The Role of Art therapy in Hospice:  An Understanding of the Grief Process for Caregivers

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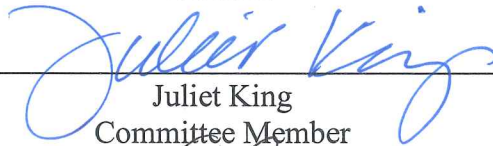in the Herron School of Art and Design
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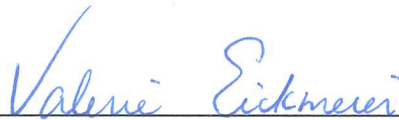
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Abstract

The responsibilities of caregiving create enormous pressures and risks for caregivers. Burnout, compromised health, depression, and depletion of financial resources are a reality of daily life for millions of Americans who are caregiving for a loved one (Family Caregiver Alliance, 2011). Family caregivers will increasingly provide care for aging parents or family members as the population of Americans over 65 rapidly increases (Family Caregiver Alliance, 2011). In addition to aging adults, other individuals in hospice care will require a caregiver for daily needs. In order to maintain the important role they play, caregivers' experiences must be examined so that appropriate support for their quality of life can be provided (American Hospital Association, 2007). A systematic study of the existing literature on grief and art therapy in the hospice setting was undertaken over a nine month period. An 8 week program was developed from the resulting data that offers group art therapy to caregivers within the hospice setting. The program was designed to assist caregivers in their journey of grief and provide a group framework for learning self-care strategies for mental and physical well-being. It was hypothesized that art therapy can potentially benefit the caregiver allowing them to provide proper care to the patient and explore their own grief process after the patient has passed. Using art therapy interventions, the proposed group can be utilized or implemented by a trained art therapist to help explore the dynamics of grief through creative process and discussion. The support from art therapy groups for caregivers is intended to result in a positive reflection of self-expression and self-awareness so that the individual can continue to live meaningfully after their loved one has passed.

Dedication

I would like to thank my classmates of the inaugural class in the Masters of Art Therapy program. I would like to dedicate this thesis to the patients I worked with during my internship at Seasons Hospice. Each and every individual has inspired and validated the efficacy of art therapy.

## Acknowledgments

**Table of Contents**

## CHAPTER I: INTRODUCTION

With the population of Americans over 65 expected to double to 70 million by 2030, family caregivers will increasingly provide care for aging parents or loved ones in a variety of settings (American Hospital Association, 2007). The growing elderly population in hospice settings requiring care from family members creates additional caregivers who will inevitably lose a loved one and experience grief and bereavement. Grief and bereavement are often terms that are used interchangeably. For the purpose of common understanding in this paper, grief is used to define the experience of one who has lost a loved one (Worden, 2002). Bereavement refers to the actual loss to which the person is trying to adapt (Worden, 2002). Caregiving is often unplanned, thus most caregivers are ill-prepared for their new role. Although hospice services provide medical and supportive care for the family, caregivers in the hospice setting still face many challenges.  More than one-third of caregivers continue to provide care to their loved ones with little support for themselves while suffering from their own health issues (Family Caregiver Alliance, 2011).  The purpose of this literature review is to investigate the potential benefits of group art therapy for caregivers in the hospice setting. It is hypothesized that art therapy can be a beneficial form of expression for caregivers during the grieving process.

### Statement of Problem

Caregivers are essential for end of life care (Feinberg, Reinhard, Houser, & Choula, 2011). When caregivers lack support and resources, they experience greater financial, physical and psychosocial effects.  Research also suggests that a loss of self occurs when caregivers experience constriction of normal daily activities due to caregiving responsibilities (Skaff & Pearlin, 1992 & Jeffreys, 2005).  As a result, the quality of care they are able to provide can be

compromised (Bastawrous, 2012). A lack of emotional support for caregivers can lead to low self-esteem, depression, suicidal ideation, and physical illness (Hill, 2002).

Difficult events or conditions of ongoing stress often bring about role change, particularly for those caring for ill family members. Life events are characterized by the loss of significant others who have been important sources for self-validation and confirmation and cannot easily be replaced (Skaff & Pearlin, 1992). Caregivers face a vast emptiness and an additional role change when their loved one dies. The grief they experience is not only for the person who has passed, but also for the empty space and unfilled time left as a result of the death (Jeffreys, 2005). Although the death of the care-recipient ends caregiving responsibilities, the emotional impact of these experiences does not necessarily end at the same time (Aneshensel, Botticello & Yamamoto-Mitani, 2004). Role loss is a pervasive stressor for many caregivers, and it can lead to the individual feeling more vulnerable (Aneshensel , et al., 2004).

**Justification of Study**

This study will contribute to the field of art therapy through an exploration of how art therapy can benefit the caregiver while his or her family member is living, as well as after the patient has passed. It intends to be a significant contribution to the field of art therapy because art therapy offers individuals a way to express their thoughts and feelings using creative processes that are both healing and life-enhancing (American Art Therapy Association, 2013). This research will enrich the field of hospice and end of life care because death and the experience of loss are universal (Barrington, 2008). In American society, the topic of death is difficult and often avoided (Barrington, 2008). A caregiver who is confronting and preparing for a loved one's death may experience fear, anxiety, and many other emotions. Honoring,

understanding, and helping individuals during this unique and vulnerable time may provide knowledge about the processes of grief and death, which may help people better understand the human experience (Barrington, 2008). One overarching focus will be to explore art therapy as a way to understand and process grief for caregivers in the hospice setting. Art making can provide a format for caregivers to confront and express overwhelming emotions, overcome depression, and find relief and resolution of grief and loss (Nainis, 2005). The following examination will suggest art therapy interventions for hospice caregivers experiencing their grieving process based on information and support gathered from current and relevant literature.

A systematic study of the existing literature on grief and art therapy in the hospice setting was undertaken over a nine month period. The accompanying research question for this research study asks, "What are the potential benefits art therapy can provide caregivers in the hospice setting during their grief process?" Art therapy offers a means to understand and communicate experiences and meanings of life (Wadeson, 1987).

The literature review addresses the hospice philosophy, the roles and tasks associated with caregiving, the grief process, and the benefits of group art therapy for caregivers. The use of art therapy in a group setting can facilitate comprehension of the most complex aspects of human existence and provides a structure for emotional chaos and a shared social setting for the construction of meaning (Hill, 2002). An 8 week program was developed that offered group art therapy to caregivers within the hospice setting. The program was designed to assist caregivers in their journey of grief and provide a group framework for learning self-healing strategies for mental and physical well -being.

**Definitions of Specific Terms**

*Grief* is defined as a system of feelings, thoughts, and behaviors that are triggered when a person is faced with loss (Jeffreys, 2005).

*Bereavement* refers to a cultural/social role or condition for a person who has experienced a death and engages in cultural rituals and behaviors associated with death (Jeffreys, 2005).

A *caregiver* is defined as a person who is responsible for the care of someone who has poor mental health, is physically disabled or whose health is impaired by sickness or old age. For the purpose of this study, a caregiver is an unpaid relative or friend of the disabled individual (Family Caregiver Alliance, 2009).

*Self-care* refers to actions and attitudes which contribute to the maintenance of well-being and personal health and promote human development. Self-care theory operates on the assumption that all individuals have a need to care for themselves. (Barrington, 2008).

*Collaborative art-making process* is defined as more than one person createing images together (Barrington, 2008).

*Hospice* is an approach that focuses on assisting individuals with a terminal illness to retain dignity during the dying process while providing medical, nursing, and supportive care (Barrington, 2008).

*Life review* is defined as an autobiography of a person that includes testimonials from people who know that person very well (Barrington, 2008).

*Reminiscing* refers to informal conversations consisting of telling stories and experiences of the past (Barrington, 2008).

**CHAPTER II: METHODOLOGY**

An integrative review of the literature was conducted to gather relevant data on

investigating art therapy for caregivers in the hospice setting. The results were then analyzed to

identify the constructs currently present in the literature as well as to identify gaps. The articles

gathered for this systematic literature review were analyzed using qualitative research methods.

An integrative review is a specific review method that summarizes past empirical or theoretical

literature to provide a more comprehensive understanding of a particular phenomenon or

healthcare problem (Whittemore, 2005). This method allows diverse methodologies in its review

and also contributes to theory development and direct applicability. Integrative reviews are the

broadest type of research review methods allowing for the simultaneous inclusion of

experimental and non-experimental research in order to understand a phenomenon (Whittemore,

2005). In this study, the phenomenon is art therapy and the grief process in the hospice setting.

Theoretical and empirical data were combined to gain an understanding of the benefits art

therapy offers to family caregivers in the hospice setting.

For each resource, information was organized to warrant immediate retrieval under the

following headings: Author/title/publish date, research design, sample description and size,

method, outcomes/conclusions, implications, and relation to the study. These headings were also

chosen to answer the research question by providing pertinent information from each article. The

search strategy for this systematic review of literature consisted of the use of multiple databases

provided through the Indiana University-Purdue University-Indianapolis library. Databases used

are included in Table 1.  References were also gathered using reference lists from resources

pertaining to relevant topics. Specific journal articles and author searches were conducted in

order to locate referenced materials. Interlibrary loan was utilized to obtain materials that would

not otherwise have been available at the IUPUI University Library. The Indianapolis Public

Library was also a valuable source for pertinent research. Table 2 includes a complete list of

terms used in the research process.

Table 1

*Databases from Which References were Retrieved*

| Alphabetical Listing of Databases Utilized | |
| --- | --- |
| Academic Search Premier | PsychARTICLES |
| Education Resources Information Center (ERIC) | PsychINFO |
| Masterfile | WorldCat |

Table 2

*Search Terms and Phrases*

| Caregivers | Grief | Hospice | Art Therapy |
| --- | --- | --- | --- |
| Caretaker | Bereavement | Palliative Care | Creative process |
| Family Caregiver | Burden | End of life | Art-making |
| Informal Caregiver | Stress | Death | Creativity |
| Home health care | Burnout | Aging | Group therapy |
| Palliative medicine | Depression | Elderly | Mental Health |

| Role change | Stress | Terminal | Psychology |
|---|---|---|---|
| | Stages of Grief | | Psychotherapy |
| | Mourning | | Support group |

Table 3

*Publication Dates of Resources*

| Publication Date | Number | Percentage |
|---|---|---|
| 2007-2013 | 19 | 22 |
| 2000-2007 | 26 | 30 |
| 1990-1999 | 23 | 27 |
| 1980-1989 | 10 | 11 |
| Pre 1980 | 6 | 7 |

Table 4

*Types of Resources*

| Category | Number | Percentage |
|---|---|---|
| Articles-including peer reviewed journals | 45 | 53 |
| Books/Chapters | 28 | 33 |

| | | |
|---|---|---|
| Internet Websites | 7 | 8 |
| Doctoral Dissertations | 4 | 4 |
| Total | 84 | 100 |

**CHAPTER II: LITERATURE REVIEW**

The purpose of the following review was to investigate the potential benefits of group art therapy for caregivers in the hospice setting. The following topics are explored and discussed thoroughly: Hospice care, the role of the caregiver, effects of caregiver burden, attachment theory and grief, the grief process, art therapy, group therapy, art therapy groups, grief and art therapy, the Expressive Therapies Continuum, and art therapy and caregiver stress, and caregiver support.

**Hospice Care**

Hospice is a form of palliative care for patients who, due to terminal illness, no longer qualify for curative medical treatment (Safrai, 2013). Hospice care provides dying patients with support and relief of total pain with all of its physical, psychological, social, and spiritual dimensions (Johnson, 2007). This form of care involves an interdisciplinary team approach that is designed to enhance a patient's life when life expectancy is months rather than years (Safrai, 2013). Hospice is not a physical place. It is a status that declares that treatment is no longer deemed effective for the patient and the prognosis is a life expectancy of fewer than six months (Safrai, 2013). Based on the patient's needs and preferences as determining factors in the setting and location of care, hospice provides in-patient care at nursing facilities and care in the home setting. Hospice care addresses the emotional, spiritual, and social impact of serious illness on the patient and on the patient's family. Guided by the mandate to control pain and to optimize quality of life, a hospice team comprised of a physician, nurse, social worker, spiritual care counselor, therapist, bereavement counselor, volunteer, and other supportive helpers coordinates a treatment plan that is tailored to the patient's individual needs (Safrai, 2013). Quality of life

remains principal for the individual receiving hospice care. The patient may need a vehicle for pain reduction, personal expression, increased family connection, and an opportunity to address end-of-life issues (Safrai, 2013).  Hospice care supports these needs while upholding the patient's quality of life. At the center of hospice care is the belief that each individual has the right to die pain-free and with dignity, and that families will receive the necessary support to allow them to do so (National Hospice and Palliative Care Organization, 2013).

The hospice philosophy is to affirm life. Hospice programs exist to give support and care to the terminally ill so that they may live as fully and comfortably as possible. Death is viewed as a normal process, and hospice programs neither hasten nor postpone death. It is hoped through the availability and supportive care of hospice staff, patients and their families will be able to satisfactorily prepare themselves mentally and spiritually for death. Establishing goals for caring and interventions to achieve the palliation of the accompanying concerns and distressful symptoms of the process of dying becomes principle. With the recognition that death is inevitable as the final moment of the natural course of human life and the terminal phase of the disease process is irreversible.

As the patient's family is central to the hospice care team, family participation in caregiving is an essential part of end of life care. Families may experience significant stress during the terminal illness of their loved one, and the hospice philosophy includes providing support for them as well. Hospice considers all aspects of the lives of patients and their families as valid areas of therapeutic concern. Hospice care seeks to be respectful of all patient and family belief systems, and employs resources to meet the personal philosophic, moral, and religious needs of patients and their families. The continuity of care provided in hospice aims to reduce the patient's and family's sense of isolation and loneliness.  Support and counseling for the

family continues into the bereavement period, as family needs and struggles continue after the death of their loved one. Hospice care programs also seek to identify, coordinate, and provide support for patients who do not have family or friends available to take on responsibilities of giving care.

### The Role of the Caregiver

In hospice, family members are usually the front-line providers of daily care for patients, working in tandem with the professional health care providers (Jennings, Ryndes, D'onofrio, & Bailey, 2003). Caregiving by family members saves the healthcare system billions of dollars annually (Schultz et al., 2003). However, caregiving activities can take their toll and the welfare of family caregivers is a major concern. Researchers have indicated that psychological symptoms are overwhelming to family caregivers. Caregiver burden is defined as the physical, psychological, emotional, social, and financial stresses that individuals experience due to providing care (Bastawrous, 2012).

A quantitative study conducted by the National Alliance for Caregiving focused on presenting a portrait of family caregivers today, and to compare it to a portrait of caregivers in the past. The study was conducted in 2004 comparing statistics from 1997, and these results were then compared and published in 2009. The studies inquired about certain core elements of caregiving situations, while also exploring new areas. The core areas that were examined include:

- The prevalence of caregivers in the U.S.

- Demographic characteristics of caregivers and care recipients.

- The caregiving situation in terms of the nature of caregiving activities.

- The intensity and duration of care.

- The health conditions and living situation of the person to whom care is provided and other unpaid and paid help provided.

- How caregivers are affected by their role, at work, at home, and in their health situation.

- Information needs and information sources.

In the same study conducted by the National Alliance for Caregiving, 1,480 family caregivers were interviewed by telephone. For the study, caregivers were defined as those who provide unpaid care to an adult or child with special needs. Statistics from the study show that the percentage of female caregivers is 66% and higher than men (National Alliance for Caregiving, 2009). In addition, female caregivers often work outside the home and spend more than 20 hours per week providing unpaid care (National Alliance for Caregiving, 2009). Most caregivers are married or living with a partner with children. While caregivers can be found across the age span, the majority of caregivers are middle-aged ranging from 35 to 64 years old (National Alliance for Caregiving, 2009). In addition, most caregivers are employed. Among caregivers between ages 50 to 64 years old, an estimated 60% are working full or part-time (National Alliance for Caregiving, 2009). Many caregivers of older people are themselves elderly. Of those caring for someone aged 65 and older, the average age of caregivers is 63 years with one third of these caregivers in fair to poor health (National Alliance for Caregiving, 2009).

Recent medical advances, shorter hospital stays, increasing life spans with better management of chronic illnesses, limited discharge planning, a shortage of homecare workers,

and the expansion of home care technology have increased the caregiving responsibilities of families (Family Caregiver Alliance, 2014). In addition to more complex care, conflicting demands of jobs and family, increasing economic pressure, and the physical and emotional demands of long-term caregiving can result in major health impacts on caregivers (Family Caregiver Alliance, 2014). Working caregivers often suffer many work-related difficulties due to their "second careers" as caregivers. Caregivers report conflicts between caregiving and employment, resulting in reduced work hours or unpaid leave. A typical day for a caregiver may include assisting a loved one with activities of daily living such as bathing, managing medicine, dressing, preparing meals, eating, house maintenance, transportation, and bowel incontinence.  In addition to these tasks, family caregivers often have their own families, daily needs, and jobs (Family Caregiver Alliance, 2014 & Houts, Nezub, & Bucher, 1996).

Nearly half of caregivers provide fewer than eight hours of care per week, while nearly one in five provide more than 40 hours of care per week (National Alliance for Caregiving, 2009). Older caregivers often spend the most hours providing care and the amount of time spent caring increases substantially as cognitive impairment worsens (National Alliance for Caregiving, 2009). Half of the caregivers interviewed (53%) stated that their caregiving took time away from friends and other family members. Those who have sacrificed this time with family and friends are far more likely to feel high emotional stress (47%) than are those who have been able to maintain the time they spend with family and friends (National Alliance for Caregiving, 2009 & Houts, Nezub, & Bucher, 1996).

Stress reduction is needed for caregivers particularly because they often feel the burden of care and continue to take on additional roles and responsibilities, often becoming ill themselves (Walsh, Radcliffe, Castillo, Kumar, & Broschard, 2007). A lack of emotional support

can lead to low self-esteem, depression, suicidal ideation and physical illness (Hill, 2002). The health and welfare of family caregivers, particularly those caring for patients who are terminally ill, can become seriously compromised (Walsh, 2003). Usual roles and responsibilities are often shifted, adding distress and decreasing caregivers' quality of life (Walsh, 2003).

**Effects of Caregiver Burden**

Providing continuous care for a loved one can be demanding and overwhelming (Jeffrey, 2005). As part of the caregiving role, a great amount of time and energy is spent on medical, legal, insurance, and financial responsibilities. The caregiver often loses the freedom of how to spend their time, including engaging in activities outside of the caregiving role (Jeffrey, 2005). Caregivers' stress can lead to depression, anxiety, burnout, physical breakdown, loneliness, exhaustion, and work related problems (Jeffreys, 2005). These components may lead to a form of stress called compassion fatigue, which is the decreasing ability to continue care at the level that the caregiver feels he or she must provide (Jeffreys, 2005).

According to a study by Ryan & Coughlin (2011), research has found evidence of caregivers experiencing more severe chronic physical conditions, leading to increased use of medication and medical visits and poorer-rated physical health compared with non-caregivers. McCorkle & Pasacreta (2001) conducted a qualitative study to assess family caregiving demands and to examine the caregivers' perceptions of providing care in the home environment. Caregivers reported that the majority of their time was spent providing transportation, offering emotional support, and maintaining the household. More than one third of caregivers reported a lack of assistance from health professionals in providing care (McCorkle & Pasacreta, 2001). In addition, caregiver demands escalated as the illness of their loved one progressed. A separate

study lends support to the isolative and stressful nature of caregiving in that 85% of a sample of 83 caregivers failed to utilize available resources to assist them in caregiving activities. In addition, 77% of the sample reported increased stress, and 28% required medication to help them cope with the burden associated with caregiving (McCorkle & Pasacreta, 2001).

In a longitudinal study, the emotional adjustment and grief intensity of bereaved caregivers was examined and pre-bereavement and post-bereavement grief were compared.  The study followed participants the first year after the death and compared the effects of caregiving and subsequent bereavement on spouses and adult children (Dutton, Shucter, Hutchin, Strause, Burnsc, Dunnd, Millerd, & Zisookd, 2000). According to research within the study, the magnitude of the stress of caregiving is underestimated (Dutton, et al., 2000). Depression and other indicators of psychological distress are highest during the caregiving period and during the first few months after death. Many symptoms of grief remain prominent for as long as thirteen months after the death of a loved one (Dutton, et al., 2000). An additional longitudinal study assessed depressive symptoms among caregivers following bereavement and connected the trajectories to earlier features of caregiving using life course and stress process theory. The study found that emotional well-being following death of the care-recipient is influenced by what has transpired previously during caregiving (Aneshensel, Botticello &Yamamoto-Mitani, 2004).

**Role shift and loss of self.** Role shifting is a pervasive stressor in the lives of many caregivers, and its influence on emotional well-being persists even after caregiving has ceased. In addition, a strong sense of self seems to sustain caregivers, just as its erosion during caregiving leaves caregivers more vulnerable (Aneshensel, Botticello &Yamamoto-Mitani, 2004). Skaff & Perlin (1992) researched the loss of self that occurs during caregiving and found that caregivers often experience role loss. Loss of self is defined by a loss of identity that comes about as a result of

engulfment of the caregiving role. Limited social contact and lack of social roles outside of the caregiver were found to be related to greater loss of self (Skaff & Perlin, 1992). The lives of family caregivers and older care-recipients are linked long before the need for care arises, joined by bonds of marriage or by the lifelong connection between parent and child (Dutton, et al., 2000). When a spouse or parent needs care, these ordinary family roles are transformed into a specialized role characterized by new norms. Study findings support the importance of roles within the family and loss of self. In addition to the primary loss of a family member, caregivers lose an important and meaningful role (Dutton, et al., 2000). Families are like systems in that they require ongoing support of each individual component to keep the system operating in balance (Rando, 1984).When an element is taken away, the system becomes unbalanced and there is a struggle to reach homeostasis (Rando, 1984; Bowlby, 1982). This is exactly what happens psychologically within families. When a family member passes away, new roles are assigned to and new demands are put on the remaining family members (Rando, 1984). Consequently, a bereaved family member may not have to cope solely with the complexities of the grief process itself, but also with an altered, out of balance system and new role responsibilities and demands as a result of the death (Rando, 1984; Skaff & Perlin, 1992).

Caregiving activities may gradually expand to a point where they restructure and take over the life of the caregiver, displacing or reducing previous activities or involvements (Skaff & Perlin, 1992). In short, the very being of the caregiver may become engulfed by caregiving activities. New roles and responsibilities are generated by death and affect the grief process of the mourner by increasing the demand for adaptation (Rando, 1984). These new roles and responsibilities are subsequently thrust onto the caregiver, along with the additional stress of a

family struggling to regain its balance, are variables that will profoundly influence the individual's grief process (Rando, 1984).

Caregivers often face a vast emptiness when their loved one dies. The grief they experience is not only for the person who has passed, but also for the empty space and unfilled time left as a result of the death (Jeffreys, 2005). Research suggests that a loss of self occurs when caregivers experience constriction of normal daily activities as a result of caregiving (Skaff & Pearlin, 1992 & Jeffreys, 2005). Difficult life events or conditions of ongoing stress often bring about role change. Life events are characterized by the loss of significant others who have been important sources for the self-validation and confirmation and cannot easily be replaced (Skaff & Pearlin, 1992). Caregivers need care and support to perform their caregiving roles and they need information and training (Jennings, et al., 2003). Caregivers need care to prevent and, if necessary, to treat the physical and mental health problems that can be associated with caregiving and bereavement (Jennings, et al., 2003). The grief process is a complex experience for caregivers and cannot be healed instantaneously.

**Attachment Theory and Grief**

Before one can fully comprehend the impact of a loss and the human behavior that goes with it, one must have an understanding of attachment. It is important to understand attachment because it is essential for healthy emotional growth and for building resilience (Bowlby, 1982). One of the key figures in attachment theory is psychiatrist John Bowlby. Bowlby's attachment theory provides a way to conceptualize the natural inclination for human beings to make strong affectional bonds with others and a way to understand the strong emotional reaction that occurs when those bonds are broken (Worden, 2002). Bowlby's research posed that attachments come

from the need for safety and security; they develop early in life, are usually directed towards specific individuals, and they tend to endure throughout a large part of the life cycle (Worden, 2002). During the course of healthy development attachment behavior leads to the development of affectional bonds or attachments, initially between child and parent and later between adult and adult (Bowlby, 1980). The forms of behavior and the bonds to which they lead are present and active throughout the life cycle, and by no means confined to childhood (Bowlby, 1980). If the goal of attachment behavior is to maintain an affectional bond, situations that endanger this bond give rise to certain, very specific reactions (Parkes, 1991). The greater the potential for loss, the more intense these reactions and the more varied emotions will occur (Parkes, 1991).

The biological process of grief demonstrates that animals show similar mourning reactions to their lost loved ones. There are many instances of grieving in the animal world. When a mate is lost, the animal will often search for its mate and exhibit manifestations of grief and sorrow akin to human loss behavior (Bowlby, 1980; Parkes, 1991; Worden, 2002). Bowlby also suggested that irretrievable loss is not taken into account; that in the course of evolution, instinctual thoughts are developed around the belief that losses are retrievable and the behavioral responses that make up part of the grieving process are geared toward reestablishing a relationship with the lost object (Bowlby, 1980; Winnicott, 1954; Worden, 2002). Several theorists state that the basic explanatory principle of attachment is that man is biologically predisposed to form attachment relationships with primary caregivers (Ainsworth, 1991; Bowlby, 1980; Klein, 1940; Parkes, 1991). Attachment behavior has become a characteristic of many species during the course of their evolution because it contributes to the individual's survival by keeping him in touch with his caregiver, thereby reducing the risk of his coming to harm, for example from cold, hunger or drowning and, in man's environment of evolutionary

adaptedness, especially from predators. Behavior complementary to attachment behavior and serving a complementary function, that of protecting the attached individual, is caregiving (Ainsworth, 1991; Bowlby, 1980; Parkes, 1991). This is commonly shown by a parent, or other adult, towards a child or adolescent, but is also shown by one adult towards another, especially in times of ill health, stress or old age (Klein, 1940; Parkes, 1991).

Bowlby (1980) stated that while an attachment bond endures, the various forms of attachment behavior that contribute to it are active only when required. Bowlby went on to say that the systems mediating attachment behavior are activated only by certain conditions, for example strangeness, fatigue, frightening events, and unavailability or unresponsiveness of attachment figure, and are terminated only by certain other conditions, for example a familiar environment and the ready availability and responsiveness of an attachment figure (Bowlby, 1980; Winnicott, 1954). When attachment behavior is strongly aroused, however, termination may require touching, or clinging, or the actively reassuring behavior of the attachment figure. Many of the most intense emotions arise during the formation, the maintenance, the disruption and the renewal of attachment relationships (Ainsworth, 1991; Bowlby, 1961).

The formation of a bond is described as falling in love, maintaining a bond as loving someone, and losing a partner as grieving over someone. Similarly, threat of loss arouses anxiety and actual loss gives rise to sorrow; while each of these situations is likely to arouse anger (Ainsworth, 1991; Bowlby, 1961). The unchallenged maintenance of a bond is experienced as a source of security and the renewal of a bond as a source of joy (Bowlby, 1961; Winnicott, 1954). Principal determinants of the pathway along which an individual's attachment behavior develops, and of the pattern in which it becomes organized, are the experiences he has with his attachment figures during his years of immaturity--infancy, childhood and adolescence (Bowlby, 1980). The

way in which an individual's attachment behavior becomes organized within his personality turns the pattern of affectional bonds he makes during his life (Bowlby, 1980; Klein, 1940). Within this framework, it is not difficult to indicate how the effects of loss, and the states of stress and distress to which they lead, can be conceived (Bowlby, 1980; Bretherton, 1992). For a caregiver, the relationship and attachment behavior with the care recipient will greatly influence the grieving process.

There is much debate regarding normal grief and how it is defined. *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM-V-TR; American Psychiatric Association, 2013) draws a distinction between natural or "normal" and pathological bereavement. As part of one's reaction to loss, some grieving individuals present with symptoms characteristic of depression. The bereaved individual typically regards the depressed mood as 'normal,' although the person may seek professional help for relief of associated symptoms. The duration and expression of 'normal' bereavement vary considerably among different cultural groups and personality factors (5th ed., text rev.; *DSM-V-TR*; American Psychiatric Association, 2013). Pathological bereavement is also known as pathological mourning, which was studied by Bowlby.

According to research on attachment and loss, some of the dissociative or repressive phenomena involved in the deactivation of the attachment system occur during pathological mourning (Bretherton, 1992; Klein, 1940). For example, complete or partial disconnection of an emotional response from its cause is common (Bowlby, 1980; Bretherton, 1992; Klein, 1940). When the disconnection is only partial, emotional responses may be directed away from the person who caused them to third persons or the self (Bowlby, 1980; Bretherton, 1992). Hence, a bereaved person may become morbidly preoccupied with personal reactions and sufferings rather

than attributing his or her feelings to the loss of a close relationship (Klein, 1940). Similarly, in disordered mourning a bereaved person's disposition toward caregiving may derive from the redirection of attachment behavior. The individual may be taking the role of attachment figure instead of seeking care (Bowlby, 1980; Klein, 1940).

**The Grief Process**

The DSM -V defines normal grief as "predominant feelings of emptiness and loss that occur intermittently, and adds waves or "pangs" of these feelings are often associated with thoughts or reminders of the deceased."  The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, but the individual can still experience positive emotions and humor. The DSM-V distinguishes normal grief from Persistent Complex Bereavement Disorder by contrasting that the presence of severe grief reactions persist at least 12 months after the death of the bereaved and that these symptoms interfere with the individual's capacity to function (5th ed., text rev.; *DSM-V-TR*; American Psychiatric Association, 2013).

When a loved one is lost, the emotional toll is profound for many. For a caregiver, the loss of a spouse, child or parent affects one's identity and the way he or she defines him or herself as a husband, wife, parent or child.  In J. Shep Jeffreys' book *Helping Grieving People: When Tears Are Not Enough*, grief is defined as "a system of feelings, thoughts, and behaviors that are triggered when a person is faced with loss. Grief is based on both internal (thoughts and feelings) and external (behavior) reactions" (Jeffreys, 2005, p. 170). Before a loved one dies, the caregiver often experiences what is known as anticipatory grief. Anticipatory grieving occurs when one prepares for death and the loss ahead (Kubler-Ross, 2005). Family caregivers may

mourn not only in terms of anticipatory grief for the death of their loved one, but also for all that they have sacrificed in order to assume the caregiving role (Jeffreys, 2005). The caregiver frequently takes on these additional roles, while caring for their loved one and dealing with their own feelings (Jeffreys, 2005). Caregivers often grieve for the way life was and mourn the deterioration of the care recipient's health. Though different than the grief that follows a death, anticipatory grief can carry many of the symptoms of regular grief – sadness, anger, isolation, and depression (Kubler-Ross, 2005). These complicated emotions are often coupled with the exhaustion that comes with being a caregiver or the stress of feeling isolated. Caregivers have likely lost the desire to engage in social activities outside of the caregiving role (Jeffreys, 2005). Caregivers need emotional support and the connection with other individuals to relieve symptoms of anticipatory grieving.

**Theories of Grief**

There are many models and theories that have attempted to explain the complex process of loss and grief. The search for a theoretical framework to appropriately understand reactions to irrevocable losses has been the major focus of researchers and theorists in the area of loss and grief for most of the last century. Prevailing models of grief up to the late twentieth century have generally viewed grief in a very specific way with particular characteristics attached to the event. The theories that will be discussed are that of Sigmund Freud, Erich Lindemann, John Bowlby, Elisabeth Kubler-Ross, and William Worden. These theories will be discussed to understand the theoretical framework of grief and explore the common themes of each theory.

Freud's paper 'Mourning and Melancholia' published in 1917, is regarded as a classic text on bereavement. He argued that the psychological purpose of grief is to withdraw emotional energy from the deceased (cathexis) and then to become detached from the loved one (decathexis). The

emphasis in Freud's ideas on grief is about personal attachment. The theory stresses that grieving individuals are searching for an attachment that has been lost (Clewell, 2002). He believed the bereaved person has to work through his grief by reviewing thoughts and memories of the deceased (hypercathexis). By this process, the bereaved can achieve detachment from the loved one and the bereaved individual's bonds with the deceased become less overpowering (Freud, 1917). He describes mourning as detachment from the loved one. Freud defines mourning as a state of melancholia suggesting that when mourning goes wrong, melancholia escalates (Freud, 1917).

Melancholia is seen as a profound presentation of depression involving a complete loss of pleasure in all or almost everything (Clewell, 2002; Freud, 1917). The process of mourning is viewed as a task to rebuild one's inner world by experiencing the intense pain of loss that reawakens the loving affect of the lost loved one. The death of a loved one can result in individuals losing their sense of identity (Clewell, 2002). It is suggested that in grieving, the bereaved is letting go of multiple attachments that are involved in the formation of a relationship. When the loss is accepted, the ego is said to accommodate the loss enabling the bereaved to search for new attachments (Clewell, 2002; Worden, 2002).

Erich Lindemann, a theorist whose work focused on bereavement, suggested that grief is part of the healing process in which he termed "grief work." He identified three tasks that constitute grief work: emancipation from the bondage of the deceased, readjustment to the environment in which the deceased is missing, and formation of new relationships (Lindemann, 1944). Emancipation from the bondage of the deceased: Attachments to the deceased must be given up to enable a new status to develop (Lindemann, 1944). This does not mean that the deceased is replaced or forgotten. It means that the emotional attachment is modified to allow the bereaved

to form other attachments (Lindemann, 1944). The focus of the bereaved is to invest in an attachment with a living person who can return the investment. This involves identifying the roles and identity of the bereaved. Emotional, physical, psychological and social adjustments will be required. Formation of new relationships involves establishing new and different attachments with a living person (Lindemann, 1944).

John Bowlby argued that attachments develop early in life and offer security and survival for the individual. Bowlby ultimately took all his observations and theories about attachment and separation and applied them to grief and bereavement. He found that there is a relational system in these attachment relationships. These attachments form a system in which the individuals are constantly impacting each other, trying to maintain their relationship in different ways (Bowlby, 1982). When a loss occurs, Bowlby suggested that grief is a normal adaptive response. Bowlby posited that the response was based on the environment and psychological make-up of the griever, and that there were normal reactions one might expect (Bowlby, 1982). The 'affectional bond' had been broken, which results in the grief process. It is when these affectional attachments are broken or lost, that individuals experience distress and emotional disturbance such as anxiety, crying and anger (Worden, 2002). These emotions are often expressed as mourning.

Bowlby suggested that there are four general phases of mourning that include numbing, yearning and searching, disorganization, reorganization (Bowlby, 1982; Worden, 2002). Numbing is characterized by feelings of disbelief that the death has occurred, providing the grieving person with temporary relief from the pain associated with the loss (Bowlby, 1982; Worden, 2002). Yearning and searching involves the process of attempting to fill the void of the loss and remain preoccupied with the person that has been lost (Bowlby, 1982; Worden, 2002).

In this phase individuals are acutely aware of the void left from the loss. They will often search for the comfort they used to feel from the individual lost and will try to fill the void of their absence. Anger and frustration is common at this phase as the grieving individual is searching for someone to place the blame on. The disorganization phase involves accepting the reality of the loss along with all the turmoil it brings (Rando, 1984; Worden, 2002). Evaluation of self without the deceased often occurs at this phase. The reorganization phase takes effect once the bereaved comes to a realization of a new life after the deceased (Worden, 2002). This phase is characterized by gradual changes as the bereaved attempts to move on with life (Rando, 1984; Worden, 2002). In this phase the grief does not diminish nor is it fully resolved, but Bowlby posited that the loss recedes and shifts to a hidden section of the brain, where it continues to influence those who have experienced grief but it is not at the forefront of the mind (Bowlby, 1982).

Elisabeth Kubler-Ross was strongly influenced by Bowlby's stages of grief and developed her own work building upon previous theories. Kubler-Ross (1969) outlined five stages an individual undergoes when coping with imminent death. These stages have also been used to identify the grief of individuals after a loss. The stages are known as denial, anger, bargaining, depression, and acceptance. These stages do not necessarily occur in order or during a specific time frame. Denial is a conscious or unconscious refusal to accept facts, information, or reality relating to the situation concerned. It is often used as a defense mechanism to cope with the loss. Individuals often become stuck at this stage when dealing with difficult loss. Anger can manifest in different ways. People dealing with emotional upset can be angry with themselves, and/or with others, especially those close to them. Anger can also be expressed towards the deceased. Traditionally the bargaining stage for people facing death can involve attempting to bargain with

whatever 'god' the person believes in. Bargaining rarely provides a sustainable solution, especially if it is a matter of life or death.   Depression is the stage characterized by feelings of sadness, regret, fear, and uncertainty. This is an indication that the person has at least begun to accept the reality of the loss. The acceptance stage symbolizes emotional detachment and objectivity. The grieving individual is beginning to come to terms with their loss. The bereaved is starting to make an effort to move on with life.

   Worden (2002) believed that mourning involves four tasks: To accept the reality of the loss, to experience the pain of grief, to adjust to an environment in which the deceased is missing, and to withdraw emotional energy and reinvest it in another relationship. The first task of grieving is to come to terms with reality that the person has died, and that they will not return in this life (Worden, 2002). The opposite of accepting the loss is to avoid it through some type of denial. Some individuals refuse to believe the death is real and become stuck in the grieving process at the first task (Worden, 2002). The second task involves the ability to acknowledge and work through the pain of the loss. Worden (2002) stated that "it is necessary for the bereaved person to go through the pain of grief in order to get the grief work done, then anything that continually allows the person to avoid or suppress this pain can be expected to prolong the course of mourning" (p. 30). The third task includes three areas of adjusting to the environment in which the deceased is missing (Worden, 2002). First, one must make an external adjustment, that is, how the death affects one's everyday functioning in the world (Worden, 2002). Second, there are internal adjustments. This includes how the death affects one's sense of self. Lastly, there is a spiritual adjustment. This includes how the death has affected one's beliefs, values, and assumptions of the world (Rando, 1984; Worden, 2002).

The fourth and final task is to emotionally relocate the deceased and move on with life. Worden posits that the goal of this task is to find a place for the deceased that will enable the mourner to be connected with them, but in a way that will not prevent the bereaved from going on with life (Rando, 1984; Worden, 2002). Worden acknowledged that bereaved individuals may need to revisit certain tasks over time, that grief is not linear, and that it is difficult to determine a timeline for completing the grief tasks.

Freud, Bowlby, Kubler-Ross, Lindemann, and Worden all theorized that one must detach from the deceased in order to adapt to the loss and continue living fully. More recent theories challenge that the resolution of grief involves continuing bonds that survivors maintain with the deceased and that these continuing bonds can be a healthy part of the survivor's life. Klass, Silverman, and Nickman (1996) explicitly questioned the dominant models of grief. Their findings suggested that perhaps these linear models, ending in a detachment from the person lost, were denying a reality of how many people grieve (Klass, Silverman, & Nickman, 1996). They suggested a new paradigm, rooted in the observation of healthy grief that did not resolve by detaching from the deceased, but rather in creating a new relationship with the deceased (Klass, Silverman, & Nickman, 1996).

Under this model, when a loved one dies, their grief process does not center on working through a linear process that ends with acceptance or a new life. Rather, when a loved one dies, the individual will slowly find ways to adjust and redefine their relationship with that person, allowing for a continued bond with that person that will endure, in different ways and to varying degrees, throughout their life (Klass, Silverman, & Nickman, 1996). The continuing bonds theory suggests that this is not only normal and healthy, but that an important part of grief is continuing ties to loved ones in this way. Rather than assuming detachment as a normal grief

response, continuing bonds considers natural human attachment even in death. The process of art therapy can facilitate the continuing bonds by providing a tangible art product to represent the deceased individual.

As a result of this research, commonalities were found between the grief models discussed. Regardless of whether the models suggest stages, tasks or processes, all these theories share a very linear structure. Although the theories explain that grieving individuals may jump between stages or tasks, it appears to be difficult for the bereaved to grasp this concept. As an individualistic and fast paced society, people feel that grief is supposed to flow sequentially through each stage and come to an endpoint. In addition, the grief theories all describe a final phase that give a sense of closure, detachment from the loss, or moving on. This paper questions the idea that the purpose of grief is to sever bonds with the deceased in order for the survivor to be free to make new attachments and to construct a new identity or to make new attachments as a replacement attachment.

**Art Therapy**

For a caregiver confronting and preparing for a loved one's death, there is fear and anxiety. Honoring, understanding, and helping individuals during this unique and vulnerable time may provide knowledge about the processes of grief and death, which may help them understand the human experience (Barrington, 2008). Art therapy is a treatment method well-suited to the needs of grieving individuals (Malchiodi, 1992). "Art therapy is a mental health profession in which individuals, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, reduce anxiety, increase self-esteem and improve quality of life" (American Art

Therapy Association, 2013). Art expression is a way to convey the painful and confusing experiences of illness that are difficult to communicate with words alone (Malchiodi, 2013). Since many individuals are unable to fully express their feelings of grief through words, art therapy offers them a unique opportunity to express their feelings non-verbally through the use of art materials (Hill, 2005). The act of painting, drawing or constructing can be a personally empowering experience in contrast to the loss of control that accompanies illness (Malchiodi, 2013). Images created through art therapy can teach individuals about core life events and provide a vehicle for expression and healing (Jones, Warren, & McElroy, 2006).

Art therapy can also provide therapeutic interventions to improve an individual's mental health (Jones, Warren, & McElroy, 2006). Art therapy can serve as a bridge between the medical and psychiatric disciplines, to treat the whole person and improve quality of life (Jones, Warren, & McElroy, 2006). Research conducted by Jones, Warren, & McElroy (2006), states that art therapy may provide an outlet for expression of missed opportunities and to make sense of past life events. Art therapy also has a role in the psychodynamic understanding of people, particularly in relation to loss (Jones, Warren, & McElroy, 2006).

Research conducted by Thompson & Neimeyer (2014) supports that there is a link between the struggle to find meaning in loss and the grief process. The same research found that therapeutic interventions, such as journaling or activities that are designed to enhance sense making benefit the individuals in processing the loss and finding meaning (Thompson & Neimeyer, 2014). One significant purpose of art making is to make meaning (Malchiodi, 2013). Making meaning can be accomplished through the creative process and focus on meaning reconstruction, metaphoric communication, and memorialization (Thompson & Neimeyer, 2014). The arts can also facilitate a natural aid in periods of transition (Thompson & Neimeyer,

2014). The creative process can promote acceptance of the range of emotions to fully embrace the creative process, encourage metaphoric communication and memorialize both one's relationship with the deceased and the grief experience (Thompson & Neimeyer, 2014).

The techniques of practice in art therapy must be clearly understood for effective treatment. The art therapist must be competent in understanding the direct experience of the therapeutic utility and psychological influence of art processes and materials. They must also be able to identify the therapeutic effect of art making leading to establishment of therapeutic goals and intervention strategies (American Art Therapy Association, 2014). Wadeson (1987) mentioned the importance of the way an art therapist processes the artwork with clients. The therapist must first address the goals that the therapist and client have set, and then think of ways to achieve these goals. She warns her readers to not blindly choose a project and figure how it might be used during the session. Wadeson (1987) advises to identify the value of a specific intervention that could address the specific goals set by the client and therapist in the specific population. The art therapist is trained to identify and delineate specific interventions and directives to achieve these goals. The facilitation of materials and discussion of artwork are also central elements in the therapy setting.

The role and competency of the art therapist is crucial for effective treatment. One overarching aim is to assist the client in achieving goals set in treatment to promote emotional and mental well-being to promote quality of life. This role delineates a different approach than other mental health professionals. The educational requirements for art therapy licensure include, but are not limited to, theories of art therapy, counseling, and psychotherapy; ethics and standards of practice; assessment and evaluation; individual, group, and family art therapy techniques; human and creative development; multicultural issues; research methods; and

internship experiences in clinical, community, and/or other settings (American Art Therapy

Association, 2014).

One goal in art therapy is to improve or restore a client's functioning and his or her sense

of personal well-being. Art therapy practice requires knowledge of and skills in usage of visual

art (drawing, painting, sculpture, and other art forms) and the creative process, coupled with

application of theories and techniques of human development, psychology, and counseling. For

the grief process, the art therapist must have the foundation of all aforementioned theories and

education, so that they may assist the client in effectively moving forward after their loss and

live meaningfully. The art therapist must understand graphic indicators and symbolism in the

client's artwork and be able to assess if the client is experiencing depressive symptoms, suicidal

ideation, or other symptoms of complex grief that may be preventing them from normal daily

living. Understanding of developmental levels, cultural factors, psychopathology, and

psychological health manifested in artwork and art making must be a skill of the art therapist in

treatment. Administration and documentation of art therapy assessments, formulation of

treatment goals, objectives, and strategies related to assessment and evaluation will also be

conducted by the art therapist.

**Group Therapy**

Group therapy is an efficient and effective way to offer emotional support (Liebmann,

2004). Group work provides a way of equalizing participation so that each individual can

participate at the right time and at their own level (Liebmann, 2004). Using art in a group

generates a lot of material and this often accelerates group processes and dynamics (Liebmann,

2004). Research on group therapy suggests that there are features inherent in the group approach

which are potent and not available in individual therapy (Yalom, 1995). (Yalom (1995) states

these factors include, but are not limited to:

- Universality; the sense that group members can diminish feelings of isolation by
  sharing feelings and problems similar to others.

- Altruism; the experience that emerges in groups of helping oneself by helping
  others.

- Instillation of hope; Group members connect with others who have experienced
  similar problems, such as anxiety, fear, anger and isolation and encourage that
  recovery is possible.

For a bereavement group, members can hear stories of others' loss and share the

universality of loss. Group members may learn to overcome specific problems in their lives by

modeling their behavior in accordance with the successful example of another group member

(Yalom, 1995). Lastly, group cohesiveness, the sense of belonging and acceptance, is pivotal to

effective group therapy (Yalom, 1995).

**Art Therapy Groups**

Death and the experience of loss are universal (Barrington, 2008). Art and the creative

process are agents of self-expression and can be transforming (Jeffreys, 2005). The support

structure within a group and the use of creative activities offer the grieving individuals what they

need most: acceptance and non-judgmental listening (Hill, 2005). The use of art therapy in a

group setting can facilitate comprehension of the most complex aspects of human existence and

provides a structure for our emotional chaos and a shared social setting for the construction of

meaning (Hill, 2005). Art therapy in a group setting has been found to be a powerful means for individuals to express their feelings and receive support from others (Hill, 2002). Through art making and sharing in a group setting, individuals begin to understand their own difficulties and their individual strengths as well as discover new possibilities to cope with their loss (Hill, 2005 & Malchiodi, 1992). Group art therapy facilitates the sharing of images and can foster a dramatic revelation of commonality (Wadeson, 1987). The group members start to feel as part of the group and can connect with individuals who are experiencing universal struggles, such as loss (Wadeson, 1987). Wadeson (1987) describes the group process:

> In an atmosphere of support and understanding, one can begin to examine one's behavior in terms of how it impacts others and to change, redefine one's sense of self, and establish more satisfactory relationships. Imagistic expression is a natural and impactful vehicle for this sort of discovery.

In today's society, individuals often become isolated from extended family members and the community. As a result, grieving individuals feel alone in the grief process and often experience a lack of adequate support (Hill, 2005). Grief and loss groups can offer caregivers the opportunity to share their experiences and re-connect with others to start the healing process. According to Malchiodi (1992) the ritual of storytelling and sharing the pain of loss with others is essential to successful recovery. Art making within a group context can involve both isolation in the process of creation and eventual connectedness to others through the sharing of the product (Malchiodi, 1992). One of the most powerful aspects of art expression in processing loss is the ability to address fear through art making (Malchiodi, 1992). The client can individually engage in the creative process and start to overcome fears and emotions associated with the

psychic pain of loss. Once a product is created, group members can respond to the product and share common themes or symbols concerning their own losses (Malchiodi, 1992).

Similarly to individual art therapy, the role of the art therapist in a group is to provide a safe space for the group members to explore their feelings and emotions. In a group setting, an additional role of the therapist is to maintain the therapeutic task of the group; which is to encourage open communication and interaction (Malchiodi, 2003). Overall, the common ground for art therapists in a group or individual setting includes the focus on non-verbal communication and creative processes together with the facilitation of a trusting environment within which people can acknowledge strong emotions. (Liebmann, 2004). The distinction between group art therapy and individual art therapy is that the process of group dynamics allows more interpersonal learning, universality and sharing of similar struggles, and awareness, recognition and appreciation of others (Liebmann, 2004).

**Grief and Art Therapy**

Substantial research has been done on death, dying, and grief (Bowlby, 1961 & 1980; Freud, 1917; Jeffreys, 2005; Kubler-Ross, 1969; 2005; Lindemann, 1944; Neimeyer, 2012; Rando, 1984 & Worden, 2002).  As previously mentioned, Elisabeth Kubler-Ross was one theorist who pioneered the concept of providing psychological care for the dying.  According to Kubler-Ross, the stages of denial, anger, bargaining, depression, and acceptance as described in *On Death and Dying* (1969) are experienced not only by those dying, but also by families and friends while grieving. Caregivers will experience psychological changes and symptoms as well. Emotional reactions may also involve shock, numbness, and pain. Allowing time and space to externalize such feelings facilitates dealing with loss and moving on with life's activities. In the

course of bereavement, these stages often act as defense mechanisms helping the bereaved cope with extremely difficult situations (Kubler-Ross, 1969). Kubler-Ross lists the stages of grief in a specific order however, in the normal process of grief; they last for different periods of time, will replace each other, overlap or exist simultaneously (Kubler-Ross, 1969). Art therapy can facilitate the grief process and each stage can be explored though the client's artwork. Since all stages will be experienced differently, an art therapy group may add a healing dynamic so that all caregivers can feel supported by other caregivers.

Later in her work, Kubler-Ross studied alongside Gregg Furth and supported his use of art as an expression and way to understand and interpret symbolic content (Furth, 1988). In Furth's book *The Secret World of Drawings*, Kubler-Ross states:

> Using this technique, we can now reach out to those suddenly faced with their own mortality or the mortality of others close by, not only establishing valuable therapeutic communication with them, but also allowing their unconscious fears and emotions to become conscious, and thus to be confronted and resolved (1988). Integrating this theory with stages of grief and bereavement, caregivers can start to process and understand their feelings on a symbolic, unconscious level (p. 44).

The idea that art making can be helpful in processing a loss is not a new concept (Dissanayake, 1988; Hatcher, 1985). Historically, humankind may have developed art to alleviate or contain feelings of anxiety, fear, crisis, and threat as well as to mark the importance of events such as death through the creation of visual imagery (Hill, 2005). Research has explored the history of self-expression through an art form during times of mourning

(Dissanayake, 1988; Hatcher, 1985). Hatcher (1985) describes this phenomenon from an anthropological standpoint:

> Whatever the theoretical explanation, it is clear that art somehow helps human beings cope with the trauma of death. Beauty and art forms have been part of funeral ceremonies since Neanderthal times. This universal human problem is met everywhere with symbolic solutions to satisfy the mind and aesthetic solutions to release the emotions (Hatcher, 1985 pp. 106-107).

Additional research expands the value of art therapy and its ability to process grief symbolically. Art therapy can allow the unspeakable to emerge in images and evoke the symbolic expression of grief (Mayo, 1996). Through the use of symbols, clients can engage in the personal meaning of loss (Tate, 1989). The artwork created during grief contains symbols and images of profound meaning that may be unable to be translated into words. The use of metaphor through art allows the grieving individual to focus on a graphic image that symbolizes their experience (Hill, 2002). Focusing on the symbol enables the grieving person to express their overwhelming feelings without having to refer directly to specific details related to the death (Hill, 2002).

Art can be also used as a container for grief. When grief causes a person to feel that their life is out of their control, art tasks can help them to organize and regain a sense of containment (Hill, 2002). Art therapy is a vehicle of expression and the creative process also acts as a grief stage facilitator. Research was conducted on art therapy interventions that encourage the fullest expression of thoughts and feelings regarding each group member's loss (Hill, 2002 & Rogers, 2007). Through the framework of group art therapy interventions, members identified new

coping skills and received grief education. Art therapy interventions can facilitate cathartic effect and kinesthetic release (Hill, 2002). Art can allow for the cathartic expression of the emotions of grief, and that catharsis allows the healing process to begin (Furth, 1988; Hill, 2002). Hill (2002) posits that "art uses active methods to experience or cathect feelings and allows destructive energy to be expressed and sublimated into a constructive channel. Irwin (1991) states: "when words fail in the grief process, art therapy can permit the cathartic venting of emotions of loss" (p. 486).

Research conducted by art therapist Vija Lusebrink (1990) states that images are a "bridge between body and mind, or between the conscious levels of information processing and the physiological changes in the body" (p. 218). Research supports that the body is often a mirror of an individual's emotions (Malchiodi, 2003). Images affect our emotions and different parts of the brain may become active when we imagine a happy or sad event or relationship (Malchiodi, 2013). The physiology of emotions is so complex that the brain knows more than the conscious mind can itself reveal (Malchiodi, 2003). For example, one can actually display an emotion without being conscious of what induced the emotion. Emotions experienced during grief are complex, and art making can help one understand how images influence emotions, thoughts, and well-being. Images can also help one understand the expressive language of visual and sensory experiences (Malchiodi, 2003).

**The Expressive Therapies Continuum**

Art therapy focuses predominantly on visual and somatosensory information; that is, how images and their expression reflect emotional experiences and how the emotional experiences affect thoughts and behavior (Lusebrink, 2004). Creative experiences have the potential to

integrate information from both hemispheres of the brain (Hinz, 2009). The Expressive

Therapies Continuum (ETC) is a spectrum that classifies interactions with art media or other

experiential activities in order to process information and form images (Hinz, 2009). This

integrative function allows for bilateral stimulation, which allows the left and right hemispheres

to work together simultaneously (Hinz, 2009). The process of bilateral stimulation creates a

therapeutic way to express one's mental energy through the art media that can then become

accessible to conscious inspection and visual processing. (Lusebrink, 2004). A single and simple

interaction with art media or experiential activity has the power to be a creative experience, and

may involve the integration of all levels of the ETC. (Hinz, 2009).

For caregivers, processing grief through creativity can assist in processing non-verbal

emotions and experiences that are difficult to convey through talk therapy (Johnson, 2007). The

creative process can help the individual gain insights to recognize the depth of their grief

(Johnson, 2007). Expressions through art media may help to recover the components of symbols

and related emotions while contributing to the exploration of the meaning of symbolic images

(Hinz, 2009). The exploration of symbols and their sensory aspects in all modalities can

contribute to an individual's growth and further the development and understanding of self and

others (Hinz, 2009).

Images can yield information, create understanding, evoke expression, and transform

thinking, feeling, and acting (Hinz, 2009). Art making can greatly enhance the experience of

insight, and it can convey multiple unconscious feelings and ideas (Rubin, 2001). The visual arts

and art therapy can have a positive effect on various areas in a person's life. When a client is

involved with art media, numerous cognitive and emotional processes are activated

simultaneously. Caregivers who experience loss can utilize these processes to gain greater insight into their grief and to use the creative process to grow as individuals.

**Art Therapy and Caregiver Stress**

Caregivers who engage in self-care learn to manage overwhelming feelings (Hill, 2002). A systematic study by Barrington (2008) stressed that some individuals who are experiencing death need to express themselves creatively so that personal meanings become more clear and concrete. The use of artistic expression can assist in confronting death and expression of thoughts and feelings that are valuable elements in the care for the total person. Artistic expression can be a dynamic tool for a person to reflect and communicate with others (Barrington, 2008).

In several quasi-experimental studies that involved art therapy for caregivers as a form of self-care, evidence supported that stress and anxiety were reduced by art making (Walsh, 2003, 2004, & 2007). By externalizing an experience through the creative process, the art can act as a vehicle for verbalizing the experience by expressing the significance of color, symbol, and recurring themes (Murrant, Loynd, Rykov & Amonite, 2002). Three studies conducted by Walsh (2003, 2004, 2007), tested the efficacy of art for caregivers of patients with cancer. Both studies used a pretest and post-test quasi-experimental design to test the effects of an art-making class on reducing anxiety and stress among family caregivers of patients with cancer (Walsh, 2007). The findings in the study indicated that the art making process reduced anxiety and stress among the caregivers. The second study done with a quasi-experimental design, found that the forty family caregivers involved reported significantly reduced stress, lowered anxiety, and increased positive emotions from the art making process (Walsh, 2004). The last study

conducted utilized a different approach.  The study proposed an implementation and evaluation

of an art intervention at the bedsides of patients with cancer and their family caregivers. The data

was collected through field notes from ongoing encounters with family caregivers and patients.

Walsh found that patients and caregivers enjoyed creating works of art and also felt less anxious

as they participated in art making.

All three studies contributed to the topic of art therapy and its efficacy with caregivers.

Walsh (2003, 2004, 2007), supported that art making was successful in engaging the participants

for therapeutic experiences. Reducing stress and anxiety among caregivers was also achieved. In

the study that implemented art at the bedside with both caregiver and patient, family caregivers

and patients with cancer were interested in and responsive to art interventions. Additional

research is needed to quantify the effects of this study for more support. Walsh (2003) reported

that the creative process provided distraction, promoted communication, and appeared to be a

comforting and stress-reducing intervention. Family members and patients completed surveys

that validated that from the participation in the process of creating, they were able to have

illuminating, joyful memories even during very difficult times (Walsh 2003).

**Caregiver Resources and Support**

Although bereavement services are considered to be integral to a palliative care program,

bereavement support remains limited by a scarcity of resources, a lack of time, and too few

qualified personnel (Demmer, 2003). In Demmer's national survey of 450 members of the

National Hospice Palliative Care Organization (NHPCO), the main attempt of bereavement

services were mailings of condolence letters and literature on grief. A study of hospice

bereavement programs in the United Kingdom recommended that a program of bereavement

support be integrated into palliative services and include volunteer counselors, bereavement services, social bereavement groups, and ongoing telephone support (Reid, Field, Payne, & Relf, 2006). Bereavement services are usually tailored to the characteristics of the population being served and differ by geographic regions, based on available community resources and the unique approach of each area (Reid et al.).

In a survey of 29,292 bereaved family members who had received palliative services through the National Hospice and Palliative Care Organization, 18% noted a need for an improvement in the support they were offered, including an increased need for communication with families and overall coordination of care (Ingleton, Morgan, Hughes, Noble, Evans, & Clark, 2004). A survey conducted in the United Kingdom with 407 bereaved family caregivers found that only 20% had the opportunity to talk to someone from health and social services after the death of their loved ones (Ingleton et al., 2004). Organizational case studies of five English hospice bereavement services in the United Kingdom revealed that all offered information, follow-up phone calls, or letters, but none used a formal risk assessment to identify who might benefit from formal bereavement support (Reid, et al.). Bereavement programs worked best when they were integrated within a continuum of care for family members beginning with pre-bereavement discussions and continuing to offer support throughout the bereavement process (Reid et al.).These alarming statistics validate the lack of resources reported by large population of caregivers. Suggestions for research from the perspectives of effectiveness, efficiency, and equity are needed to provide the evidence to address the gaps in health services and meet the needs of this neglected population.

Contrary to these statistics, a countless number of hospice agencies and other organizations claim to provide support and resources for caregivers. Some include, but are not

limited to, The National Alliance for Caregiving, Family Caregiver Alliance, The National Hospice and Palliative Care Organization, National Caregivers Library, American Cancer Society, and The Alzheimer's Association. The aforementioned organizations are the most well-known online resources that provide support. All of the websites have a plethora of information and education for caregivers. This information includes numerous support groups, workshops and other counseling services for caregivers.

A survey conducted by the National Alliance for Caregiving (2009), interviewed 1,713 caregivers regarding their caregiving logistics, daily tasks, burden, and need for support. According to the study, if caregivers were to look for information to help them take care of their loved one, their top source of information would be a health or caregiving provider including a doctor, nurse or other health professional, a caregiving provider, or social worker. The internet is also a common resource, and was reported to be used frequently by caregivers. However, half of all caregivers say they have used the internet in the past year to find caregiving information. Among those who used the internet for a caregiving related purpose, three in four looked for information about their loved one's condition or treatment (78%), while a smaller majority (58%) sought information about caregiving services (National Alliance for Caregiving, 2009).

Other goals of their online research include finding doctors or other health professionals (36%), finding information about care facilities (34%), or learning about how to do caregiving tasks (26%). Very few (13%) looked for support for themselves as caregivers (National Alliance for Family Caregiving, 2009).The increase in utilizing the internet may be one reason caregivers do not feel supported. While the internet provides accessible education and information, the socialization and interaction with other caregivers is a crucial element to gain the support

caregivers need. Attending support groups or workshops with a trained clinician is another

essential need for caregivers who do not feel supported.

**CHAPTER IV: RESULTS**

Caregivers are a vast and diverse group. Caregiving experiences range from those that are relatively easy to manage, to those that are burdensome. This paper has discussed the burdens of caregiving and the extensive stress it places on the caregiver. The results of this paper conclude that with the caregiving role, caregivers are experiencing overwhelmingly negative physical, emotional, or financial consequences.

Caregivers with the heaviest responsibilities are vulnerable to risks such as a decline in health, emotional stress, and economic hardship. As the baby boom generation ages over the next 25 years, the numbers of people needing care will swell. This suggests that in the future, caregivers will be older, on average, than today's caregivers and may have greater infirmity of their own. In addition, the younger people who step into a caregiving role in the future may perceive they have less choice about becoming a caregiver. This current literature review has recognized the alarming statistic that nearly 66 million caregivers are a critical extension of the United States' formal health care system. Without their efforts, there would be a shift of recipients into public programs such as Medicaid, and the quality of life and the health status of many who need care would decline. It is imperative to advocate and provide support for caregivers so they can continue in their roles successfully.

The benefits of art therapy for caregivers in the hospice setting are analyzed and proposed in the literature review. Research supports the value of art therapy and its ability to process grief symbolically and nonverbally. While there is not an overwhelming amount of research specifically on group art therapy for caregivers and the grief process, that author can attest to the major findings of the study involving enough evidence to support the research question proposed in this paper. The lack of abundant research merits further investigation for utilizing art therapy

for this population. As a result of the research supporting art therapy's efficacy in processing loss, the author hypothesizes that the proposed group art therapy model will benefit caregivers in the hospice setting.

**A Proposed Model of Group Art Therapy for Caregivers**

The goal of the proposed art therapy group for caregivers is to provide a model to address the challenges of grief, educate on the grief process, normalize those reactions, and provide peer support. The group intends to focus on bereaved caregivers whose loved ones have already passed. An art therapy framework will be used and integrated with the grief theories aforementioned in this paper. This task oriented model will provide art therapy directives that complement the grief process.

As previously discussed, in order to help individuals process and understand their grief in the group setting, the art therapist must have extensive theoretical and experiential understanding of group art therapy and counseling methods and skills. Training in group art therapy also encompasses principles of group dynamics, therapeutic factors, member roles and behaviors, leadership styles and approaches, selection criteria, and short and long term group process. In addition to group therapy knowledge, the theoretical foundation of human development and attachment must also be understood and practiced by the clinician. Not only will the relationship with the deceased be examined, but the relationship with the remaining family members and role changes will also be discussed in the group.

Art therapy is a natural vehicle for opening doors to nonverbal communication when facilitating a group in which initial discussion is difficult (McNutt, 2013). With an art centered focus for the group discussion, peer connection is made as members identify with each other's

grief reactions. The art created will also become tangible objects of memorial and remembrance for those lost. The author hypothesized that a systematic literature review on art therapy for caregivers in the hospice setting along with an analysis of findings would demonstrate that art therapy can be a beneficial therapeutic approach for caregivers experiencing grief. From this research, it is discovered that an eight week program using art therapy interventions will be developed to benefit caregivers.

The structure of the group will include six to eight participants. The goals of the group are to identify the emotional experiences that group members may share and how members can support one another. Gaining relief from sadness, continuing with their lives, and growing emotionally are additional goals for the group. The members' experiences of grief will be encouraged for sharing and discussion. Art therapy directives are recommended to the participants in order to facilitate expression of their experiences related to loss and growth. The group will hear from each member about their artwork and a group discussion concerning the illustrated issues will be facilitated (Hill, 2005 & Liebmann, 2004). The process of recognizing thoughts and feelings within a group will aid in the alleviation of the caregiver's grief and assist the process of healing.

The 8 week group outline curriculum includes weekly sessions will be 90 minutes and include an opening ritual, art making, discussion, and a closing ritual. The opening and closing rituals will be determined by the group in the first session. The group will also focus on one or more relevant tasks of mourning (See Table 4.1). Each weekly theme will correspond with the tasks. The goals of the group include:

- To provide creative sanction for the expression of grief

- To promote adaptive mourning responses

- To provide a safe space for individuals to share their experiences with others

**Table 4.1                        The Four Tasks of Mourning**

*Task 1: To accept the reality of the loss.* To come full face with the reality that the person is dead, that the person is gone and will not return; that reunion is impossible in this life.

*Task 2: To experience the pain of grief.* Allowing yourself to experience and express your feelings, difficult thought it may be. Many feelings and experiences are normal: anger, guilt, loneliness, anxiety, and depression.

*Task 3: To adjust to an environment in which the deceased is missing.* There may be many practical daily affairs you need help and advice with, but there will be a great sense of pride in being able to master these challenges. The emotions involved in letting go may be painful but, again, necessary to experience.

*Task 4: To emotionally relocate the deceased and move forward with life.* To effect an emotional withdrawal from the deceased person so that this emotional energy can be used in continuing a productive life. Rebuilding your own ways of satisfying your social, emotional, and practical needs by developing new or changed activities or relationships.

Based on Worden (2002).

**Week 1/Task 1: Introduction**

Introduction to the group

Facilitators' roles are established and grief models and education are introduced.

Introductory mandalas

Establish opening and closing ritual.

Closing: Allowing time for closing remarks and ritual.

Directive: Using the inside of the mandala, create an image that represents how you see yourself. On the outside of the circle, represent how others see you.

Materials: Pre-drawn mandalas, markers, colored pencils, pastels, paint.

Rationale: The first group serves the purpose of establishing rules, building rapport, and becoming acquainted in the group setting. Facilitators' roles are established as the groundwork is explained and the group is introduced to Worden's (2002) tasks of mourning. The framework of the eight-week curriculum will be discussed. In addition, the facilitator will encourage the group to share their feelings of grief reactions and normalize each member to promote universality within the group. In addition to the closing ritual, each week the group will close by everyone saying one word that best describes where they are. As members will be educated on grief, it will be an important element to assess where each member is in their grief process. The goal of the mandala intervention is to compare and contrast inner versus outer personas. Additionally, this process can help identify hidden emotions and give client perspective and insight on what they show others.

**Week 2/Tasks 1 and 2: Soul Collage: Expression of Grief Related Feelings**

Directive: Using a 5" x 8" card and collage images, create feelings you are experiencing due to the loss in your life.

Materials: Pre-cut magazine images, words, tissue paper, scissors, glue.

Rationale: The 5x8 cards provide a sense of containment for what could be overwhelming feelings of grief. The use of magazine images is not intimidating and often removes the pressure of needing to "feel artistic." The collage provides a container for grief, a tangible product, and facilitates discussion of difficult feelings. According to Worden's tasks of mourning, the first task of grief to is accept the reality of the loss. The outward expression of grief facilitates discussion of difficult feelings. Through art making, members will explore feelings that may be difficult to express verbally. Art therapy invites participation in a safe and supportive environment, where individuals' efforts at self-expression are reinforced in an effort to confirm that their feelings are valid, fears are understood, and their needs are legitimate and important (Hill, 2005). Creating a tangible product will help the client project their emotions onto the artwork and can help them begin to process their feelings of grief.

Discussion

Clean up/ Closing Ritual

**Week 3/Task 2: Feelings Word Inventory and Body Outline; Continuation of Grief Feelings**

Materials: Assorted paper, felt-tip markers, glue, scissors

Directive: The Feelings Word Inventory (a list of 70 different loss-related emotions) is non-threatening due to its cognitive nature. Using felt-tip markers, the group will circle all the words that apply to their loss, then circle the five most relevant words. Using a standard body outline, group members will map those feelings in the body outline, complete with a color-emotion symbol key.

Rationale: Grief is experienced throughout the body differently. The body tends to carry memories that may be unconscious. This intervention allows the individual to explore physiological and emotional qualities of grief. The body acts as a safe container for feelings that are often volatile. Once feelings are identified, participants are often surprised at their strength and complexity. The sharing also helps participants identify physical aspects of grief such as exhaustion, headaches, loss of appetite, sleep disorders, etc. For the second task of Worden's model, allowing yourself to experience and express your feelings and normalizing them is a goal.

Discussion

Clean up/Closing Ritual

**Week 4/ Task 2: Making a Clay Grief Mask; Exploring Grief's Character**

Materials: Clay, mats, carving tools.

Directive: Each individual is given a ball of clay. The group is then encouraged to pound, poke, tear, rip, and shred the clay, finally forming it back into a ball. The group is then asked to remember the Feelings Word Inventory from the previous week. The group will be asked, "What is the strongest feeling you are experiencing now? Make a mask expressing that feeling."

Rationale: Creating a mask that represents the most powerful of feelings allows the client to express emotions through kinesthetic movement. The goal for this task is to create a vehicle that

allows for the expression of the most difficult emotional reactions. Once the feeling is manipulated through psychical movement, the clay is then sublimated to represent the current state of the client. This allows each individual to express difficult emotions and the masks acts as a mediator for the client.

Discussion

Clean up/ Closing Ritual

**Week 5/ Tasks 2 and 3: Narrative Therapy: Sharing of Pictures and Mementos**

Directive: Participants are asked to bring mementos and images of their loved ones. Using their mementos, visually narrate a story to share with the group.

Materials: Collage, found objects, glue, images, and any other media clients may want to use to represent their loved one.

Rationale: Trust and safety must be established before sharing stories of the people who have died. Thus, at week 5 the group should be ready to share on this level. The images and mementos give form to feelings to help make the loss more concrete. These objects also serve as a tool to help group members externalize their feelings of grief and loss, individualizing them from the deceased. Telling the story facilitates the adjustment to life without their loved one. The tangible objects are evidence of the loved one's existence and acknowledgment of his or her death.

Discussion

Clean up/ Closing Ritual

**Week 6/ Tasks 3 and 4: Reinvesting in Life**

Directive: Continuing through Worden's tasks of mourning, the group will engage in guided meditation or relaxing yoga for the first half of the session. Have pre-cut pieces that make a large mandala. Using materials, each member will create a piece of the mandala individually. The group will then connect all pieces to complete the mandala. If using sand, group will dismantle the image and pour into remaining bottles to keep. The group will decide if they would like to make a two-dimensional mandala or a three-dimensional mandala.

Materials: Three-dimensional materials: Sand, shells, beads, feathers, stones, or any other found objects that the group wishes to use. If using two dimensional materials: mural paper, paint, pastels, markers, tissue paper.

Rationale: The physical activity will be designed specifically for grieving individuals to explore the physical nature of grief. Introducing self-healing strategies and their importance will be a goal in this session. The yoga or meditation is introduced in a way that participants may identify and let go of the physical manifestations of grief. Group members will be asked to revisit the body outline project from Week 3 and compare the different feelings held within the body. The process of creating a group mandala is a unifying experience in which the group can express themselves individually within a unified structure.

Discussion

Clean up/ Closing Ritual

**Week 7/ Tasks 3 and 4: Grief Mask; Adjusting to the Loss**

Directive: Using the clay mask created in Week 4, clients will paint the mask and represent their current feelings.

Materials: Assorted acrylic paint colors and paintbrushes.

Rationale: Three weeks have transpired since the clay grief masks were made. During this time, thoughts and feelings about the deceased have changed. The painted feelings will look different than the sculpted feelings. This comparison gives clients the opportunity to reflect upon and discover those changes. By this time, the whole mood of the group is different. The room is no longer filled with anger, sadness, isolation or other feelings that often characterized the earlier weeks. A willingness to move on and a sense of completion is the goal for this session.

Discussion

Clean up/ Closing Ritual

**Week 8/ Task 4: Memory Box: Moving on and Saying Goodbye**

Directive: Create a memory box by using materials provided to symbolize the deceased. You may write down thoughts, feelings, or memories of your loved one.

Materials: Various containers, paint, glitter, glue, Mod Podge, pens, lined paper, collage images, assorted tissue paper, found objects, pictures or mementos that belonged to the deceased.

Rationale: The memory box provides a symbolic storage for the individual's loved one to be remembered. The memory box allows for a containment of feelings about the death and about the end of the group. It also gives members a tangible place where they can revisit their loved one after the group has ended. It provides a living project that can be continued and added to after the group has disbanded. Additionally, the box gives clients a living project that they can continue to add to long after the group has ended.

Discussion

Clean up/ Final Closing Ritual

## CHAPTER V: DISCUSSION

The caregiving demand on families is not new, although the caregiver role has changed dramatically from promoting improvement to providing high technology care and psychological support in the home. Caregivers are of vital importance in meeting the patient's physical and psychosocial needs and in accomplishing treatment goals. The burden of caring for loved ones may adversely affect family caregivers who lack adequate resources or who are insufficiently prepared for this new, complex role. There is mounting evidence that changes in family roles and the burden placed on family caregivers may have negative effects on the quality of life of both patients and their caregivers.

Art making, by nature of its two-step process of expression and reflection, allows both the isolation of internal focus and the connection with others. As the visual symbols of loss are shared with others in the group, they also promote deeper self -understanding as well as connection. Participants have the opportunity to demonstrate these elements of cooperation, creativity and re-creating of their personal vision by experimenting with art media (Hill, 2005). In summary, the creative experience of making art during the time of traumatic loss provides a tremendous opportunity for self -exploration, healing and growth. Art therapy can support the individual's need to express and creatively transform the issues of grief and can help prevent some of the psychological, social and behavioral problems resulting from unresolved grief. Additionally, the values of empathy and connection are enhanced by the process of creating art together in a group format.

Bereavement researcher and art therapist Barbara Tranger-Quarry (2014) states:

Understanding oneself and having others understand us is central to our humanness. Since ancient times, visual art has provided a way for one human to understand and identify with another in the moment, from generation to generation, and age to age. Not by merely viewing the art, but by seeing oneself in the art.

All the grief theories discussed acknowledge that grief holds a painful emotional adjustment which takes time and cannot be healed quickly. Rather than being in contradiction to each other, it may be safe to say that each separate theory helps to comprise a piece of the larger puzzle in the grief process demonstrating collectively that grief is a complex process that holds both universal characteristics and unique variations. When discussing the nature of resolution of grief, we are at the core of the most basic questions about what it means to be human, for the meaning of resolution of grief is tied to the meaning of our bonds with significant people in our lives, our place in our family and community, and the meaning we ascribe to our individual lives in the face of our own mortality.

As previously mentioned, loss is inevitable. Through the investigation in this literature review, research supports that art therapy can help individuals understand grief by nonverbal and symbolic processing. Using the proposed art therapy group model, future research can further investigate the efficacy of art therapy for caregivers and the grief process.

## CHAPTER VI: CONCLUSIONS AND RECCOMENDATIONS

Researchers continue to suggest that innovative approaches are needed for the hard-to-reach caregiver population (Barrington, 2008). Most of the research found has included a non-Hispanic, white, demographically homogeneous, sample which may limit generalizability of findings (Barrington, 2008). Using art therapy as a form of self-care is an approach that merits further investigation with a variety of populations and in different settings. An overview of the burden and needs of family caregivers has been discussed. Interventions that can meet those needs and the development of a program have been proposed for implementation in the hospice setting. Additional research is needed with regard to the identification of factors that predict those caregivers at highest risk for distress. However, research has consistently shown that caregivers who are ill themselves have difficulty caring for patients with complex care needs.

Art interventions that are implemented while the caregiver is still actively engaged in caring for the care recipient should be further researched and understood. There is a lack of supporting research on the entry into the role of caregiving, and what caregivers experience before they take on this role (Bass, 1990 & 1991). Assessing what changes after a loved one dies may also be an implication for further investigation. Increasing caregiver awareness of the importance of self-care needs to be supported by evidence. The efficacy of art therapy within the grief process for caregivers in hospice needs to be investigated further. Research is warranted to quantify these findings and determine long term-effects. Another limitation includes the lack of funds for creative approaches such as the proposed art therapy group. Funding from outside sources may be needed to sustain such programs.

Salaries dedicated for arts-in healthcare personnel are needed to ensure leadership and provide direction for ongoing volunteer training. The integration of arts programs into healthcare

facilities requires a philosophical and monetary commitment from healthcare administrators. Advocating for the efficacy of art therapy through grant writing and research is suggested.

Future research may assess characteristics of the caregiver– care recipient relationship, including factors such as closeness and affection, happiness with the relationship, centrality of the relationship in the caregiver's life, as well as the level of dependency and conflict between caregiver and care recipient (Barrington, 2008). These indicators of the quality and importance of the relationship should be explored to assess their impact on both caregiving and bereavement outcomes. Themes of inadequacy as caregiver and role reversal should be investigated. A comparison of spouse and adult children as caregivers and the issue of role reversal should be explored.

Additional implications for further research may include to identify and help caregivers who are most at risk for deteriorating health, financial security, and quality of life so that they can continue to provide care while maintaining their own well -being. Researchers, clinicians, and health care professionals should identify and advocate for supportive programs that promote caregivers' well -being and improve their ability to continue providing care for themselves and the care-recipient.

Immense possibilities for further research in combining the fields of bereavement and art therapy are evident from the comprehensive investigative results of this study. The research from this study validates important benefits from expressive arts activities, which appeared to facilitate the expression of the full range of emotions. The proposed art therapy group is one example of the benefits of creativity for caregivers who are experiencing grief. A gap exists between the statistics of the caregiver population and the apparent lack of support services that

include art therapy. Future research is suggested to investigate more successful art therapy programs and services for bereaved populations. In addition, more investigation regarding the efficacy of art therapy and grief should be taken into consideration.

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