual (Rogers, 1954). The basis of evaluation lies within the individual (Rogers, 1954). The third condition of constructive creativity is "the ability to toy with elements and concepts" (Rogers, 1954, p. 255). This is the ability to play spontaneously with "colors, ideas, relationships, juggle elements into impossible juxtapositions, shape wild hypotheses, make the given problematic, express the ridiculous, translate from one form to the other, and transform into improbable equivalents" (Rogers, 1954, p. 255). Through this toying and exploration, the individual is able to experience the "creative seeing of life in a new and significant way" (Rogers, 1954, p. 255).

Rogers stated that there were conditions that fostered creativity. Creativity cannot be forced, but must be permitted to emerge (Rogers, 1954). The first condition is psychological safety, which is made up of three subcategories. The first subcategory is "accepting the individual as having unconditional worth" (Rogers, 1954, p. 257). This happens when the individual facilitating the session believes that the other individual is "of worth in his own right and in his own unfolding, no matter what his present condition or behavior" (Rogers, 1954, p. 257). The second subcategory is providing a space free from evaluation (Rogers, 1954). When the individual facilitating the session is free of judgment towards the other individual, they are

fostering creativity. Evaluation is a threat and creates a need for defensiveness (Rogers, 1954). The third subcategory is understanding empathically (Rogers, 1954). This happens when the individual facilitating the session sees the other individual as a person. This permits the individual's real self to emerge, which allows for self-expression in varied and original modes (Rogers, 1954).

The second condition to fostering creativity is psychological freedom. This happens when the individual facilitating the session allows the other individual complete freedom for symbolic expression (Rogers, 1954). The freedom to be oneself takes responsibility, and often leads to the inner conditions of constructive creativity (Rogers, 1954).

Approaches with Older Adults

There are many approaches that are used to work with older adults. Some of the most common ones are cognitive training, cognitive behavioral therapy, cognitive stimulation, and cognitive rehabilitation and each approach aims at increasing the cognitive functioning in older adults (Marusic & Grospretre, 2018(Mansbach, Mace, & Clark, 2017).

Cognitive training. Cognitive training aims to improve the cognitive functioning and/or slow brain aging (Marusic & Grospretre, 2018). It is implemented in individual or small group settings. Cognitive training involves "guided exercises of standard tasks in the fields of memory training, attention or problem solving" (Marusic & Grospretre, 2018, p. 641). The training difficulty is based on individual needs and abilities.

In a computerized cognitive training study with older adults study, Lampit, Valenzuela, and Gates (2015) found that computerized cognitive training was beneficial for varying levels of cognitive impairment. Participants were asked to complete a 30-minute session one to three times a week (Lampit et al., 2015). The researchers found that the "cognitive benefits in addition

to technical simplicity, accessibility, and lack of side effects make computerized cognitive training one of the most promising interventions in the field of cognitive aging" (Lampit et al., 2015, p. 2612).

In a review article by Marusic and Grospretre (2018) about non-physical approaches to counteract age-related functional deterioration found that cognitive training "induced brain plasticity in the population of cognitively healthy older adults" (p. 643). For the purpose of this review, a non-physical approach was one in which did not require any physical movements such as walking (Marusic & Grospretre, 2018). The non-physical approaches used included cognitive training and mental techniques such as motor imagery. An example of a motor imagery technique included finger tapping training to observe finger tapping performance and mentally crossing a slackline or standing on one leg to improve gait (Marusic & Grospretre, 2018).

Cognitive behavioral therapy. Cognitive behavioral therapy (CBT) is a partnership with the client, "teaching them skills for questioning and re-evaluating negative automatic thoughts" (Jayanthi Rani & Gayatridevi, 2018, p. 38). This method challenges negative thoughts through positive experiences (Jayanthi Rani & Gayatridevi, 2018, p. 38). Core beliefs are challenged from this new way of thinking. The focus is on present and future behavioral changes rather than past difficulties (Jayanthi Rani & Gayatridevi, 2018).

Studies have found cognitive behavioral therapy to be an effective tool to use with older adults (Jayanthi Rani & Gayatridevi, 2018; Goodkind et al., 2015). Jayanthi Rani and Gayatridevi (2018) conducted a quantitative study about cognitive behavioral therapy as a tool for increasing mental health for institutionalized older adults. They found that cognitive behavioral therapy "is proved to be efficacious in managing stress and depression and enhancing well-being of elderly living in Institutions" (Jayanthi Rani & Gayatridevi, 2018, p. 43).

A quantitative study conducted by Goodkind et al. (2015), found that cognitive behavioral therapy was effective in aiding in late-life depressive symptoms. Participants were asked to complete the Beck Depression Inventory-11 to track depressive symptoms, the Stroop Task to assess for verbal fluency, and the Wisconsin Card Sort Task (WCST) to assess executive functioning. The researchers found a connection between the scores on the WCST and response to CBT (Goodkind et al., 2015). This finding suggests that those who have higher executive functioning responded better to CBT (Goodkind et al., 2015.

Cognitive stimulation. Cognitive stimulation consists of group activities where individuals can "train their social and cognitive functions in a non-specific manner" (Marusic & Grospretre, 2018, p. 641). This includes activities such as group discussions, organized leisure activities, and therapeutic talks about memories and/or past experiences (Marusic & Grospretre, 2018). It is the most widely used psychosocial treatment for people with mild-to-moderate dementia (Piras et al., 2017).

Piras et al. (2017) conducted a quantitative study that found cognitive stimulation to be beneficial as an evidence-based intervention for sustaining general cognitive functioning in individuals with vascular type dementia. Additionally, van Zon, Kirby, and Anderson (2016) studied cognitive stimulation in older adults residing in long-term care facilities using a quantitative method. They found measurable gains in the cognitive abilities of older adults living in long term care. The study demonstrated it is possible for older adults to acquire new information and access general knowledge easily (van Zon et al., 2016).

Cognitive rehabilitation. Cognitive rehabilitation is an individualized approach designed for patients and their families to benefit from cooperation with healthcare professionals to jointly identify goals and attain them (Marusic & Grospretre, 2018). This includes activities,

such as putting together a puzzle, making change, and card recall, to improve cognitive functions of the individual in everyday life (Marusic & Grospretre, 2018).

A quantitative study conducted by Mansbach, Mace, and Clark (2017) found computer-assisted cognitive rehabilitation to be an effective intervention for improving global cognitive functions in older rehabilitation patients with mild cognitive deficits on a short-term basis. The quantitative study conducted by Winocur et al. (2007) supported these findings and found cognitive rehabilitation to be an effective intervention for older adults with cognitive impairment.

Person-Centered Theory

Carl Rogers developed person-centered theory with the belief that the therapeutic relationship should be viewed as "person to person to rather than healthy counselor to unhealthy client" (Hazler, 2011, p. 145). This was a shift from the psychoanalytic and behavior approaches used to work with clients in the early 20th century (Hazler, 2011). Person-centered theory involves having confidence in each client. This confidence comes from the belief that all people have motivation to grow in positive ways (Hazler, 2011). This positive view on human nature has five key elements. These elements include: "people are trustworthy, people innately move toward self-actualization and health, people have the inner resources to move themselves in positive directions, people respond to their uniquely perceived world, and an interaction with external factors" (Hazler, 2011, p. 146).

In person-centered theory, individuals are seen as trustworthy, even if their actions appear to be the opposite. When actions are the opposite, this is often due to the ideal view of self not matching their real self (Hazler, 2011). According to Hazler (2011), all individuals try to improve and act in the world in an honorable a manner as possible.

Individuals are always trying to obtain the greatest amount from themselves (Hazler, 2011). Individuals will pursue measures to develop their abilities. This movement away from the control of others based on presumptions of worth leads to autonomy and self-control (Hazler, 2011). Hazler (2011) states the movement towards autonomy and self-actualization provides individuals with the primary motivational strength behind development.

Person-centered theory believes that individuals have the capacity to carry out the motivation for positive development (Hazler, 2011). Individuals have the ability to grow in positive directions. Developed from two principles of human-dynamics, the first principle is that people have more potential than they use, and the second principle emphasizes that success is found in the journey rather than a preconceived goal (Hazler, 2011). These principles aim to help the individuals recognize and accept their own abilities (Hazler, 2011).

According to person-centered theory, all individuals will perceive events differently. Individuals will relate to the world and their own actions from a unique context (Hazler, 2011). Words, behaviors, feelings, and beliefs are selected to match the view of the individual (Hazler, 2011).

Person-centered theory takes into account the external factors that may affect psychological development and critical internal forces (Hazler, 2011). Examples of this include when a person identifies that other individuals may contain emotions based on how well the person integrates morals and actions of others (Hazler, 2011). This recognition discourages individuals from using their own judgement to make personal choices and promotes an alternative method that requires taking actions based on the alleged wishes of others (Hazler, 2011).

Therapist in person-centered theory. In person-centered theory, Raskin & Rogers (2005) state that the therapist,

> assumes that clients can be trusted to select their own therapists, to choose the frequency and length of their therapy, to talk or to be silent, to decide what needs to be explored, to achieve their own insights, and to be the architects of their own lives (p. 131).

The therapist's intention is to provide congruence, unconditional positive regard, and empathy (Raskin & Rogers, 2005).

Congruence proposes the similarity between the thoughts and the behavior of the therapist through genuineness (Raskin & Rogers, 2005). The therapist does not put up a professional front. Genuineness is defined as the therapist being able to express the emotions within at the moment (Kirschenbaum & Henderson, 1989).

Unconditional positive regard refers to the therapist accepting the client's continuously changing feelings (Raskin & Rogers, 2005). The therapist's respect for the client will not be affected by their choices, characteristics, or outcomes (Raskin & Rogers, 2005). When the therapist fully accepts the client's thoughts, feelings, wishes, intentions, and description of themselves or others, then change is more likely (Kirschenbaum & Henderson, 1989).

The therapist shows unconditional positive regard through empathy. Empathy can be described as having an interest in the clients view of the world (Raskin & Rogers, 2005). The therapist receives these communications with understanding and appreciation (Raskin & Rogers, 2005). This interaction between the therapist and client is one of warmth, sensitivity, and respectfulness through a difficult exploration of ones emotional world (Raskin & Rogers, 2005). Listening is one of the most potent sources of change (Kirschenbaum & Henderson, 1989).

Person-Centered Care with Older Adults

Person-centered care with older adults is considered the "gold standard for health care across the United States and abroad" (American Geriatrics Society, 2016, p. 15). According to the American Geriatrics Society (2016), person-centered care is individualized to guide all aspects of health care, supporting realistic health and life goals. This is achieved through the relationship between the individuals, others close to them, and the providers (American Geriatrics Society, 2016).

There are five main factors in person-centered care for older adults. They include promoting a continuation of self and normality, knowing the person, welcoming family, providing meaningful activities, and being in a personalized environment (Edvardsson, Fetherstonhaugh, & Nay, 2010).

Promoting a continuation of self and normality means supporting the individual and maintaining interactions that were consistent prior to diagnosis and encouraging the family to continue with a life as normal as possible (Edvardsson et al., 2010). Families should rely on staff to help with supporting and creating normality for their loved one.

Knowing the person includes the staff knowing the history, preferences, needs, interests, and particularities of the individual receiving care (Edvardsson et al., 2010). This is essential for initiating meaningful conversations, activities, and routines, and an awareness and understanding of medical/health statuses and needs so that care plans can be individually developed, implemented and evaluated (Edvardsson et al., 2010).

Welcoming family includes developing and maintaining trust that staff will actively communicate changes and significant events with the family (Edvardsson et al., 2010). Creating a team approach with the staff and family allows for care plans to be made for the individual and

encourage the family to maintain relationships and normal activities with the individual after the move to an aged care facility (Edvardsson et al., 2010).

Providing meaningful activities includes providing individually targeted activities that provide meaningful experiences that reaffirm that individuals are able to do the things they enjoy (Edvardsson et al., 2010). Activities should be adapted to the individuals ability to boost self-esteem through the successful completion of activities (Edvardsson et al., 2010). This should include the ability to partake in social events which creates an atmosphere of community and participation in an aged care setting (Edvardsson et al., 2010).

Being in a personalized environment includes enriching the environment with personal items such as photographs, furniture, plants, decorations and other memorabilia that are either familiar to the individual or that they were known to like (Edvardsson et al., 2010). Places with nice interiors are often viewed as more relaxing and comfortable (Edvardsson et al., 2010). Views from windows that could include gardens or other nature settings are supportive and provides of a feeling of being connected with nature (Edvardsson et al., 2010).

Person-centered therapy focuses on understanding older adults from within their own views of the world (Von Humboldt & Leal, 2013). Person-centered therapy provides an outlet for negative or despairing experience to be expressed, fully felt and received empathically (Von Humboldt & Leal, 2013). Poey et al. (2017) conducted a longitudinal, retrospective cohort study using an in-person survey and found that the individuals in nursing homes that had fully implemented person-centered care were more likely to rate their quality of life, quality of care, and overall satisfaction highly.

Sense of Coherence, Quality of Life, and Orienting to Time and Space

Sense of coherence. Sense of Coherence (SOC) is defined as a general orientation to life where individuals perceive issues as structured, predictable, and explicable and feel confident that they have the resources to deal with the issues and are motivated to do so (Slootjes et al., 2017). This can be broken down into three components: comprehensibility, manageability, and meaningfulness (Slootjes et al., 2017). Comprehensibility is developed through consistency; receiving consistent messages and stimuli (Slootjes et al., 2017). It is based on a stable environment which includes consistency, continuity, and permanence.

Manageability is developed through a good load balance throughout the life course (Slootjes et al., 2017). Good load balance can be defined as an individual meeting set requirements (Slootjes et al., 2017). Overload can occur when an individual cannot meet higher demands, which can result in insecurity and the feeling of failing (Slootjes et al., 2017). Underload can occur when too little is being asked of an individual, which can result in disinterest and demotivation (Slootjes et al., 2017). It is important for individuals to find a load balance that is challenging and engaging, but not more than they can handle (Slootjes et al., 2017).

Meaningfulness is developed through participation in shaping outcomes in socially valued contexts (Slootjes et al., 2017). The individual should participate in the decision-making process and feel heard (Slootjes et al., 2017). The participation in decision making is only beneficial if it is an activity that is socially valued (Slootjes et al., 2017).

Older adults' SOC is challenged by specific issues later in life such as grieving for losses, illness, feelings of worthless and solitude, retirement, and disability and death (Von Humboldt & Leal, 2013). A high SOC has been shown to protect against negative health outcomes in terms of

perceived health, quality of life, mortality, and disability (Boeckxstaens et al., 2016). In the study done by Boeckxstaens et al. (2016) found that older adults with a high SOC were shown to have lower mortality rates and less functional decline than the study population as a whole (Boeckxstaens et al., 2016). The study indicates that a high SOC extends beyond perceived health and quality of life toward mortality and functional decline (Boeckxstaens et al., 2016.

In a cross-sectional study by Takahashi et al. (2015) aimed at examining the association with SOC and being homebound among community-dwelling older adults. The study found that having a high SOC has the potential to improve homebound status among older adults (Takahashi et al., 2015).

Quality of Life. Quality of life for older adults has primarily focused on housing, financial status, and health (Lindner et al., 2016). Limited studies explore the subjective aspects of quality of life such as leisure time, learning, relationships, and the self as a person (Lindner et al., 2016). For the purpose of this thesis, the subjective quality of life areas discussed are creativity, leisure, and learning.

Creativity. Creativity is an attitude towards living and it may or may not be associated with artistic talent or scientific originality (Smith, 1989). Creative activity is a process where an individual seeks an original solution to a problem or challenge (Fisher & Specht, 1999). Through creativity, older adults can explore new endeavors, develop their sense of identity, and cope better with the process of aging (Price & Tinker, 2014). Older adults who have had a meaningful, creative life have been shown to tolerate beginnings of illness, aging, and death with more tolerance and calmness (Smith, 1989).

Creativity can help develop problem solving skills, sustain adaptive competence, deepen self-understanding, and promote meaningful involvements (Fisher & Specht, 1999). The creative

process challenges individuals to use accumulated skills to manipulate tools and resources to express an idea (Fisher & Specht, 1999). Creative activity helps an older adult see themselves as competent and capable of doing diverse activities (Fisher & Specht, 1999).

Through creative activity, older adults can surpass negative aspects of life by focusing on the positive and promoting the optimization instead the minimization (Fisher & Specht, 1999). It also provides the older adults with a sense of accomplishment and purpose; encouraging a sense of contribution, something to look forward to, and something of themselves to leave behind (Fisher & Specht, 1999). Not only does it provide a sense of accomplishment, but also provides a sense of connection with others. This could be through interactions with others with similar interests, companionship and social support (Fisher & Specht, 1999).

Leisure. Leisure is considered to be a central factor explaining successful coping with later life transitions (Nimrod & Shrira, 2014). Participation tends to decline with advancing age, which may be explained through constraints such as health and illness, psychological, cultural-environmental, and technical constraints (Nimrod & Shrira, 2014).

Leisure activities may help to identify and define a purpose for life (Janssen, 2004). Participation in meaningful leisure activities allows older adults to express abilities, gain control over their environment, and be able to identify components of life that are important (Janssen, 2004). It is important that the leisure activities for older adults are meaningful, age appropriate, and can allow a sense of accomplishment or satisfaction (Janssen, 2004).

Nimrod and Shrira (2014) found that as people age, it becomes more important for involvement in leisure activities. There is still a need for stimulation and challenge in leisure activities for older adults, especially as needs and interests change (Janssen, 2004). There may be a need to modify or adapt past leisure activities with a focus on quality rather than quantity

(Janssen, 2004). Involvement in meaningful activities may help preserve identity, contribute to a sense of integrity, and potentially a chance for self-renewal (Janssen, 2004).

Learning. Older adults have a stronger motivation to learn despite learning slower, needing more practice, and having varying interests (Boulton-Lewis, 2010; Tam, 2010). The motivation behind learning is often for self-fulfillment and pleasure (Boulton-Lewis, 2010). Older adults want to learn things related to health, safety, leisure and transportation, and technology (Tam, 2010). Taking up some form of educational activity allows an individual to maintain their intellectual capacity as they age (Mackowicz & Wnek-Gozdek, 2016). It helps to improve self-esteem and personal development, provides opportunities to adapt to an ever-changing reality, maintain social ties, and participate actively in social life (Mackowicz & Wnek-Gozdek, 2016).

Education of older adults has been aimed at maintaining their self-sufficiency and independence for as long as possible (Jenkins, 2011; Mackowicz & Wnek-Gozdek, 2016). Education supports the development of new interests and productively fills time (Mackowicz & Wnek-Gozdek, 2016). Older adults learn from formal, nonformal, or informal learning dimensions (Wang et al., 2018). Formal learning programs are organized and structured (Wang et al., 2018). Nonformal learning programs are managed by local authorities, enterprises, and voluntary organizations (Wang et al., 2018). Informal learning programs are unstructured and realistic in nature (Wang et al., 2018).

Orienting to time and space. Orientation is a fundamental mental function that processes the relations between the behaving self to space (places), time (events), and person (people) (Peer, Salomon, Goldberg, Blanke, & Arzy, 2015).

In the quantitative study conducted by Peters-Founshtein et al. (2018) found that the "core of mental-orientation is disrupted in Alzheimer's disease (AD), manifesting in different domains of spatial navigation, episodic memory, further imagination and thinking about other people" (Peters-Founshtein et al., 2018, p. 696). Participants underwent the Addenbrooke's Cognitive Examination (ACE) and the Frontal Assessment Battery (FAB) prior to being shown stimuli during the mental-orientation task. The stimuli included names of two cities, two events, or two people. The researchers then asked the participants to determine which of the two is closer to themselves: spatially closer to current location, chronologically closer to the present time, or personally closer to themselves (Peters-Founshtein et al., 2018). Researchers were tracking success rates and response times. The researchers found that mental-orientation is successful it is able to be personalized to the individual, which makes it well suited for longitudinal studies (Peters-Founshtein et al., 2018).

Art Therapy

> The American Art Therapy Association (AATA) (2017) defines art therapy as:
>
> an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship (para.1).

Art therapy is facilitated by a professional art therapist and effectively supports personal and relational treatment goals (AATA, 2017). Art therapy is used to increase cognitive and sensory-motor functions, and self-esteem and self-awareness, support emotional resilience, enhance social skills, and decrease and resolve conflicts and distress (AATA, 2017).

Art Therapy with Older Adults

Older adults' participation in an enriched environment may foster neurogenesis and improve cognitive performance (Pike, 2013). Art therapy naturally incorporates physical activity, socialization, and problem solving (Pike, 2013). Older adults may be more cautious and less willing to take risks (Orr, 1997). They may need encouragement by initially being offered simple structured activities to minimize anxiety (Orr, 1997).

Older adults incorporate autobiographical information into their artwork and initiate episodic memory through reminiscing about their lives (Pike, 2013). Art therapy can help to improve attention, self-esteem, personal satisfaction and morale, calmness, and sociability (Gross, Danilova, Vandehey, & Diekhoff, 2015). Creative activity gives the individual an opportunity to exercise their power to make decisions and choices, and act autonomously upon those decisions (Gross et al., 2015). By participating in an art therapy program, older adults "may remain engaged with peers and their communities and become motivated to stay active in their lives" (Stephenson, 2013, p. 151).

Hanneman (2006) discussed rules for creative realizations that can be used with older adults. The first is that the focus is not on the final product but rather the process of the creation (Hanneman, 2006). Process of creation can be defined as the entire sequence of events from the start of a drawing to the end of a session (Innes & Hatfield, 2001). The process includes behavior and affect, verbalizations, and the use of materials (Innes & Hatfield, 2001). The second is that the aim of the creative act is to provide the opportunity to get in contact with the inner self and current living place (Hanneman, 2006). Through the process of creativity, an individual may become occupied in a way that is personally significant, which can help to draw out abilities and powers (Kitwood, 1997). The third is to try to develop new forms of expressions and alternative

procedures (Hanneman, 2006). The last rule is to try to support openness and inquisitiveness for unusual solutions and the ability of improvisation and flexibility (Hanneman, 2006). Through new forms of expressions and alternative procedures and support, older adults can learn new strategies to avoid negative behaviors and thoughts (Hanneman, 2006).

In conclusion, art therapy for older adults can help with feelings of loss, change, uncertainty and depression associated with aging (Ehresman, 2014). Artistic expression can help promote emotional resiliency to changing life circumstances (Ehresman, 2014). Art therapy provides a safe place and opportunity to disclose difficult emotions and provide an outlet for feelings of grief and loss (Ehresman, 2014). The artistic creation can be empowering because it allows for choices and decision making when other aspects of life are out of the individuals control (Ehresman, 2014). Art therapy also has the ability to improve mood and self-esteem because it can adapt to the needs of any individual (Ehresman, 2014).

By understanding the specific life conflicts related to later life, therapists and other healthcare professionals can begin to provide more appropriate care for older adults (Kelley, 2017). The largest conflict in later life is looking back on ones life and leaving something behind (Broderick & Blewitt, 2015; Cohen, 2006; Peck, 1956). There are many approaches that are used with older adults, but most aim to improve cognitive functioning rather than psychological or emotional functioning (Goodkind et al., 2015; Jayanthi Rani & Gayatridevi, 2018; Lampit et al., 2015; Mansbach et al., 2017; Marusic & Grospretre, 2018). Person-centered care is becoming a popular approach used with older adults due to its ability to be individualized to the needs of the individual (Hazler, 2011; Raskin & Rogers, 2005). Art therapy provides a framework where older adults can explore life conflicts in a safe, non-judgmental way (Ehresman, 2014; Hanneman, 2006).

CHAPTER III

METHODS

Design of Study

The purpose of this grant funded mixed methods study was to identify if individual, group, and open studio art therapy sessions would improve the quality of life for aging adults at two facilities. A mixed methods study uses both quantitative and qualitative data. The quantitative portion of the study employed a pre, mid, and post Brunnsviken Brief Quality of life scale (BBQ) to identify if participants found art therapy to be beneficial. The qualitative data collected included session information from each participant which included material choices, program attendance, overall theme of structured groups, and verbalizations.

This thesis reviewed and analyzed the results of the BBQ data from the pre and mid point of the study and the material choices, program attendance, and overall theme of structured groups. It was hypothesized that there would be an increase in the BBQ scores between pre and mid scores after participating in art therapy for 16 weeks, and that the overall themes would coincide with the developmental theories outlined by Erikson, Peck, Cohen, and Rogers.

Location and Time Period of Study

The study took place at two facilities, an adult day service and a skilled nursing community in a metropolitan area. An adult day center is defined as a professional care setting in which older adults, adults living with dementia, or adults living with disabilities receive individualized therapeutic, social, and health services for some part of the day ("Adult Day Centers," n.d.). A skilled nursing facility aids individuals daily living activities that require a licensed professional. They are state-licensed and provide nursing and rehabilitative care under the direction of a skilled medical professional 24 hours a day (Caregiver Foundation, 2019). The

full study took place September 2018 through April 2019 and it was approved by The Indiana University Institutional Review Board (IRB). This thesis reviewed the data collected from September 2018 - December 2018.

Subject Type and Source

Participants were guests at the adult day service center and elders at the skilled nursing community. This led to varying levels of cognitive functioning amongst the participants because no information was attained about cognitive impairments related to older adults. The study anticipated 30 participants, and age range from 65 - 100.

Recruitment, Enrollment, Inclusion and Exclusion Criteria

Subjects were recruited for the study by the researcher, the adult day service's Project Manager, and the skilled nursing community's Activities Coordinator. Flyers were posted and distributed at both facilities. Individual emails were sent out to potential participants' legally authorized representative regarding the study, along with contact information for the researcher to schedule intake interviews with participants and representatives. Participants were enrolled in the study after the informed consent was signed by the Legally Authorized Representative (LAR).

Subjects must be guests at the adult day service or elders at the skilled nursing community. Subjects and/or their personal representatives who did not provide consent for participation were excluded in the study. Although, they were able to participate in all art therapy services offered at either facility.

Investigational Methods and Procedures

Informed consent. Prior to participation in the study, each subject was presented with the consent form. The researcher assisted each participant by reading the consent form aloud

paused at identified areas of the form to asses understanding (See Appendix A). The consent form was signed by the participant and their LAR. The signed consent form was stored in a locked, secure file on-site.

Confidentiality of the participants was maintained by assigning unique identifying numbers on all data collection forms (see Appendices B-D). Information and stories shared within the sessions were held confidential, and participants were able to leave the study at any time for any reason. To ensure participant's understanding, the rules and parameters of the study were reviewed at the pre and mid of the study.

Instrumentation and data collection. For the purpose of this study, the pre and mid BBQ were reviewed and analyzed, along with the material choices, program attendance, and overall theme of structured groups. The BBQ was developed to be a brief, easy-to-use self-rating scale of quality of life (QoL) concordant with the overall life satisfaction (Lindner et al., 2016). The BBQ, which was normed with an adult population, is a "valid and reliable measure of QoL that is sensitive to difference between clinical and non-clinical groups, with a psychometric performance on par with longer, more complex QoL instruments" (Lindner et al., 2016, p. 189).

The BBQ was administered to each participant in September and December. The researcher assisted participants by reading aloud the pre, and mid scale. This measure takes an average of 10 minutes to administer and is composed of 12-items that include domains of leisure time, view of life, creativity, learning, friends/friendships, and self as a person (Lindner et al., 2016). Participants chose from 5-point multiple choice options (see Appendix B). The total score is computed by multiplying the Satisfaction and Importance items for each life area and summing the six products for a total score (0-96) (Lindner et al., 2016) (see Appendix B).

Session information collected from each participant included the material choices, program attendance, and focus/theme of structured groups.

Data analysis. The BBQ rating scale was used to calculate the score for each of the life areas. To calculate each of the life area scores, Satisfaction and Importance are multiplied together for a maximum score of 16 in each life area. A maximum score of 96 is possible on the BBQ. A score of 96 means that participants completely agree on the Satisfaction and Importance of all six life areas on their quality of life. The data was compared between pre and mid assessment to identify an increase in the overall BBQ and the three domain areas.

The themes were collected weekly, organized, and reviewed for commonalities. Larger themes were developed as a result of these commonalities and reported.

Possible Risks and Management of Risks

Possible risks included participant's feeling uncomfortable answering the BBQ scale questions, and concerns with confidentiality. Participants were able to skip questions that they did not want to answer. Confidentiality was maintained by assigning a unique identifying number to participants for data collection forms. No identifying information was collected, and all information was stored securely. Information collected from participants from this study may be used for future research studies or shared with other researchers. If this happens, additional precautions will be utilized to maintain confidentiality.

Additionally, participants were provided contact information for the researchers, primary investigator and the Indiana University Human Subjects Office. Participants could withdraw from the study at any time and continue to participate in art therapy services offered at each site.

Limitations and Delimitations

The limitations of the study include circumstantial influences that could have affected the pre and mid questionnaire scores. These influences could include changes to the participant's routine, health diagnoses, medication changes, and extenuating circumstances within each facility. Another limitation included the use of a rating manual with older adults with a potential for mild cognitive impairments. Lastly, there is a need for a LAR to participate in the study portion.

Delimitations of this study included performing the research study at two facilities with a small sample size and not including participants with advancing stages of dementia that included progressive loss of memory and organization. Additionally, the results of the analysis will only provide a small sample of the overall data that will be collected from the study.

CHAPTER IV

RESULTS

The study comprised of two sets of participants, program participants and study participants. Overall 50 individuals participated in the programming offered. This section will discuss observations and themes of these participants. Of these 50, 14 participated in the study portion which included the pre/mid BBQ. The term participant in the following section, will include both study and program participants.

Quantitative Results

It was hypothesized that the older adults who participated in the individual, group, and open art studio art therapy sessions would show an increase in the BBQ scores and that the themes that emerged from those sessions would coincide with the developmental theories for older adults. The BBQ provided a baseline measure for quality of life. The difference between the individuals' pre and mid BBQ scores were used to identify if a change in quality of life had occurred which could be correlated to participation in art therapy.

The BBQ scale is a subjective quality of life measurement. It includes the life areas of leisure time, view of life, creativity, learning, friends and friendships, and self as a person. The scale is rated by multiplying the Significance and Importance of each life area for a maximum score of 16 per area. The maximum score on the BBQ is 96. For the scores, an increase show more significance and importance, and a decrease shows less significance and importance. To address questions that received no answer, the score from the same section was used (Philip Lindner, personal communication, March 22, 2019). For example, Participant 51 only identified a score for Satisfaction and not for Importance. In turn, the Satisfaction score was used for both. For the purpose of this thesis, the overall BBQ score, and the scores for the life areas of leisure

time, creativity, and learning were analyzed, along with material choices, program attendance, and overall theme of structured groups.

Of the 14 study participants, 13 were female and one was male. Four participants dropped out of the study between the pre and mid assessments. Those included 2 males and 2 females. Each site lost two participants. For the art therapy program as a whole, there were a total number of 50 participants.

Table 1 shows the overall BBQ scores for each participant. There was an overall increase in five of the participants pre to mid scores. There was an overall decrease in six of the participants pre to mid scores. There were three participants who showed no change, and two reported the maximum score of 96.

Table 1

BBQ Scores

Participants	Pre	Mid	Difference
2	56	92	+36
3	92	96	+4
4	96	92	-4
6	74	96	+22
7	96	96	0
8	96	92	-4
9	46	65	+19
10	96	96	0
51	89	85	-4
52	88	69	-19
53	66	53	-13
56	36	36	0
57	62	39	-23
58	32	41	+9

Note. The maximum score for the BBQ is 96 points.

Table 2 shows the BBQ scores for participants in the life area of leisure. Seven participants had no change in their pre to mid scores. Of these seven participants, six had the maximum score of sixteen for both pre to mid. There were four participants whose scores increased and three participants whose scores decreased between pre and mid scores.

Table 2

Leisure BBQ Scores

Participants	Pre	Mid	Difference
2	0	16	+16
3	16	16	0
4	16	16	0
6	6	16	+10
7	16	16	0
8	16	16	0
9	9	9	0
10	16	16	0
51	16	9	-7
52	12	12	0
53	2	3	+1
56	6	4	-2
57	9	16	+5
58	2	3	+1

Note. The maximum score for a life area is 16.

Table 3 shows the BBQ scores for participants in the life area creativity. There was an increase in four participants and a decrease in four participant scores. There was no change in seven of the participants scores. Six of those participants had a maximum score of sixteen at pre and mid assessment.

Table 3

Creativity BBQ Score

Participants	Pre	Mid	Difference
2	16	12	-4
3	16	16	0
4	16	16	0
6	12	16	+4
7	16	16	0
8	16	12	-4
9	0	12	+12
10	16	16	0
51	16	16	0
52	16	16	0
53	12	3	-9
56	3	9	+6
57	6	9	+3
58	9	9	0

Note. The maximum score for a life area is 16.

Table 4 shows the BBQ scores of the participants for the life area of learning. There was an increase in six of the participants scores from pre to mid. There was a decrease in two participant's scores and six of the participants had no change and had a pre to mid maximum score of sixteen.

Table 4

Learning BBQ Scores

Participants	Pre	Mid	Difference
2	16	16	0
3	12	16	+4
4	16	16	0
6	12	16	+4
7	16	16	0
8	16	16	0
9	6	12	+6
10	16	16	0
51	16	16	0
52	12	9	-3
53	8	12	+4
56	1	3	+2
57	9	6	-3
58	3	4	+1

Note. The maximum score for a life area is 16.

Table 5 shows the BBQ scores for the life areas of leisure, creativity, and learning. Participants 4, 7, and 10 remained consistent across the life areas of leisure, creativity, and learning. Participants 3, 6, 8, and 51 remained consistent across two of the three life areas, however the scores varied for each person. There were seven participants whose scores varied across the life areas of leisure, creativity, and learning.

Table 5

Individual BBQ Scores for Leisure, Creativity, and Learning

	Leisure		Creativity		Learning	
Participants	Pre	Mid	Pre	Mid	Pre	Mid
2	0	16	16	12	16	16
3	16	16	16	16	12	16
4	16	16	16	16	16	16
6	6	16	12	16	12	16
7	16	16	16	16	16	16
8	16	16	16	12	16	16
9	9	9	0	12	6	12
10	16	16	16	16	16	16
51	16	9	16	16	16	16
52	12	12	16	16	12	9
53	2	3	12	3	8	12
56	6	4	3	9	1	3
57	9	16	6	9	9	6
58	2	3	9	9	3	4

Qualitative Results

The qualitative results include participant chosen material choice/use, program attendance, and overall theme of structured groups. Figure 1 shows the material choice/use during the art therapy sessions. Materials were categorized into 3D materials, 2D materials, and mixed media. Three-dimensional materials included acrylic beads, Model Magic, popsicle sticks,

and socks. Two-dimensional materials included pens, pencils, colored pencils, Kwik Stix, watercolors, tissue paper, and acrylic paints. Mixed media materials included the use of both 2D and 3D materials during a session. An example of this is a sock snowman, premade craft kits, and sculpture using popsicle sticks, wire, and Model Magic.

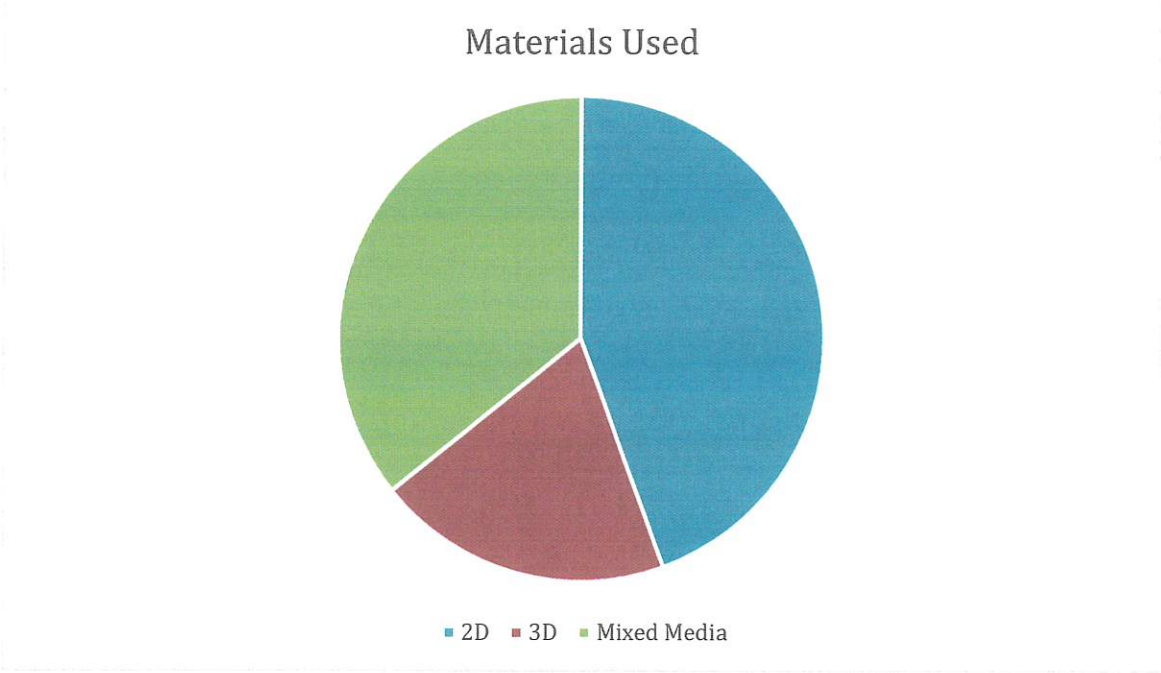

Figure 1. Materials used during art therapy sessions.

Program attendance for study participants was tracked using the participation log. Table 6 shows the number of sessions that study participants attended art therapy programming.

Table 6

Participant Program Attendance

Participants	Frequency of Art Therapy Program Participation
2	4
3	2
4	3
6	1
7	2
8	2
9	9
10	3
51	9
52	3
53	6
56	6
57	4
58	4

Note. Out of 16 weeks.

The themes that arose from the art therapy sessions from the participants included rapport building, self-esteem, memory making, reminiscing, learning, decision making, and stress management. Rapport building became an important theme early on in the study with directives such as ink blots, embroidery, and building a bird feeder. Through the process of rapport building, a theme of self-esteem arose which included directives focusing on jewelry making,

identifying a self-symbol, and tissue paper paintings. Memory making as a theme included directives such as co-creating with a family member and making faux stained glass from tissue paper. Reminiscing directives revolved around the holidays. Decision making became an important theme with a directive that centered around a foam mosaic picture. Directives that focused on stress management included mindfulness beads, cross-stitching, and mandalas.

CHAPTER V

DISCUSSION

Overview

The major findings in regard to challenges, data collection, person centered approach, researchers' observations and overall scores are discussed.

Major Findings, Themes, and Outcomes

This study utilized person-centered theory as a framework for the art therapy program that was developed as a result of a grant. This grant included data collection of individual and group art therapy sessions that were available to the guests at an adult day service and elders in a skilled nursing facility. Fourteen program participants agreed to participate in the study portion of the program that included the collection of pre, mid BBQ, and testimonials. Additionally, data was collected on the program including tracking participation, material use, session themes, and general observations.

As part of the session documentations, the researcher noted developmental levels, through session dialogue, for all participants and tailored art therapy sessions to provide a richer experience, and support conflicts and resolutions identified in the research. This approach to art therapy was support by the research on person centered care (American Geriatrics Society, 2016; Poey et al., 2017; Edvardsson et al., 2010). Assessing for developmental conflicts and resolutions provided insight and context of understanding for the researcher during the development and on-going reflection on art therapy programming. Overall, this approach to program development and assessment allowed the researcher to provide meaningful therapeutic engagements. This approach helped to strengthen rapport and supported participants inner resources, and helped guide the art therapy sessions. This approach supported the literature by focusing on the art

making process instead of the art product (Hazler, 2011). Through participant verbalizations and researcher observations, it was evident that participants found the art therapy programming beneficial; whether that was learning how to paint, spending time telling stories and reminiscing, or just having company for an hour.

Program development and developmental theory. Observations during art therapy sessions provided the most insight into the developmental stages of the individual participants. Erikson, Peck and Cohen have stated that the largest conflict that older adults face is being able to look back on their life and leave something behind, whether it's something tangible such as a family heirloom or wisdom that they have accrued over their lifetime (Broderick & Blewitt, 2015; Cohen, 2006; Peck, 1956). Through the art therapy programming, the participants were able to share accrued knowledge during individual sessions, show family treasures that were given as gifts or passed down generationally, or teach the researcher a new skill. Art therapy provided an avenue for exploration of the conflicts describe by Erikson, Peck, and Cohen for the participants to share their experiences in a meaningful way and potentially moving towards resolution (Broderick & Blewitt, 2015; Cohen, 2006; Peck, 1956).

The decline of the body at an accelerated rate compared to the mind, was the foundation of Peck's developmental conflict for older adults; body preoccupation versus transcendence (Peck, 1956). Many of the participants experienced challenges in mobility including being wheelchair bound, partially paralyzed on one side of the body due to a stroke, or the progression of aches and pains that can make walking, grasping, and balance challenging. These ailments became reasons for the lack of interest or perceived ability to participate. Each of the participants commented on their physical limitations and potential problems that would arise out of participating in an art therapy program. Consequently, the researcher adapted the art directives,

materials and tools to support and increase participation. Some of the adaptations included hand over hand creating, adaptive art materials such as adding foam to paint brushes for grip, giving multi-step directions throughout the process, and the use of visual aids.

Cohen (2006) was concerned with the quality of life of older adults in the later stages of their lives. Cohen (2006) believed that the resolution for this conflict is to "restate and reaffirm major themes throughout one's life, and also explore novel variations on those themes and to further attend to unfinished business or unresolved conflicts" (p. 9). A person-centered approach in art therapy allowed participants to talk about self-selected topics including successes and shortcomings through storytelling and reminiscing about major life events. It provided an open, non-judgmental space where they could discuss any topic. The researcher found that the most common topics were self and family, which included unfinished business or conflicts, hopes and future plans; and that for many faith was an important element in this resolution. This supported Fowler's (1991) belief that a resolution for many conflicts was faith.

Creativity and learning. Rogers theory of creativity supported the person-centered care approach through the understanding of the unconditional worth of the individual and creating an environment that was comfortable and safe enough for taking risks and gaining mastery. Art making allowed the exploration of developmental needs less threatening.

The uniqueness of art making engaged participants in tasks that supported control and mastery. This included material choice, content of the artwork, time participating, and topic of discussions. Through continued participation, exposure to materials and art making led to a sense of mastery and empowerment in the therapeutic process. All of these things may show an improvement in quality of life (Cohen, 2006; Fisher & Specht, 1999; Gross et al., 2015; Price & Tinker, 2014).

Art therapy and the creative process of art making is able to integrate cognitive training and stimulation to improve cognitive functioning, improve self-esteem and attention span, build rapport, and enhance problem solving skills by adapting the sessions to meet the needs and abilities of the participants. For example, individuals with cognitive impairments were provided directives that were broken down into smaller steps and stretched out over multiple sessions; and hand over hand or co-creation was implemented to assist those with physical limitations. The researcher found that challenges with eyesight and mobility were the most common reasons for the researcher to make adaptations for participation. Through the adaptations made, the older adults were able to successfully complete their art making which led to increased feelings of self-esteem and attention span.

Much like cognitive stimulation, group art therapy sessions promoted social engagement amongst the participants which led to conversations around memories and past experiences. With a focus on learning and skill building, one ongoing art therapy group integrated art history into the art making process. Each participant was provided an individually selected piece of artwork by a famous artist and provided step by step instructions on the recreation of the artwork. This directive promoted social engagement amongst those who participated through active discussions around personal memories and the art making process.

Quality of life. The umbrella of quality of life encompasses sense of coherence where individuals perceive issues as structured, predictable, and explicable. They feel confident that they have the resources and motivation to deal with issues (Slootjes et al., 2017). Art therapy targets two components of sense of coherence: manageability and meaningfulness. Manageability in art therapy provided a way for the participants to be challenged appropriately through art making without becoming overwhelmed. When the art making became less

challenging, the researcher was able to tailor the process to make it more challenging without becoming overwhelming.

Meaningfulness in art therapy occurred through decision-making processes and feeling heard by the researcher and other participants (Slootjes et al., 2017). In addition, the selection of materials, artwork content, and discussions were participant driven and in turn demonstrated a level of meaning. For example, a participant wanted to paint a picture that had sentimental value of a place that helped them get through a difficult time in their life. The researcher and participant co-created until the image represented the image from years past. This was the turning point for the participant, and they verbalized a sense of empowerment, agency, and autonomy in the process and resulting product.

Brunnsviken Brief Quality of life scale. The BBQ provided a time efficient pre and mid measure of quality of life. The researcher was able to assist participants by reading the questionnaire aloud and shortening the questions if needed. An overall pre to mid change was found when looking at individual scores of the participants. Five participant's score increased overall, with the highest increase of 36 points. Three participants' overall scores remained the same from pre to mid assessment. These results showed that 57% of study participants showed an increase or maintained their quality of life scores while enrolled in the study. Six participants showed a decrease in overall scores, one of which decreased by 23 points. These results showed that 43% of study participants showed a decrease in their quality of life scores while enrolled in the study. These results could indicate that opportunities offered either aligned or did not align with personal interests, or that changes in their environment, cognitive, physical, and psychological health could have influenced these results.

The following section separates the three components from the BBQ that this study was assessing: leisure, creativity, and learning.

Leisure. The most common leisure activities observed by the researcher were watching television, listening to the radio, reading, prayer and resting in their rooms. These activities occurred in isolation of other individuals, residents, or staff. This was consistent with the research by Pruchno and Rose (2002) who found that most older adults spend their days alone (2002). Obligatory and discretionary activities left little time for activities that would enhance connection, learning, and creativity (Pruchno & Rose, 2002). The focus of the researcher was to provide the participants with quality leisure activities through art making that promoted social engagement, identifying and defining a purpose, and something to look forward to. The art therapy programming provided additional opportunities for discretionary activities for the participants of the study. It allowed for personal expression their abilities, control of their environment, and identification and reflection on meaningful aspects of their lives. The themes that arose during the sessions that aligned with leisure and identifying important aspects of their lives included memory making and reminiscing. A consistent theme throughout the art therapy programming was the importance of faith and family which included directives such as co-creating with family members or speaking about holiday and family traditions.

The pre to mid results of the BBQ increased for five of the participants, one of which had an increase of 16 points. Seven participant scores remained the same, and they all had the maximum score of 16. These results showed that 86% of the participants in the study increased or maintained the importance of and satisfaction with leisure outlets, which could imply that through participation in the art therapy programming participants were engaged and found these engagements life enhancing. Two participants saw a decrease in scoring, and one had a decline

of 7 points. These results showed that 14% of study participants showed a decline in the Significance and Importance of leisure activities in their quality of life. It is notable that all of the participants who were guests at the adult day center experienced no change, while the elders at the skilled nursing facility saw either an increase or a decrease from pre to mid scoring. Those at the adult day center had more autonomy within the setting which could have led to feelings of increased control. Additionally, since those participants lived with family members and there may be more options for enrichment outside the facility.

Creativity. Person-centered theory and art therapy provided a framework under which creativity could thrive and participants were able recognize and accept their artistic abilities. Art therapy programing invited family members to be involved as a key component of person-centered care for older adults. For example, a participant and family member recreated a memory of co-creating art together when the family member was a child. This experience fostered memory-making and encouraged a sense of connection.

Art therapy provided a safe space for the participants to explore new art making processes, since many noted that they had little or no experience making art. The major theme that best encapsulated creativity was rapport building through creativity. The researcher provided no-fail directives, such as ink blots, embroidery, and building a bird feeder, as an introduction into the art making process. This provided opportunities for problem-solving and to deepen an understanding of themselves. For example, due to issues with grasping, a participant found that they enjoyed finger painting the most due to a sense of control. This participant was able to make connections between finger painting and playing an instrument that required the same motion and finger use. Through art experiences, many participants verbalized that they were left with a sense of accomplishment with their final artworks, even passing their creations on to family

members. This artwork served as a transitional object or memorabilia to strengthen the sense of connection amongst the participants and their loved ones.

The results from the life area of Creativity on the BBQ showed an increase in four of participants, one of which had an increase of 12 points. Seven participant scores remained the same, and they all had the maximum score of 16. These results showed that 79% of the participants in the study increased or maintained the importance of and satisfaction with creative outlets, which could imply that through participating in this programming, creativity increased QoL. Three participants showed a decrease in scoring, and one had a decline of 9 points. These results showed that 21% of study participants showed a decline in Importance and/or Significance of the life area of Creativity in the QoL. This could indicate that the creative opportunities offered were not aligned with personal interests and it would support providing broader opportunities for creative expression which could be determined through a needs assessment of the participants.

Learning. Art therapy provided alternative way of learning for the participants. The structure of the art therapy sessions were flexible, unstructured times that supported experimentation and skill building. During observations of participants and verbalizations during sessions, the researcher noted the participants took an active interest and began using art making outside of sessions, which demonstrated motivation and the pleasure and fulfillment of their new-found artistic abilities.

By participating in an informal learning program, the participants were able to engage their intellectual capacities through art making. Art making requires processes that are not typical of problem-solving tasks, such as methodological problem solving, organization, cognitive flexibility, self-construct, self-reflectiveness, abstract thinking, planning, willed action, source

and working memory (Dietrich, 2004; Ellamil, Dobson, Beeman, Christoff, 2012). The materials that best aligned with problem solving tasks were those that included mixed media because it allowed for the participants to abstract ideas together. It also improved their self-esteem and social ties with those around them, productively filling time with meaningful activities instead of watching television or resting. The increase in self-esteem was seen through positive self-talk and family reports. Self-esteem was one of the major themes that arose during sessions. The directives that focused on building self-esteem included jewelry making, identifying a self-symbol, and tissue paper paintings.

The scores from the BBQ pre and mid assessment suggest that art therapy is conducive to learning. Six of the participants increased their scores, one of which had an increase of 6 points. Six participants remained the same, and they had the maximum score of 16. These results showed that 86% of the participants in the study increased or maintained the importance of and satisfaction with learning, which could imply that through participation in this programming, learning increased QoL. Two participants showed a decrease in scoring, and both had a decline of 3 points. These results showed that 14% of study participants showed a decline in Importance and/or Significance of the life area of Learning in the QoL This could indicate that learning opportunities offered were not aligned with personal interests, environment, physical, and psychological changes could have influenced all of the study. The life areas of Leisure, Creativity, and Learning all showed a higher or maintenance of QoL which is greater that the overall QoL scores. This data may support that participation in art therapy may improve QoL overall.

Challenges. The researcher noticed inconsistencies in the participants answers centered around the environment and other individuals being present during the administration. For some

participants, the preassessment was completed with family members present, this may have skewed the results. There were assessments where the family members influenced the participants answers or requested that the researcher read questions over leading to the potential for a different answer than initially provided. For other participants with no family members present, the participant was asked the questions from the BBQ and were able to answer without judgement or influence. All mid assessments were completed with the study participants only. The environment of the preassessment may have led to discrepancies in pre to mid scores rather than a result of participating in the study.

While the BBQ has proven to be a reliable research tool (Lindner et al., 2016), the researcher believes that it is not a reliable tool while working with the older adult population. The researcher observed that the likert scale multiple choice numbers were difficult for the participants to answer and the language posed challenges in understanding. The researcher made the questions simple for those individuals who asked for clarification. For example, the researcher shortened the questions for leisure time to include "I am satisfied with my leisure time" instead of "I am satisfied with my leisure time: I have the opportunity to do what I want to relax and enjoy myself".

Due to the poor self-report measure, the results of this study may not be accurate to how older adults gauge their quality of life in the domains of leisure time, view of life, creativity, learning, friends/friendships, and self as a person. The researcher has identified that dementia, mild cognitive impairments and psychological diagnoses may have led to inconsistency in score reporting. The researcher did not have access to diagnostic, pharmaceutical, and other health related information and any information gained regarding dementia, mild cognitive impairment, and psychological diagnosis were obtained informally from family members and care staff.

These were not psychiatric facilities. Psychiatric services were provided by outside entities, for a select set of individuals. The researchers were not notified if any additional therapeutic services were provided for study participants.

Another factor that could have hindered the results of the BBQ were the participants willingness to participate. To be in the study, the participants legally authorized representatives were required to provide consent prior to enrollment. Two participants were uninterested but were enrolled by the family, and minimally participated in the sessions offered. The researcher found that residents at the nursing home who only enrolled in the program were more willing to participate in art therapy on a regular basis than those individuals who were enrolled in the program and study. This could be due to the individuals being more connected through companionship and less connected through the study portion.

Data collection. There existed difficulties with recruitment, though fourteen participants were able to be a part of the study, eighteen individuals originally completed the informed consent and pretest process. Four dropped out of the study due to increased cognitive impairment and the inability to complete the mid test process. The researcher noted that there were several participants who were unwilling to participate in sessions due to a lack of interest in art making.

The recruitment process took longer than expected due to the formality of running a research study with human subjects. Some were confused or uncomfortable when read the consent form, resulting in a lack of participation. Many older adults did not want to participate in a study, but still wanted to partake in the art therapy programming.

Although the researcher had initially planned to document the number of participants who participated in an open studio session and the verbalizations made by each participant, it became apparent that it would be difficult to achieve due to the participants wanting one-on-one

time with the researcher. It was found that program participants willing to share what they had gained from participating in the art therapy programming, although few enrolled in the study were willing to talk about their experience.

Participation. The researcher found it difficult to start an art therapy program with older adults in the locations of the study due to the schedule of activities that were already in place. It took longer than expected to build rapport with the participants due to the inconsistencies in program providers. The participants also had days where they were ill, had visitors, or were sleeping during scheduled sessions. The number of participants in the study (14) and the program participants (50), is a small sample compared to the number of residents and guests at the two facilities.

Space. Although the researcher was able to adapt space to make art, it was often difficult to conduct sessions in common spaces. This led to a number of sessions being interrupted by others, duties of the staff at each site, and loud noises such as the television and the help signal. This also led to an issue of privacy and confidentiality with many of the participants uncomfortable sharing serious topics for fear of others around hearing. The spaces that the researcher often worked in were small which limited the directives that could be done with participants.

Companionship. This research highlights the importance of improving the quality of life for older adults. Art therapy is uniquely equipped to provide older adults with meaningful activities, social engagement, and learning opportunities which has the potential to address the resolution of life's conflicts. This study assessed creativity and learning through art making and leisure as the time spent in the process was not obligatory and was self-selected. Participants verbalized during sessions that companionship became a key factor in their willingness to

participate. The researcher observed changes in participant behavior and affect when it was time for art therapy sessions. Participants went from sleeping and watching television to becoming fully engaged in the art making process.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

Sophia Loren had described the resolution for beating age as one's mind, talents, and the creativity that one brings to their life and the ones they love (Emling, 2015). With the growing older adult population, it is important to help these individuals live their best lives until the very end. Research has found that a person-centered care approach, meaningful activities, and social engagement can help the aging population (Edvardsson et al., 2010); Fisher & Specht, 1999; Smith, 1989; Von Humboldt & Leal, 2013).

The present study used a person-centered framework to develop art therapy programming at an adult day service and a skilled nursing facility. The study had a total of 14 participants and utilized the BBQ as a measurement tool for quality of life measures. It was hypothesized that there would be an increase in the BBQ scores after participation in individual and group art therapy sessions for 16 weeks, specifically in the life areas of leisure, creativity, and learning. While the results from the overall BBQ were not statistically significant, the life areas of Leisure, Creativity, and Learning all showed an increase from pre to mid assessment. There was also a significant unintended result of companionship. In this researcher's opinion, each of the life areas, leisure, creativity, and learning, was shown to have been more impactful in the lives of the participants when they were done with another person.

The participants were able to create despite having cognitive and physical impairments. The researcher supported each participant in their personalized art making process. Art therapy provided an opportunity to explore important concepts that went beyond verbal approaches for older adults allowing them to use images to express their thoughts, emotions, ideas, and challenges (Hinz, 2006).

Recommendations

It is recommended for future research to continue to measure quality of life pre, mid, and post intervention to provide additional support for the use of art therapy to increase quality of life for older adults. This study would benefit from multiple levels of care for older adults, such as those still living at home or assisted living centers, to help diversify the study population. Including older adults from multiple levels of care would help the researcher to determine when the most opportune time is to see an increase in quality of life using art therapy. Increasing the number of participants may have increased the significance of the results.

The present study can also be used to inform future programming for art therapy adult day centers and skilled nursing facilities. Person-centered care was found to be an effective approach for working with older adults. It allows for personalization for each individual participating in art therapy programming based on developmental, physical, and psychological factors. It aides in boosting self-esteem and improving problem-solving skills.

A more informal approach to studying older adults is recommended. Implications for a formal approach included low participation rates and the difficulties pertaining to language. The use of an informal approach may glean richer results through observations and verbalizations than the use of a formal assessment tool.

It is recommended that there be a space dedicated to art making. This would provide the participants with a safe, distraction free space in which they could create artwork. It would also provide the researcher adequate storage space to store art materials and participant artwork.

Another assessment, or the creation of a new assessment tool, may better support the older adult population. The BBQ proved to be difficult for participants to answer due to likert

scale rating and language use. A more informal and simplified assessment tool about the subjective domains of quality of life would be ideal.

In conclusion, this mixed methods study design demonstrated that participation in a 16-week art therapy group has the potential to increase quality of life for older adults. The study found that increasing companionship through Leisure, Creativity, and Learning is beneficial. The art therapy programming provided a unique framework for meaningful activities, social engagement, and companionship. The participants were able to create despite any obstacles that may have prevented them from participating

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APPENDIX A

INFORMED CONSENT

INDIANA UNIVERSITY INFORMED CONSENT STATEMENT FOR RESEARCH

Impact: Art Therapy and Aging Adults
Healthcare Initiative
IUPUI 1805467216

ABOUT THIS RESEARCH

You are being asked to participate in a research study. Scientists do research to answer important questions which might help change or improve the way we do things in the future.

This consent form will give you information about the study to help you decide whether you want to participate. Please read this form, and ask any questions you have, before agreeing to be in the study.

TAKING PART IN THIS STUDY IS VOLUNTARY

You may choose not to take part in the study or may choose to leave the study at any time. Deciding not to participate, or deciding to leave the study later, will not result in any penalty or loss of benefits to which you are entitled and will not affect your relationship with Joy's House, Greenhouse Cottages of Carmel, or Indiana University

WHY IS THIS STUDY BEING DONE?

The purpose of this study is to understand the benefits of art therapy for aging adults. The participants will be offered individual and group art therapy and qualitative and quantitative methods will be used to identify if the participants found art therapy to be beneficial

You were selected as a possible participant because you are a guest at Joy's House or an Elder at Greenhouse Cottages of Carmel

The study is being conducted by Eileen Misluk, Assistant Professor at Herron School of Art and Design, IUPUI in the Masters of Art in Art Therapy Program. It is funded by Healthcare Initiatives.

HOW MANY PEOPLE WILL TAKE PART?

If you agree to participate, you will be one of 25 at your location for total of 50 participants taking part in this study.

WHAT WILL HAPPEN DURING THE STUDY?
If you agree to be in the study, you will do the following things:

- Participate in individual, group, and/or open studio art therapy sessions.
- Sessions will be offered 3 times per week from 30-60 minutes. There will be approximately 12 hours of art therapy programming per week.
- All sessions are held on site at either Joy's House or Greenhouse Cottages of Carmel for.
- Complete a pre, mid, and post survey about your current quality of life. These will take approximately 30 minutes and will be administered in August, December, and April.
- Participants who do not participate in the study are able to attend all art therapy sessions offered on their site.
- The study will begin in August and commence in April.

WHAT ARE THE RISKS OF TAKING PART IN THE STUDY?
While participating in the study, the risks, side effects, and/or discomforts include: There is minimal risk associated with this study. A potential risk of completing the survey is being uncomfortable answering the questions. Additionally, there is a risk of possible loss of confidentiality.

To minimize the potential risks during the survey, the participant is able to skip any questions that make them uncomfortable or they are able to stop taking the survey at any time. Additionally, to reduce the potential of loss of confidentiality, each participant will be provided a unique ID number that will be used for all study documents.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THE STUDY?
The benefits to participation in the study that are reasonable to expect are increase involvement in creative activities such as art making, an increase in social activities, and the benefit of participating in an art show.

WILL I RECEIVE MY RESULTS?
We may learn things about you from the study activities which could be important to your health or wellbeing. If this happens, you can decide whether you want this information to be provided to you. This would include if the statistical analysis of the results of the pre/mid/post survey results show significance as a result of participating in the study. If

you decide that you want this information, you may need to meet with professionals with expertise to help you learn more about your research results. The study team/study will not cover the costs of any follow-up consultations or actions. Please initial one of the following options:

_____ Yes, I want to be provided with this information.

_____ No, I do NOT want to be provided with this information.

HOW WILL MY INFORMATION BE PROTECTED?

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. No information which could identify you will be shared in publications about this study nor will databases in which results may be stored. The researcher will maintain confidentiality of the participants by assigning unique identification numbers on the data collection forms which include: material choice, verbalizations, and number and type of sessions attended. Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and her research associates, the Indiana University Institutional Review Board or its designees, and the study sponsor Herron School of Art and Design, Indiana University Purdue University of Indianapolis faculty.

WILL I BE PAID FOR PARTICIPATION?

You will not be paid for participating in this study.

WILL IT COST ME ANYTHING TO PARTICIPATE?

There is no cost to you for taking part in this study.

WHAT FINANCIAL INTEREST DOES THE RESEARCHER HAVE?

One or more individuals involved in this study may benefit financially from this study. The Institutional Review Board (an ethics committee that helps protect people involved in research) has reviewed the possibility of financial benefit. The Board believes that the possible financial benefit is not likely to affect your safety and/or the scientific integrity of the study. If you would like more information, please ask the researchers or study staff.

WHO SHOULD I CALL WITH QUESTIONS OR PROBLEMS?

For questions about the study contact the researcher, Eileen Misluk, at 317-278-9460.

For questions about your rights as a research participant, to discuss problems, complaints, or concerns about a research study, or to obtain information or to offer input, please contact the IU Human Subjects Office at 800-696-2949 or at irb@iu.edu.

WILL I BE CONTACTED ABOUT RESEARCH IN THE FUTURE?

Information collected from you for this research may be used for future research studies or shared with other researchers for future research. If this happens, information which could identify you will be removed before any information or specimens are shared. Since identifying information will be removed, we cannot ask for your additional consent.

CAN I WITHDRAW FROM THE STUDY?

If you decide to participate in this study, you can change your mind and decide to leave the study at any time in the future. The study team will help you withdraw from the study safely. If you decide to withdraw, tell the researcher and you will be removed from future survey collection procedures. You will still be able to participate in all programming offered.

PARTICIPANT'S CONSENT

In consideration of all of the above, I give my consent to participate in this research study. I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.

Participant's Printed Name:_____

Participant's Signature:_____ **Date:**_____

Printed Name of Caregiver:

_____

Signature of Caregiver:_____ **Date:**_____

Printed Name of Person Obtaining Consent:_____

Signature of Person Obtaining Consent:_____ **Date:**_____

APPENDIX B

ART THERAPY PROGRAM LOGS

Participant Initial	Study Participant		Type of Programming: Include theme/goal/directive			Materials Used	Verbalizations
	Yes: Number	No	Individual	Group	Open Studio		

APPENDIX C

DATA COLLECTION TRACKER

Participant Number	Pre: date completed (September)		Mid: date completed (December)			Post: date completed (April)		
	GDS	BBQ	GDS	BBQ	Testimonials	GDS	BBQ	Testimonials

APPENDIX D

Brunnsviken Brief Quality of life scale (BBQ)

The following 12 questions are about how you experience your quality of life. It covers six areas, how satisfied you are with these, and how important they are to you. Circle the number that best reflects your experience.

	Do not agree at all				Agree completely
1. I am satisfied with my **leisure time**: I have the opportunity to do what I want to relax and enjoy myself.	0	1	2	3	4
2. My **leisure time** is important for my quality of life.	0	1	2	3	4
3. I am satisfied with how I **view my life**; I know what means a lot to me, what I believe in, and what I want to do with my life.	0	1	2	3	4
4. How I **view my life** is important for my quality of life.	0	1	2	3	4
5. I am satisfied with opportunities to be **creative**; to get to use my imagination in my everyday life, in a hobby, on the job, or in my studies.	0	1	2	3	4
6. Being able to be **creative** is important for my quality of life.	0	1	2	3	4
7. I am satisfied with my **learning**; I have the opportunity and desire to learn a new, exciting things and skills that interest me.	0	1	2	3	4
8. **Learning** is important for my quality of life.	0	1	2	3	4
9. I am satisfied with **friends and friendship**; I have friends that I associate with and who support me (as many friends as I want and need).	0	1	2	3	4
10. **Friends and friendships** are important for my quality of life.	0	1	2	3	4
11. I am satisfied with **myself as a person**; I like and respect myself.	0	1	2	3	4
12. My satisfaction with **myself as a person** is important for my quality of life.	0	1	2	3	4

Note. Permission to reprint.

Lindner, P., Frykheden, O., Forsstrom, D., Andersson, E., Ljotsson, B., Hedman, E., ... Carlbring, P. (2016). The brunnsviken brief quality of life scale (bbq): Development and psychometric evaluation. *Cognitive behavioral Therapy*, *45*(3), 182-195.