ON THE MEANING OF GROWING OLD:
ART THERAPY WITH A GROUP OF INSTITUTIONALIZED ELDERS

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A Thesis

in

The Department

of

Art Therapy

August 1996

Canada

ABSTRACT

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The combined effects of the aging process and institutionalization often result in multi-losses for the elderly individual. This thesis will examine the ability of the art therapy process to help a group of elders in their struggle to balance the tension between a sense of despair and hope. The dynamics of the creative process has the potential to nourish the soul of the elder, through the provision of a safe container in which to work through the inevitable feelings of despair brought on by illness and impending death.

In addition to the ability of psychotherapy to ease the emotional problems that the aging process may initiate, psychological work with elders can help them to realize that change is ongoing even in later life. This idea is central to George Pollock's mourning-liberation process and will be referred to along with an exploration of the capacity of the art therapy process to assist a group of institutionalized elders in their search for meaning and resolution, enabling them to experience transformation and growth in this final stage of living.

Acknowledgements

I would like to thank the members of my thesis committee; Leland Peterson, Irene Gericke, and Dr. Pierre Gregoire for their guidance and encouragement Leland your support, guidance, and wisdom is something that I will always remember.

I would also like to extend a very special thank-you to the elders' who have taught me so much. They have shared their life stories, their wisdom and their tremendous courage in the face of illness and death; teaching me that life truly is a gift and one which is worth living to its fullest.

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Introduction:

This thesis will examine a part of our population which is often neglected and avoided Demographic trends indicate that the size of the old and very old population of ، ·t-industrial societies is growing and over the next few decades this trend will only increase While the majority of elderly people continue to function normally there are those who come up against barriers which are insurmountable without help Often this results in admission to an institution or a residential care facility. Most if not all people who enter an institution do so as a result of some crisis in their home. Brearley, (1977), describes this experience·

> The elderly individual is therefore coming into a strange environment at a time of low personal strengths. It may well be that he has been battered into a state of apathetic withdrawal from the world and his first need is for repair of the damage that has been done. (p. 67)

Considerable literature exists on the effects of loss, deprivation and distortion of relationships. Clearly methods of coping with stress and loss are learned very early in life and the way older people respond to stress will often be a reflection of coping mechanisms learned at the beginning and throughout the life cycle Erikson, (1986), writes:

> The elder is challenged to draw on a life cycle that is far more nearly completed than yet to be lived, to consolidate a sense of wisdom with which to live out the future, to place him or herself in perspective among those generations now living, and to accept his or her place in an infinite historical progression. (p 56)

For Erikson, (1986), old age marks the stage of development which seeks to bring into balance the tension between " a sense of integrity, of enduring comprehensiveness, and an opposing sense of despair, of dread and hopelessness " (p. 54). It is the process of integrity vs despair within the institutional environment that will be the major focus of this thesis. The combined effects of the natural aging process and institutionalization result in multi-losses for the

individual, losses in their ability to communicate verbally, personal losses through illness, death of loved ones, loss of control over lifestyle, and the ultimate loss of self. A lack of purpose or meaning in life occurs for many elderly people entering care, which can lead to feelings of overwhelming despair. It is the premise of this thesis that art therapy, with its unique ability to offer an alternative to verbal forms of communication will provide elderly people who have difficulty expressing themselves with words with a means of enabling the unsayable to be said. Weiss, (1984), writes " as long as man has breath, he communicates. His voice may be silent, his language may not be understood, but he is still living soul with a story to tell " (p xv).

People living in residential care facilities for the elderly are prone to gamut of neuroses and psychoses that affect the rest of society. However, they are perhaps more vulnerable to, and less able to defend themselves against, those fears and anxieties which emerge when living in such close proximity to death. A further complication arises in the fact that attitudes concerning death in Western societies tend to be negative. Death creates feelings of fear, hostility, recrimination, and denial. Death exposes us. If we accept that in every stage of life there is some meaning and purpose, then meaning must exist in the dying process of a human being. Every human being has fundamental needs: the need for biophysical exchange, the need for psychosocial exchange and the need for spiritual integration (Missinne, 1990). Spiritual concerns, the need to know our place in the universe and the meaning of our own existence, may be more pronounced in old age and in dying adults. Creative activity, meditating, praying, and searching for meaning are all parts of our spiritual life. Often the need to address spiritual concerns is neglected. Nurses and doctors attend to the biophysical needs of the person while social workers, therapists, family, and friends ensure that the psychosocial needs of the sick and dying are tended to. It is my belief that it is equally important to create an atmosphere wherein people can explore and give expression to their spiritual concerns. Caregivers who have confronted their own fears and anxieties about death; who have come to terms with and are aware of their own spiritual needs are more open to spiritual needs of a dying or sick person

(Conrad, 1985). Each of us is continually faced with the threat of death; each of us must find a way to cope with this reality. Robert Kavanaugh, (1974), writes:

> Honest recognition of our latent feelings about human mortality enables us to be free enough to make some choices. Only when we know our feelings can we respect our unique reactions. No longer need we pummel and even smash our emotional selves behind artificial defenses. Once free, we can choose the masks we want or need, even sometimes going maskless, instead of compulsively avoiding the reality of all death and grief because we lack the humility and courage to be any other way. . It helps immensely for professionals to inspect the masks they wear, encouraging honest feedback from patients or families. Those who believe their traditional stance is one of objectivity may soon learn how narrow the line is between objectivity and coldness . (p 26)

This thesis begins with a look at what it means to be old. Our attitudes about aging and death as individuals and as part of North American society will be explored. It then moves to a discussion of the psychological and psychosocial aspects of later life in Chapter 2. A major focus of this section will be on the issues of loss, dying and death with an overview of the writings of J Bowlby, E. Kubler-Ross, and T. Ranou. Chapter 3 focuses on the institutional environment and its impact on both the resident and the therapist. It is the author's feeling that the institution becomes a kind of container which isolates the individual and which has the power to bring about transformation or despair

In chapter 4 the author will examine two ancient structures of thought which focus on humankind's capacity and desire for transcendence. In researching for this thesis the author became interested in structures of thought which examine the basic elements of human existence; particularly those which focus on the areas of mental and spiritual growth. . the Kabbalah and Alchemy. Because the kabbalah has its roots in Judaism and the my work focuses on experiences with members of an elderly Jewish community, it seemed appropriate to study some of its more basic tenets. The Kabbalah is an extraordinary system of theoretical and practical value which describes definite theories about the human mind. It is form this viewpoint that the author will discuss some of the ideas which this vast body of text contains. This is not an

attempt to reduce the Kabbalah to the terms of modern psychology, nor is it a substitute for the primary sources which are complex and difficult. As with many psychological theories the writings of the Kabbalah support the idea that the desire for transcendence is a basic human need and its attainment comes through a unity among our physical, emotional, and spiritual selves. Hoffman, (1981), has written, " the Kabbalah, with its fundamental belief in the sanctity of life, its emphasis on the higher reaches within each of us, and its unswerving ethical basis in Judaism, carries with it a universal and timely meaning " (p. 5).

The idea of man's potential for transcendence is further explored in chapter 4 which focuses on the writings of Kat Duff who compares the process of illness to alchemy. Duff, who writes from both a personal and professional experience, views illness not simply as a state of being, but rather as a process of transformation. For Duff the hospital environment becomes a metaphor for the closed container, whose limitations in combination with the immobility of illness, enables this transformation to take place precisely because there is no way out. Again the author must state that only the very basic elements contained in alchemy will be used, as a metaphor to describe the experience of working with a group of elders in the context of art therapy.

What can art therapy contribute to the lives of the institutionalized elderly, approaching the end of the life cycle, and who are perhaps facing the denial of death which seems to permeate our society? In Chapter 5 a review of the literature available on art therapy and the elderly will be explored. Art therapy can offer the elderly an opportunity for change; a means of taking back control; and it can facilitate feelings of mastery and accomplishment. Visual communication can allow people to explore and express their anger, acceptance, and fear of illness and death in ways that allow this expression to be acceptable. (Miller, 1985) For those individuals suffering from dementia, particularly Alzheimer's, who have lost the capacity to speak, to communicate in ' normal ' ways, or who have become confused and disoriented and who withdraw from the world as a result, art can provide the individual with the possibility of

preserving and maximizing their eroding sense of self. Through use of metaphor art therapy can offer opportunities for more organized self expression Arthur Robbins, 1980), has maintained that ". . . the metaphor can serve as a bridge for raw, primitive communications.   " (p 42) The metaphorical equivalents of feelings inherent in the dynamics of the image have the capacity to give form to otherwise chaotic feelings. Johnson et al., (1985), write that " Interactive group work is now widely recognized as a primary therapeutic intervention that serves to build a sense of community for cognitively impaired, institutionalized elderly" (in Knight, 1986, p. 272)

In Chapter 6 an in depth exploration of the use of art therapy in a residentia; hospital for the elderly will be examined primarily in the context of group art therapy The dynamics of the institution and of those residents living within its walls will be compared to the alchemical and vegetative processes of illness, often expressed through images of plants and animals (Duff, 1993) In Shamanic traditions, soul loss, is one of the major causes of illness Native aboriginal beliefs indicate that soul loss occurs when a person suffers severe trauma, such as an accident, assault, or death of a loved one, and the person loses some of his or her vital essence. During these times the pe,son often feels alienated and vulnerable. " It is becoming increasingly clear, " wrote Jean Achterberg, " that what the shamans refer to as soul loss___that is, injury to the inviolate core which is the essence of a person's being___does manifest as despair, immunological damage, cancer, and a host of other very serious disorders " (p 121).

One of the tasks of illness, according to Duff, is to reclaim one's soul by calling up lost memories, by listening to our dreams and intuitions and by nourishing ourselves by doing those things that make us happy. " This is illness can function to compensate for onesidedness, reestablish equilibrium, and allow new solutions to evolve, on a metabolic level as well as the psychological; one could say it is a call for self-realization, whether it ends in death or recovery " (Duff, 1993, p. 75). Creative activity through the art therapy process has the potential to nourish the soul of the individual, through the provision of a safe container in which to work through the

inevitable feelings of despair brought on by illness and the possibility of death. It opens up a possibility for transformation and ultimately a emergence back to a place that can accept the limitations that illness imposes with a strengthened resolve and a newfound dignity.

Pollock, (1989), writes about the mourning process in older adults: " my own work on change suggests that crises and reorganizations are facilitated by a transformational adaptive process which I will call the mourning-liberation progress and which has a creative outcome " (p. 351). He goes on to say that " . . . the completion of the mourning-liberation process in aging or even the aged person, accomplished through intensive therapy, can result in creative freedoms, further development, joy, and the ability to embrace life " (p. 355). Part of the process, for the elder, involves the mourning for past self and this idea is echoed in the writings of Hannah Segal, (1952), who makes a direct link between the need for reparation and the origin of the creative impulse. This naturally leads the artist towards the creation of a whole new world.

Gordon, (1978), has examined the myths and theories about the origins of death and its symbolic meaning. She believes that an essential ingredient in the art of living must include the acceptance of death. For Gordon, the creative process can assist the person in their search for meaning in life. The intimate link between death and creativity has been discussed by many authors in terms of the psychological experience of transcendence For those elders who find themselves living in institutions, facing illness and death, art therapy can provide a means to work through the issues and conflicts that arise from the final transformation___death.

CHAPTER 1: On the Meaning of Growing Old

As far back as the sixteenth century it is not hard to find negative references to aging and old age in literature, science, and popular Western culture. Associations of old age with impending death make it frightening, sad, and even repulsive to many people. A great achievement of the twentieth century has been to add over twenty years to the average life expectancy of each individual. However with this lengthening of the average life span comes a question: What do we do with our increasing geriatric population? Stokes, (1992), writes that:

> It is uneasily suspected that most elderly people endure poor health in deprived circumstances, neglected by their children and such family as they have left. Abandoned within their communities, solitary, and ignored, as they grow to be really aged, intellectual decline and advancing physical disability inevitably leads to a miserable existence within an institution. (p. 1)

In society the rapid increase in numbers of older people is viewed as a major contemporary economic and social challenge. Stokes concludes that the evidence ". . . does not support the view that elderly people are in the main neglected by relatives and rejected by their communities " (p. 7). Institutionalization is usually the result of major dependency needs such as illness or disabilities. He goes onto say that the increasing numbers of elderly people will produce many changes in society, particularly in the way we view old people. " If a true shift in social attitudes occurs this would represent a reverse in a 200 year historical trend of growing denigration of elderly people " (p. 8).

Perhaps it has been the association of old age with impending death that makes aging frightening, sad and even repulsive to so many people. In order to appreciate our own and others understanding of responses to loss, illness, and death, we need to understand the socio-cultural attitudes which exist within Western culture. Rando, (1984), writes that " Each society's response to death is a function of how death fits into its teleological view of life. For all societies, there

seem to be three general patterns of response: *death-accepting, death-defying, or death-denying* " (p. 5). Rando maintains American culture is death-denying. There is a widespread refusal to confront death. In fact North American society will go to great lengths to shield themselves from the reality of death. Many people are sent to nursing homes and hospitals to die, away from home, family, and friends. " At the very moment that people most need the comfort of human companionship and sentiment they are isolated in a hospital room to await death alone and unassisted " (p. 5). This insistence on putting our sick and aging away only succeeds in strengthening the myth that death and dying is something to fear. Even twentieth century literature often reflects the view that old age is the worst of misfortunes, worse even than death. Simone de Beauvoir, (1972), in her book The Coming of Age, writes:

> How hard and painful are the last days of an aged man! He grows weaker every day; his eyes become dim, his ears deaf; his strength fades; his heart knows peace no longer; his mouth falls silent and he speaks no word. The power of his mind lessens and today he cannot remember what yesterday was like. All his bones hurt. Those things which not long ago were done with pleasure are painful now and taste vanishes. Old age is the worst of misfortunes that can afflict a man. (p.145)

There is no denying that the aging process is accompanied by many profound losses: of health, of people we love, of a home, of work and status, of control and choices. There is a growing recognition among students of aging that " . . . it is our attitude toward our losses as much as the nature of our losses which will determine the quality of our old age " (Viorst, 1986, p. 320). In her book Necessary Losses, Viorst sites the writings of Robert Peck who speaks about two attitudes about aging. The difference between these two attitudes is the difference between " body preoccupation " and " body transcendence, " between treating physical aging as our enemy or our master___ and making some sort of reasonable peace with it " (p. 321). In modern society, with its worship of beauty and youth; with its obsession for health and for prolonging life; the task of accepting the changes that the natural aging process brings are even more difficult. Kubler-Ross, (1974), describes attitudes towards old age in this way:

Many people believe that death is a welcome friend to most elderly people. This is only partially true. Old age is not synonymous with being " glad to die,". Many of these old patients who welcome death may not be in a stage of acceptance, but rather one of resignation, when life is no longer meaningful. (p. 142)

Kubler-Ross maintains that we (society) deprive our elders of the chance to contribute in meaningful ways, to offer all the wisdom and experiences they have accumulated over many decades. " Living means to give and to take, to receive and to serve others___and it is the latter that is often missing in our retirement centers, which results in the old man's (or woman's) wish to die, because life is not worth living anymore " (p. 142). Even if an elder's view of life's end is positive and viewed with hope, he or she still has to deal with societies view of aging. Although life expectancy has risen, for the most part, these elderly people are seen as being sexless, useless, and powerless. Indeed the noted Gerontologist, Robert Butler, (1963), echoes this view when he writes:

Old age in America is often a tragedy. . . we pay lip service to the idealized images of beloved and tranquil grandparents, wise elders, white-haired patriarchs and matriarchs. But the opposite image disparages the elderly, seeing age as decay, decrepitude, a disgusting and undignified dependency. (p. 66)

Today, with the disintegration of family ties, and other supportive group interactions; with the advances in technology and its resulting depersonalization and alienation; North Americans no longer have " the sense of continuity or relationship with others that might help them transcend death in a meaningful way, leaving them with existential anxiety" (Rando, 1984, p. 7).

The medical profession has placed great emphasis upon preserving life at any cost. Mauksch, (1975), writes that " in our modern technological society, dying is something you do in a hospital." He goes on to say " but hospitals are efficient impersonalized institutions where it is very difficult to live with dignity ___where there is no time and place in the routine to deal with the human needs of sick human beings" (p. 7) Dr. Mauksch explains why it is that hospitals fail to respond to the specific needs of people who are dying. As a result of advances in science and technology, medicine and other health professions have experienced dramatic growth and

development. Institutions are now ". . . fundamentally committed to healing, to curing, to restoring, and to the recovery process " (p. 8).

Dr. Mauksch explains that the hospital too has its own culture and social system within the institutional walls. The mandate of the institution and the social roles of its occupants reflect the needs of the greater society at large. The current emphasis on healing makes the dying or chronically ill patient a threat to that defined role. As a result the patient who cannot be cured is perceived to be a failure in the eyes of hospital staff. Mauksch, states that " the organizational context of dying within the hospital must be understood as an institutional response to an event which today is identified as a failure, although it also remains a reminder of the limits of medical knowledge and capabilities. " He goes onto caution the reader in this way: " In the case of the dying patient, the current culture of the hospital. . . is counterproductive to the needs of the dying patient. Dying is a total experience, and at the point of dying, the diseased organ ceases to be the primary issue " (p.8).

For the health professionals who are committed to the recovery process and to healing, the death of a patient brings forth feelings of inadequacy and failure. Often they are left feeling that something more could have been done; or even worse that a mistake was made which contributed to the patient's death. Another way in which the dying patient threatens the institution is when their individual needs cease to translate into the routines and rituals of the facility. " The routine orders, the predictable activities, when applied to the dying patient, cease to be meaningful, cease to be effective, and, above all, cease to be satisfying either to the people doing them or to the patients who receive them. As well, even the language of the institution suggests a denial of death. Patients do not die, they ' expire ' or ' pass away '; in the operating room they are ' lost on the table '. The institution and its staff tend to reward the patient for maintaining this denial phase perhaps as a form of protection and to prevent emotional involvement.

Denial, according to Dr. Kubler-Ross, (1974), is the first stage of the death and dying

process. The other 4 stages are those of anger, bargaining, depression and acceptance. It is

likely that most individuals will experience some if not all of these stages following admittance to

the institution. Unfortunately most institutions have not been designed to absorb and to cope with

these needs. " . . . the showing of emotions, the sharing of feelings, and, particularly, the

showing of such personal indicators as tears are taboos in our society, particularly for

professionals and especially for males " (Mauksch, 1974, p. 11). Dr. Mauksch suggests that one

way of changing the system is to rely on teamwork where the human resources within the

institution are utilized to help the individual and his/her family work through the stages of grief

towards acceptance. Currently this philosophy is in place in most geriatric facilities. However,

even though the institution is a place which houses a network of different occupations there are

often inadequate communications and departments are often isolated from each other to the

detriment of the patient. The patient's needs then present a challenge to the health professions

and to the educational processes by which we introduce students into these professions. This will

require changes in the culture of our training institutions. Mauksch, (1974), offers this conclusion:

> Our hospitals and our health professions have built super highways of medical
> technology in which the patients' disease and their organs loom large and where we
> focus with efficient specificity upon the disease process which we seek to cure. Patient
> care, however, writes its own script and the dying patient is but one extreme example of
> the time when the professional challenge demands that we abandon the comfortable
> road of predictable mileage and dare to venture into the narrow byways which adapt
> them-selves to the individuality of the real world___ in this case to the specific needs
> and human processes of the patient who has entrusted himself to the care of people who
> could most effectively use themselves as the instruments of help and hope. (pp. 23-24)

CHAPTER 2: Psychological Issues

Movement through the life cycle is a gradual process which cannot be anchored to specific chronological ages where people easily pass from one developmental stage of life to another. Psychological aging is a complex and unique phenomenon. Stokes, (1992), feels that regardless of the age at which individuals consider themselves to be old, " a set of attitudes come into play which are often based on myth and ill-informed stereotype." He goes on to say that " reduction in enthusiasm for life, withdrawal from activity and lowering of morale may be less often the effect of physical aging than an attitude to oneself as aged and without value. Later life is not viewed as a time for growth and achievement " (p. 19). A large part of this negative attitude is influenced by society not having a positive conception of old age. " After a lifetime of productivity and involvement older people often wish to be of continuing use to somebody. It is their misfortune that modern society's expectations are at variance with this desire " (p. 19).

Cultural influences, as well as biological and psychological factors, affect adult development. The concept of life stages provides a useful framework for understanding how people change as they grow older, particularly for therapists working with an elderly population. Understanding what it is like to be at the end of one's life helps practitioner's to be empathic and effective. Relatively few health professionals have had personal experience with the developmental issues faced by the elderly. Toseland, (1990), writes that ". . . it is essential for practitioners to sensitize themselves to the issues that older adults typically struggle with in the latter parts of their lives. Practitioners can begin this process by identifying their own feelings and attitudes toward the aging process " (p. 6). Toseland cautions the reader that evidence indicates it is more likely for practitioners to underestimate the capabilities of clients and attributes this distortion to a negative image of the aging process.

Possibly the most influential theory that extends beyond the middle age to include a psychology of old age is Erik Erikson's analytical theory of human psychosocial development. Erikson developed a model which includes eight developmental stages extending from infancy through to old age. The eight stages and associated life crisis are as follows:

1. Infancy   Basic trust vs Basic mistrust
2. Childhood (1)   Autonomy vs Shame and Doubt
3. Childhood (2)   Initiative vs Guilt
4. Childhood (3)   Industry vs Inferiority
5. Adolescence   Identity vs Role confusion
6. Young Adulthood   Intimacy vs Isolation
7. Adulthood   Generativity vs Stagnation
8. Old Age   Ego Integrity vs Despair

As a person progresses through life he/she will need to negotiate significant crises and aspire to developmental tasks specific to each of Erikson's stages. Toseland, (1990), writes that for gerontologists ". . . it is the penultimate stage of generavity versus stagnation (or rejectivity, wherein the person continues to grow but does not share their experience), and the final stage of integrity versus despair (or disdain, including self-disdain) which holds the greatest interest " (p.20). Erikson et al., (1986), ask this question: " How, on the basis of a unique life cycle and a unique complex of psychosocial dynamics, does each individual struggle to reconcile earlier themes in order to bring into balance a lifelong sense of trustworthy wholeness and an opposing sense of bleak fragmentation ? " (p. 55) Perhaps, in order to understand the experience of the aging adult it would be helpful to focus on the last two stages of Erikson's developmental themes.

2.1 Generativity versus Stagnation

The success in integrating feelings of integrity and despair is in part determined by the successful negotiation of Erikson's preceding stage of generavity versus stagnation. According to Erikson, (1986), generavity can be understood as a responsibility of each generation of adults to " . . . bear, nurture, and guide those people who will succeed them as adults, as well as to develop and maintain those societal institutions and natural resources without which successive generations will not be able to survive." He goes onto say that " giving up the official positions of responsibility in the family and community may confront the elder with unwelcome feelings of stagnation " (pp. 73-74). Parenthood has been a primary focus of adulthood responsibility for most people. Through reconsidering their children's successes and failures an elderly parent may be able to validate the caring they themselves provided during the years of active parenting. It is important to note that many elders were young parents during the Depression and World War II, making it impossible to pursue their own educational and professional goals. Erikson makes this comment: " To some extent, they have experienced their children's creative and productive accomplishments as a validation of their own unexpressed creativity and productivity " (p. 82). Others issues which may result in feelings of stagnation involve coming to terms with retirement and reduced income as well as the possibility of having to accept care from others, relinquishing the role of caregiver. The ability to be open and flexible in the face of inevitable age-related changes is necessary in order to avoid them dominating the final years of life.

2.2 Ego Integrity versus Despair

The achievement of ego-integrity, for Erikson, requires that individuals have reached a stage where they feel that major life goals have been attained, that they can look back on their lives with acceptance not regret, with a harmony between past, present and anticipated future, and with a loss of fear of death. It is not surprising that for most people integrity is rarely achieved. Throughout the life cycle the individual has, in some way, anticipated the "the finality of old age, experiencing an existential dread of ' not being ' alongside an ever-present process of integrating those behaviours and restraints, those choices and rejections, those essential strengths and weaknesses over time that constitute what we have called a sense of ' I ' in the world " (Erikson et al., 1986, p. 56). The reality for those nearing the end of the life cycle, is the realization that death will come sooner rather than later. In the imminence of death many elders will find the future difficult to plan for. The future becomes doubtful and unknowable and this uncertainty can eventually become overwhelming creating feelings of despair within the individual.

For some old people fear of death manifests itself as fear of a painful, lingering illness. Others associate death with loneliness and a fear of abandonment. It is not unusual to hear an elderly person worry about becoming ' a burden ' to their family and friends. Often underlying such a statement is the desperate hope that if they do become seriously ill, someone will accept responsibility for their care.

One way in which the elderly defend against despair is by viewing their grandchildren as extensions of themselves into the indefinite future. By focusing on their grandchildren's future they can move beyond " . . . the inescapability and unknowability of their own death, to a concern for the long lives that they see ahead of these young people " (Erikson et al., 1986, p. 66). Another defense for the elderly person is to focus their concern onto modern society and the

current state of the world. Often these concerns become opportunities for the elderly to speak about the principles that they have used in living their lives, an opportunity to pass on some of the wisdom that can only come with a lifetime of experience. Religious beliefs and rituals often play an important role for many old people. Religion may have been a force around which life's decisions have been made, and now can offer consolation and provide the individual with a feeling of continuity and a most needed sense of community.

An important part of bringing into balance feelings of integrity versus despair is the ability to acknowledge and accept the inalterability of the past. Erikson et al., (1986), explains the attempt at balancing opposing elements in this way:

> As the elder seeks to consolidate a sense of lifelong wisdom and perspective, he or she endeavor, ideally, not to exclude legitimate feelings of cynicism and hopelessness, but to admit them in dynamic balance with feelings of human wholeness. Later life brings many, quite realistic reasons for experiencing despair: aspects of a past that cause unremitting pain; aspects of the future which is both wholly certain and wholly unknowable. Thus, some despair must be acknowledged and integrated as a component of old age, anticipated from the beginning of life. The elder engages in this integration as he or she acts and reflects on the various issues discussed above. In addition, this ultimate integration comprises all of those conscious and unconscious processes by which the individual at the end of life seeks to reexperience and to bring again into scale each of the psychosocial themes that have, in turn, given shape to the life cycle. (p.72)

Not every person will be fully able to use the perspective afforded by a long life. It is the effort of attempting to bring about a move toward wholeness that is the basis for growth at all stages of the life cycle.

2.3 Grief, Dying, and Death

According to Toseland, (1990), a critical aspect of the psychological circumstances of old age is the perception of time left.

> When younger, activity can be delayed, frustrations and failures dismissed with the intention ' to try again ' and goals deferred until later. In old age such ' futurism ' is obsolete. Unfulfilled dreams and hopes will remain just that, unfulfilled. Thus, one of the major losses in later life is the loss of a psychological future. (p. 22).

Related to this concept of time left is the heightened awareness of one's own mortality. This realization is related not only to the awareness that one's own death is imminent; it is also influenced by the loss experienced through the death of close relatives and friends. It is a mistake to assume that the aging process does not present the older person with all of the issues and conflicts which are experienced by anyone who is facing death. Thus, it becomes imperative for the health professional to have a good understanding of the characteristics of the processes of grief and dying in order to facilitate appropriate therapeutic intervention when working with the elderly or the terminally ill. A great deal of literature exists on the processes involved for those people who are facing death or who have experienced significant loss in their lifetimes. It would be impossible to explore all of the available material within the body of this thesis. Instead a discussion of the common themes and issues present in situations of illness and death will be examined. Old age brings many losses, and there are those people who will have great difficulty accepting and working through issues of loss and death. But there is a view that argues that if we truly mourn the losses of old age, mourning can liberate us, can lead us through to " creative freedoms, further development, joy and the ability to embrace life " (Viorst, 1986, p. 318).

The grief of elderly people with terminal or chronic illnesses involves mourning for not only future losses, but for losses in the past and present as well. It is a gross exaggeration to say that the elderly are all at peace with their coming death. Rando, 1984, writes, " It is an error to

assume that advanced age precludes the normal difficulties inherent in facing death " (p. 247). In 1917, Freud published his classic paper " Mourning and Melancholia " in which he described the normal process of grief. He wrote:

> The reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as fatherland, liberty, an ideal, and so on . . . .It is also well worth notice that, although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a morbid condition and hand the person over to medical treatment. We rest assured that after a lapse of time it will be overcome, and we look upon any interference with it as inadvisable or even harmful. (Freud, 1953, p. 153)

Freud asserts that grief is prompted by loss and need not involve a death; he proposes that not only is grief normal and expectable, but, it implies a self-healing aspect to grief. Pathological grief, according to Freud, can occur in situations where a profoundly painful dejection exists; when there is a cessation of interest in the outside world; where there is loss of the capacity to love; where there is an inhibition of activity by withdrawal from everything not connected with the lost object. Bowlby, in 1961 and later on in 1980, presented a theory of grief that has four main phases. The first phase is a period of *Numbness* where varying degrees of denial of the loss are usually present. This is followed by the phase of *Yearning and Searching.* The individual has a strong urge to find, recover, and reunite with the lost object. Anger at the loss is visible in the restlessness and irritability directed towards the self and others. Disbelief, tension, tearfulness, and the desire to cling to the memory of the lost object may be apparent. The third phase of *Disorganization and Despair* is characterized depression and a disinclination to look toward the future or to see any purpose in life. The final phase of *Reorganization* occurs when the bereaved breaks down attachments to the lost object and starts to establish new interests and ties with others.

Kubler-Ross, (1969), outlined five stages of death and dying which she applies to those coping with imminent death as well as to those experiencing loss. The first stage of *Denial* involves a period of shock and acts as a buffer against the overwhelming reality of the situation.

Stage two is *Anger* which replaces denial with feelings of rage, envy and resentment. The third stage is that of *Bargaining*. If the person has been unable to face the facts in the first period and has reacted with anger, what often follows is an attempt to enter into an agreement which may postpone the inevitable happening. With stage four, *Depression*, the individual fully experiences the enormity of the loss. If he/she has enough time and has some help in working through the other stages, he/she will reach the fifth stage of Acceptance. Kubler-Ross, (1969), writes that:

> He will have been able to express his previous feelings, his envy for the living and the healthy, his anger at those who do not have to face their end so soon. He will have mourned the impending loss of so many meaningful people and places and he will contemplate his coming end with a certain degree of quiet expectation (p. 112)

Most theories on the processes of grief an death may have different names and focus on different topics, but they all entail loss. They all cover the same basic feelings with differing labels. According to Rando, (1984), psychological reactions to loss and death fit into three broad categories:

> *Avoidance*, in which there is shock, denial, and disbelief; *Confrontation*, a highly emotional state wherein the grief is most intense and the psychological reactions to the loss are felt most acutely; and *Reestablishment*, in which there is a gradual decline of the grief and the beginning of an emotional and social reentry back into the everyday world. (p. 28)

Rando warns the reader of the danger that the word stage implies the " existence of an invariant and sequential process " (p. 28). She states that some practitioners and caregivers have responded to the dying or bereaved in terms of stages rather than focusing an individuals needs at that point in time. Any process of mourning involves a re-sifting of all the stages and this will vary accordingly.

> To use the Kubler-Ross schema as an example, to try to push patients through the stage of Depression in order to try to get them to Acceptance is doing them the grossest misservice, since their individual needs are not being attended to; it is also a

misinterpretation of the purpose of the theory, which is to provide a general pattern, but not suggest a static, necessary, or absolute course. (p. 28)

It is our responsibility as caregivers to support those responses that help an individual cope. These ego-coping mechanisms are crucial to the person's survival and are not an indication of weakness. According to Rando, (1984), all people involved with the dying experience high degrees of stress. In the initial phase of acute crisis coping mechanisms may be somewhat primitive until more adaptive mechanisms take over. It is what Rando calls the " living-dying interval " that can become a time of repeated stress. "The dying person is physically ill, and this drains him of his psychic energy. . . Consequently, he may lack the energy for the effective use of coping mechanisms and his range may become more limited " (p. 252). Rando goes onto say that in the terminal phase, typical coping mechanisms fade and are replaced by a withdrawal and increasing detachment.

According to Rando, for most people death is a gradual process. This is particularly true for those individuals who are institutionalized. During this " chronic living-dying interval " it is important that reasonable expectations for continued ' normal ' living be maintained by the resident, staff, and family. Rando makes this comment " Frequently patients unnecessarily restrict their lives or are avoided by significant others because of a misunderstanding of their symptoms. " She goes onto say that " it is not uncommon for family members to express fear of contamination . . . and for the patient to experience rejection, isolation, and possibly abandonment as a consequence of family members fears " (p. 212). It is important to note that similar responses may also be present among residents, and among the multitude of staff and volunteers within an institution. Residents must learn to cope with the inconsistency of care and support. " Feelings of alienation may develop, fueling their fears of abandonment, unacceptability, and isolation " (p. 213).

The main defence mechanism that allows for a retreat from death is regression. When regression does not offer sufficient protection, then often the person may give in to feelings of despair. The phenomenon of regression is therapeutic when it enables the individual to relinquish some independence and to accept some restrictions. Rando describes this effect " It aids the caregiver-patient relationship, in which there necessarily will be some dependency on those who are responsible for care. " However, regression can be detrimental when " . . .patients' egocentric and dependent behaviours make them a problem to caregivers, and, ultimately to themselves " (p. 254). A certain amount of structure and routine becomes necessary for the resident to depend on and to gain a sense of control. Residents should be given a refuge in which the possibility of planning and action can be maintained. Meaningful tasks or activities give the person something to strive for and to mark time with. " They engender feelings of accomplishment and control, and support and foster the continuity of the patient's self-image " (p. 255). Due to the nature of illness a person can become engrossed in the physiological manifestations of the illness which can result in withdrawal from external happenings. Here the resident may be experienced as a nuisance because of constant somatic complaints. The sadness of this situation is evident because often these individuals are ignored or neglected, which is unfortunate because their real needs are masked by these behaviours. When regression or other coping mechanisms fail to offer enough protection then a person may simply give up. " When the patient sees no way out and the future appears totally bleak, passive surrender to fate may be the only way to escape overpowering anxiety, and so the patient blends in with his hostile environment " (Rando, 1984, p. 256).

Acceptance, withdrawal and detachment, and hope are three issues that arise repeatedly in working with patients facing death. Rando notes that, on some level, almost everyone accepts the reality of death as inevitable. However, a person may not be willing to go or be at peace with the fact that death will happen. Here the issue of withdrawal and detachment become important in terms of treatment. During the course of an illness there is a time when " the patient has been

slowly loosening the ties that bind, gradually moving towards a state of detachment and separation from that which must be left behind " (Rando, 1984, p.268). The patient becomes involved in making the transition through which the journey must be made alone. The patient's self-involvement is a natural part of the process of death through which everyone passes. This withdrawal can be experienced by families and significant others as a lack of love and desertion and may be difficult for them to accept.

The third issue, hope, is something that usually is present from the moment of diagnosis. Rando, (1984), states that

> The type and quality of hope will change throughout the course of the individual's terminal illness. Initially hope is that the diagnosis will be proven incorrect. This changes, upon confirmation of the diagnosis, to hope that there will be a cure or some miracle that will enable the patient to escape death. Later, this hope is transformed to a smaller scale and the patient hopes that life will be optimal, albeit limited. Smaller hopes related to everyday life and activities. . . may remain until the end. . . Some degree of hope persists through all phases of dying, through the emotional reactions, grief, and defenses. Frequently it is this hope that sustains the patient through suffering. (pp. 269-270)

As caregivers, we can support the patient's hope by helping the person facing death retain control, dignity, and self-esteem. Focusing on the here and now; emphasizing remaining potentials and abilities; fostering opportunities for accomplishments and mastery; encouraging reminiscence are some of the ways in which caregivers can support the person coping with illness." Hope is an essential requirement for existence to continue, for the threat of demise to be confronted, and for life's meaning to be sustained " (Rando, 1984, p. 270).

Perhaps one of the least discussed yet most critical issues pertains to our own expectations for death and dying. The trend today is to view death in a romantic fashion. There is a myth that if all the ' right ' things are done then the dying person can experience a beautiful, serene and accepted death. Many caregivers want to rectify society's cruelty and reluctance to address the dying. Rando writes " There is a determination to get patients to reveal their

innermost feelings and fears about death, even if they don't want or need to." She goes onto say that " the disillusionment that confrontations with death may bring is often compounded when it is recognized that frequently people die angry or hurt, without emotional closure " (pp 271-272). Because of unrealistic expectations there is a danger of professional burn out among caregivers. The dilemmas that dying people experience cannot be fixed, they can only be coped with, and accommodated. We need to remember that we cannot do anything about the psychic pain of loss and impending death. Without this acceptance, caregivers can become bitterly frustrated and feel as if they have failed. Kavanaugh, (1972), describes the dying process in this way

> At birth as at death, man is alone. At birth, our aloneness can only be felt in primitive feelings, while at death, our feelings are resurrected and we know our isolation. The human struggle for the dying is not so much in letting go as in reaching out for revelry in what we hid from ourselves in life. (p. 78)

Whether or not we have the chance to experience our death as an instrument of growth, we can enrich our life by remembering that we will die. Viorst, (1986), writes that " . . . we also will have to live with a sense of transience, no matter how passionately we love whatever we love, we don't have the power to make either it, or us, stay " (p. 362). If we accept that nothing is permanent in life, that change is always possible and likely than perhaps we can use this reality to come some kind of inner acceptance about the dreaded changes that life can present us with In the following chapter I will examine one of the most traumatic changes in life___ that of entering an institution or hospital.

CHAPTER 3: Institutionalization

With few exceptions an increasing number of the elderly are being placed in nursing homes and institutions. Daniel Baum, (1977), paints a rather grim but perhaps accurate picture of the state of most Canadian institutions:

> People are there to die. Once they walk through the nursing home door and take their rooms, they will not walk out again. They are stripped of their assets, given a small personal allowance, promised minimal nursing care, regulated severely in their routine and medicated to institutional compliance. In a very real sense, they are encapsulated and warehoused for death. They are removed from the community, and the community accordingly does not have to see either old age or death. (p. 3)

Harsh words, written two decades ago, but surprisingly little has changed to alter this dark image of the institutional environment which exists today. Brearley, (1977), writes that " in recent years geriatric medicine has emerged as a recognizable branch of medicine but both hospital and residential services for the elderly have suffered from being provided in outdated buildings ". He goes onto say that " the elderly, until recently, have been at the end of the queue for resources, partly because of society's general attitudes to aging, partly because of the low value and status accorded to work with older people, and partly because the elderly themselves often accept a low self-evaluation and are inclined to make few demands " (p. 1). Forbes, Jackson, et al., (1987), write that the trend in the prevalence rate of institutionalization of the elderly has increased. This tendency has increased substantially in the eighty and over group, particularly among females. Forbes, et al, write that " the role of community support programs and services in preventing or delaying the institutionalization of the elderly is clearly important ". They go on to say that " associated with institutionalization of the elderly are health, demographic, socioeconomic and psychological factors, as well as advanced age itself " (p. 45).

In this chapter I will discuss how the institution can influence psychological intervention, and how intervention needs to be adapted to maximize residents' quality of life in these settings.

In my opinion in many respects it is the institution that needs to be treated; institutional values, expectations and norms must be taken into account; staff attitudes and reinforcements must also be considered (Woods & Britton, 1985). There is still a tendency for too limited a view of 'environment ' which does not include the broader institutional contingencies that influence staff and their attitudes. This area is not well documented. Woods and Britton, (1985) state, that the " whole institutional context must be understood. Intervention programs aiming at major changes may require a fundamental restructuring of the institutional setting for success " (p. 266).

Certainly ' institution ' has become a word full of negative connotations associated with deprivation, resignation, and apathy. However, Woods and Britton point out that the reason for the person entering the institution and their understanding of what that means also can contribute to attitudes about institutionalization. " Passivity and dependence may be seen as also arising from the process preceding admission, confirming the persons' self-perception as someone having no valid social roles rather than simply resulting from the institutional lifestyle " (p. 268). Certainly the socio-cultural view of institutionalization evokes mixed feelings both in individuals and society. Forbes et al, (198¨i, write that:

> Attitudes towards old age and the elderly affect both the view of institutional care and the climate in long-term care facilities. Much has been written about society's negative view of older people and the way in which the values of western and urbanized, industrial countries devalue the place of the elderly in the social structure. Not surprisingly, these attitudes influence both those delivering health and social services to the elderly, and those receiving them.
> (p. 88)

So what are the effects of institutional living on the elderly? Townsend, (1962), lists six different effects of institutional life taken from his study:

1. Loss of occupation

2. Isolation from family, friends and community

3. Tenuousness of new relationships

4. Loneliness

5. loss of privacy and identity

6. Collapse of self-determination

Townsend's study presented a depressing picture of wide variations in both homes and institutions for the elderly. According to Brearley, (1977), admission to an institution always involves the person in loss, both of social roles and of material possessions. Each individual brings their own particular needs to the institution. " He needs to influence and affect the other members of the new group, to impress upon them his own sense of identity. . . to preserve a sense of self. As well as this he brings the conflict between the need to feel secure, wanted and to be protected on the one hand and the need to remain a separate independent being on the other " (p. 23). Brearley suggested that a further conflict arises that includes not only the aims of the institution, but also the needs of staff members and those of the residents. Staff may sometimes fear involvement in interpersonal relationships with residents because of anxieties and the inevitability that a relationship will end because of discharge or death. " Less tangible are the anxieties aroused through relationships formed in enclosed situations: painful feelings that realistically belong to earlier relationships may become attached to very close relationships formed in circumstances of enforced physical or emotional dependence " (p.24). As a result ' ritualization ' and

' standardization ' of task performance become the institution's solution for avoiding the need of constant decision-making processes involved in the day to day reality of institutional life.

Brearley, (1977), looked at institutional behaviour in terms of a conflict relationship. For him the institutionalization of conflict leads to " regularized procedures for change and for the handling of power " (p. 24). A conflict may be functional in that it can stimulate interest, assist in

the resolution of problems, and prevent stagnation. Within the institution conflict can lead to passive (structural) violence or, in extreme cases, to active physical violence. This is due in part to the perception of staff as ' all powerful ' presence who can give or withhold desired objects which give either intrinsic or extrinsic satisfaction. Brearley, (1977), defines passive violence as ". . .that which creates a gap between what an individual needs (which demands a concept of human rights) and that which he is able to obtain " (p. 24). Active violence is attributed to structural limitations placed on the individual. For Brearley, regimentation, depersonalization, and role-deprivation are expressions of violence and create an unrealistic conflict situation One important way to understand this phenomenon is to become involved in the ways in which the institution impinges on the individuals within it. By improving communication between staff and staff, staff and residents, and residents and residents, an increase in understanding may come about which in turn can reduce levels of violence and create a realistic conflict leading to change. Brearley, (1977), writes that " both passive and active violence clearly result when staff have little support, poor training and are under pressure of overwork and overcrowding as well as working in a low-status position " (p. 26). The challenge for the therapist becomes one of clarifying communication; interpreting the institution to the resident; offsetting some of the effects of institutional living; and exploring ways to find resolution of conflict.

One of the most difficult issues which confront the elderly resident is the reduction of **choice**. Loss of roles and relationships; loss of material possessions; and loss of mobility all contribute to reduction of choice. Brearley, (1977), writes that " admission to institutional care emphasizes loss: more roles have to be given up, relationships are cut off by geographical, transport, or financial considerations, and home and furniture may have to be given up " (p. 32). Closely linked to issue of choice is the need for residents to retain **independence and individuality**. This may simply translate to being able to dress oneself, to move around freely and choose levels of involvement in hospital activities, meetings etc and

respect for privacy. All residents have the right to **dignity and respect**. " Treating people with respect involves looking beyond the stereotype to the whole needs of the individual " (p. 33).

Personal satisfaction seems to be a fundamental need: " to be able to feel that life is purposeful and meaningful is vital " (Brearley, 1977, p. 34). Erikson, (1986), writes about the elderly in this way: " they may be understood as seeking to bring into balance the tension between a sense of integrity, of enduring comprehensiveness, and an opposing sense of despair, of dread and hopelessness " (p. 54). The achievement of ego integrity involves an acceptance of past life, recognition that the present is meaningful, and a realization that death is unavoidable. This is not easy for some people to achieve, particularly if ones' life is perceived as unproductive or that present circumstances are deserved. It is not enough to see the achievement of ego integrity vs despair as being the sole responsibility of the individual. Brearley, (1977), writes that " the deprivations that many older people suffer are often the result of the unpredictable failure of health or of the external effects of actions taken by the wider society." He goes onto say that " satisfaction and happiness . .depend on the congruence of the inner mental state with external circumstances " (p. 34).

In conclusion, the propensity towards a condition of ' despair ' depends not only on the inner processes of the elderly person but are inextricably interwoven with the institutional environment. Older people coming into the institution are coming form a state of crisis and experience a multitude of losses. Brearley, (1977), writes that " admission to any form of residential or institutional care implies that the individual has in some way broken out, or broken down, in his previous life. The danger lies in the attitude that the older person has failed in their outside life. Kent, (1963), writes that reactions to a state of crisis may take a number of forms. " Complete adjustment in a mature way on intellectual and emotional levels, through poor adjustment, to regression, rejection, paranoia, and depression " (In Brearley, 1977, p.136). An inability to adjust can involve feelings of being on the point of being engulfed, wandering,

disorientation, and restlessness, and even physical flight from the unbearable institution. Mauksch, (1974), describes two conflicting roles which a new resident may experience upon admission to the hospital. The new role that emerges is one where the person feels that he must survive in the hospital which is experienced as ' all powerful '. A second role occurs when the resident feels he/she must keep in good standing with the hospitals' staff. Mauksch, writes that " the second role competes at times with the objective of getting care." Here the person feels that " If I have pain and I need something and I know that the nurse might get angry if I turn on my light too frequently, I see myself caught in a power system " (p. 19).

All of these experiences suggest that the residents learn that in order to survive effectively within the institution, they must learn the ' rules of the game '. Ultimately the climate of dependence on staff and on the institution can drain the patient's sense of uniqueness and of human worth. Goffman, (1961), speaks of a ' stripping process ' which embraces the institutionalized individual totally and which strips the person of his autonomy, identity, and of any distinguishable separate status. Even the design and architecture as well as procedures ". . . tend to discourage the patient from forming a patient community and an interaction system with other patients " (Mauksch, 1974, p.16).

In many ways the institution has responded admirably to the challenge of healing, but in doing so, it has paid a price by reducing for the sake of human efficiency, the conditions of dignity and of individuality so important to those who are ill and dying. In emphasizing instruments and techniques health professionals have diminished their sensitivity and have denied their commitment to their own resources and to their internal strengths. While currently institutions are beginning to embrace these attitudes much more time and effort needs to be devoted to the development of skills and approaches if residential care is to be used to its full potential in the future.

Chapter 4: ILLNESS and MYSTICISM

Because the need for spiritual integration seems to be a primary concern for those facing death, and in particular for the elderly population, this chapter will examine some universal attitudes and structures which focus on issues of death and illness from a more spiritual position. Of particular interest are the teachings of two primary structures which reflect the thought-life of mankind: Alchemy and the Kabbalah. Jelliffe, (1917), describes these structures:

> Hence the products of mind in evolution are more plastic more subtle and more changing. They are to be found in the myths and the folklore of ancient peoples, the poetry, dramatic art, and the language of later races. From age to age however the strivings continue the same. The living vessels must continue and the products express the most fundamental strivings, in varying though related forms. (pp. iii-iv)

Since the beginning of time as we know it, mankind, with his symbol making propensity unconsciously transforms objects or forms into symbols and expresses them both in religious (spiritual) ways and through the visual image. The world's earliest known art in evolutionary terms, made its first appearance some thirty millenniums ago in the form of paintings and engravings on the walls of caves. Pfeiffler, (1982), writes that " Art . . evolved rapidly, and changed rapidly, in response to changes in structure of society. Ultimately it became an essential aspect of prehistoric living, as essential as subsistence and reproduction for the survival of the human species " (p. 18). The images of long ago seem to reflect not only the day to day living of early humans but they imply the need for organization of societies, of initiations, rites of passage and ceremonies which celebrate the life and death cycles of mankind, as well as the world of plants and animals. Pfeiffler suggests that the rapid changes taking place in prehistoric times created a need for primitive societies to record life experiences and to communicate these experiences to others. " Survival demanded new ways of transmitting, from generation to generation and before writing had been invented, the contents of an expanding tribal encyclopedia, a body of new rules and traditions about how to relate to others " (p. 228). Pfeiffler believes that these early images are the first evidence of applied or institutional art. He writes

that art was produced in the service of belief, ceremony, and community. It also is the first evidence of the universality of art, of the need for expression of the artistic impulse and of the importance of integrating the physical and psychic experiences in order to live a more complete life which is a basic premise of art therapy.

It seems clear that virtually every culture in recorded history has possessed at least a rudimentary notion regarding the mind-body connection. Shamans and tribal leaders have effectively responded with both psychological and somatic techniques to treat illness Some Eastern cultures, such as those found in China and Tibet, have practiced sophisticated methods of diagnosis and treatment that are now being used in the West. In his book Psyche and Death, Edgar Herzog, (1966), writes that:

> To open oneself up to death is to accept the aspect of " becoming ", that is, of transformation, which is the very stuff of life, and so, at length, to realize that the human condition transcends itself. On the other hand it is also true that the " excess of death " has produced a tendency in men and women to shut themselves off from this aspect of life by putting aside all thought of death. This leads to the inhibition of *real* becoming, and creates in its place an appearance of security which is.... continually threatened by unconscious anxieties giving rise to *neuroses.* (pp. 9-10)

This existential approach to mythology and death is enormously beneficial to understanding neuroses and to coming to terms with the basic conditions of human existence. Mankind has always attempted to express and to come to terms with life and death experiences by means of images. The emphasis on the magical elements of life, on the idea of ' spirit ' and ' soul ' display the first tendencies of primitive mans' attempt to give meaning and form to the unconscious, to what lies beyond the grasp of reason, in other words human instinct. Jung et al., (1964), write that " Even civilized men must realize the violence of their instinctual drives and their powerlessness in the face of the autonomous emotions erupting from the unconscious " (p. 264). The authors go onto say how vitally important it is and has been for mankind to integrate into their lives the symbol's psychic content which is instinct. The dangers threatening civilized man can be seen as the suppression and wounding of our instinctual side. Acceptance, on the other

hand, can lead to wholeness and a fully lived life. For Jung, the symbol " is an object of the known world hinting at something unknown; it is the known expressing the life and sense of the inexpressible " (p. 310).

In order to better understand the meaning behind the symbol it might help to examine some of the forms of thinking present in the middle ages which show the essential relationships of what is found in the unconscious of present day mankind. Jelliffe, (1917), maintains that the same trends are present to-day in all of us though hidden behind a different set of structures, which use different mechanisms for energy expression:

> The unceasing complexity of life's accumulations has created a great principle for energy expression___it is termed sublimation___and in popular parlance represents the spiritual striving of mankind towards the perfecting of a relation with the world of reality___the environment___which shall mean human happiness in its truest sense. One of the products of this sublimation tendency is called Mysticism . . . .Much of the strange and outre, as well as the commonplace, in human activity conceals energy transformations of inestimable value in the work of sublimation. The race would go mad without it. It sometimes does even with it, a sign that sublimation is still imperfect and that the race is far from spiritually well. (p. v)

The Kabbalah has entranced many persons from all faiths for centuries. It provides a detailed and coherent world view of the nature of human existence and our relation to the cosmos. The many complexities of Jewish visionary tradition and philosophy written in its vast texts cannot be fully examined within the body of this thesis. Instead the author will focus on the Kabbalah's psychological insights as it pertains to illness and creativity. Hoffman, (1981), writes:

> The Jewish mystical way represents another age-old body of knowledge which has long dealt with human vitality and affliction. Though frequently dismissed in the modern era as merely an outmoded repository of medieval conjectures, in several respects it has anticipated some of the most contemporary approaches in behavioral medicine. Its chief teachers have indeed been thinking " holistically " for more than a half-millennium. (p. 68)

Jewish visionaries have insisted that no matter how strictly physical a discomfort may feel, it is inevitably connected to an emotional link. Early Hasidic leaders of the eighteenth century

emphasized the precepts of modern psychosomatic medicine The Kabbalah, developed in an essentially Hebrew tradition, is based on this holistic perspective. It teaches that the best way to heal ourselves is through the confrontation of underlying emotional tensions According to Hoffman " . . .equally important is the cultivation of an unforced detachment from what we are doing, an ability to momentarily stand aside at various times during the day, and simply gain a little perspective on our whirl of thoughts and activities " (p. 72). The development of this inner quality is the surest path to emotional and physical health.

4.1 THE KABBALAH:

Rooted in 3rd century mysticism the Kabbalah is an extraordinary system of theoretical and practical wisdom designed to provide its students with a path of mental and spiritual growth According to Scholem, (1969), most if not all Kabbalistic speculation and doctrine concerns itself with the realm of divine revelations or *Sefiroth*, " in which God's creative power unfolds " (p 35) The hidden dynamic of life fascinated the Kabbalists and they always spoke of it as a language of symbols, since it was not accessible to the direct perception of the human mind. At the theoretical level, the task for the Kabbalist is the understanding of the spiritual dimensions of the universe, " while at the practical level they allow him to use the powers associated with these dimensions for magical purposes (that is for the processes of physical, psychological or spiritual transformation) " (Fontana, 1994, p. 152). The Kabbalah is so complex in structure that an understanding of Hebrew is necessary in order to study it properly. Its most accessible form is through the *Sefiroth* or Tree of Life. According to Fontana, (1994), the sefiroth explains creation

> In the act of calling the universe into being, God revealed ten of his attributes, each of which is represented in the sefiroth by a *sefirah*. The sefirah are linked together in a set of precise relationships: the path begins at Keter (the crown) which denotes all that was, is, and will be, and leads eventually to Malkhut (the kingdom) which corresponds to the presence of God in matter. The direction of the path from Keter to Malkhut, through the attributes of wisdom, understanding, mercy, judgement, beauty, eternity, reverberation,

and foundation, is governed by the three Divine Principles of Will, Mercy and Justice. In most visualizations of the sefiroth, the path takes the form of a zigzag or lightening flash as the three divine principles, which are associated with balance (Will), expansion (Mercy) and constraint (Justice), operate in turn. (p. 153)

Modern day proponents of the Kabbalah have attempted to relate twentieth century knowledge about inner processes to its long standing beliefs. Some books have found analogies between the Sefirotic scheme and Jungian psychology. Hoffman, (1981), writes that " in one such psychological format, the highest triad corresponds to the ineffable dimensions beyond us, the second triad to our own latent spiritual powers, the third to our ego, and the lowest Sefirah to our involuntary bundle of instinctual drives " (p. 58). Hoffman goes onto explain that Jewish esoteric discipline suggests that each of our attributes must be tempered by its opposite. For example, direct intellectual activity is inefficient without the capacity to reflect and integrate what we have learned. The objective of the those following the teachings of the Kabbalah must be to integrate all of our inner aspects into a harmonious whole. Jewish mystics have speculated that four separate but interconnected universes exist:

1) Aziluth or Emanation - mentioned in the ' Torah ' it represents the ten names
of God referring to different qualities of transcendence relating to our deepest inner
source which ordinarily we are oblivious to.

2) Beriah or Creation - this realm incorporates our personality and its
structure, concepts, and viewpoints.

3) Yetzirah or Formation - relates to the biological realm of the human body and
its many life functions.

4) Assiyah or Action - refers to both the corporal pains and sensual delights
that we experience in everyday life.

The Kabbalah has for centuries been profoundly concerned with the mind-body relationship. Our emotional and physical aspects are simply two facets within the same organism: they are inseparable. Hoffman, (1981), writes that " predicting by centuries the

discoveries of contemporary health scientists, Kabbalists have focused on the presence of suppressed frustration and anger, as well as severe depression, as signs that suggest oncoming bodily disorders " (p. 73). Of great interest to the author is the emphasis by Hasidic masters who related severe depression to the triggering of disease. They even pinpointed one of its major diagnostic signs: the inability to shed tears, which they carefully distinguished from normal sadness or grief. Hoffman further suggests that it seems " no act of historical chance that Freud and most of his disciples were of Jewish background, some from Hasidic ancestry " (p 74). It is important to mention that while the Kabbalah does emphasize the emotional elements of illness, it has never ruled out its more exogenous causes. Thus, the Kabbalah has for centuries incorporated bodily oriented methods of healing in combination with the psychological.

Where the Kabbalah perhaps differs from other religious and spiritual dogma, is on its respect and recognition of our sensual needs. " The Kabbalah has therefore stressed that to simply deny or repress our physical side is at best a mere subterfuge, a temporary measure. It will not work In fact, the great sages have indicated, this practice may even result in greater emotional turmoil " (Hoffman, 1981, p. 76). For the Kabbalists, sexuality has always been viewed as a basic quality in the universe symbolizing the existence of two primary influences which underlie every aspect of creation. The stern, patriarchal God-the-Father or Yaweh, has its own female counterpart in the heavenly Mother or Shekinah However this view was not supported by the non-Kabbalist rabbinical authorities who sought to dilute its powerful hold on the Jewish people. As a result almost all traces of this notion were obliterated from prayers and rituals by the start of the Industrial Age. Hoffman makes this comment: " For this reason, some Kabbalists today insist that a major cause of the decline of impassioned Jewish religious belief and worship is precisely due to this elimination of feminine images and symbols from day-to-day practices___ leaving a more barren, masculine repository of values " (p. 81). As well as acknowledging a basic respect for our bodily nature, the kabbalists were also aware of the importance of physical well-being as a prerequisite for mental expansion. Hoffman quotes an

anonymous disciple of Abraham Abulafia, who states " the Kabbalistic way of method consists, first of all, in the cleansing of the body itself, for the bodily is symbolic of the spiritual " (p. 97). Once the body is prepared then a daily regime of meditation was recommended.

The Kabbalists viewed our ordinary personality as a direct barrier to the awakening of hidden potentialities. To truly attain peace the individual should meditate on one emotional trait at a time and by confronting say ones anger through self-examination until it no longer has any power over the person. In this way one could then achieve transcendence. Kabbalists supported such techniques as relaxation therapy and guided imagery to achieve inner harmony and peace. As well they also accepted both the negative and positive aspects of the human psyche and saw the role of meditation as a way to, make visible our inner conflicts, worries, and resentments. Only by confronting our ' shadow side ' can the individual successfully achieve transformation and bring about change.

For the Kabbalists two of the most direct methods to bring forth our hidden potentialities was through music and through dreams. Today, healing professionals are increasingly recognizing this unique power of music (and other art forms), to heal both our minds and bodies. Hoffman, (1981), writes " around the globe, musicians and therapists are utilizing sound as a powerful means of combating depression and altering our perceptions of ourselves and the cosmos " (p. 165).

It is interesting to note that the didactic function of art has little importance in Judaism. However many beautiful architectural and ritual objects exist within the Jewish culture and tradition. Judaism is enriched by a great number of ceremonies designed to inspire participants and observers. Jewish ritual assumes God's special relationship to the Jews and emphasizes the religious significance of historic events. Ritual has great psychological importance for the modern Jew. Kanof, (1975), writes that " for thousands of years this unique system of ritual,

which affects every detail of daily living, has been the identifying characteristic of the Jewish

people, and has made the Jew a part of a large, great, and holy community " (p. 11). A large

number of sacred objects were developed for the performance of these rituals. In a sense

religious observance has stimulated artistic creation. Kanof goes onto make this statement:

> In the long history of man's cultural striving, the close relationship of art and religion is
> universal. Over a great part of this span, religion was the main spur to art, first in human
> and animal representations of primeval man, then in the luxuriant embellishment of the
> ancient Temple, and on through the epochs of lavish church and synagogue decoration
> Art, in turn, has been an impressive populizer of religion and its ethics and a great
> inspiration for religious feeling.
> (p. 12)

This is not to say that the use of painting and sculpture does not exist within the Jewish culture

The Renaissance marked the move away from religious art towards an expression of freedom in

creating artworks with a Jewish theme or influence but not necessarily connected to Judaism

The Kabbalists have dealt extensively with death and dying. Dying is seen as an

important stage of inner development. It is depicted as one stage in the evolution of the soul.

Hoffman, (1981), describes the ideal attitude in which to meet physical death:

> The goal is to be as lucid and self-composed as possible. The very worst kind of
> orientation encompasses fear, confusion, or outright denial. The more calm, trusting, and
> at peace is the individual, the better able he or she becomes in making a smooth and
> successful transition to the World to Come, we are told. (p. 191)

This attitude might serve useful for the more prevalent views about death which exist today both

for Jews and non-Jews alike. The rapidly growing ' hospice ' approach to caring for the terminally

ill supports this view emphasizing the right of the dying to remain as lucid and aware as possible.

The Kabbalists also believed that life continues after death. How one lives their present life

directly effects our dwelling in the next. Hoffman, explains further:

The Kabbalists thus do not posit the existence of one region of everlasting beneficence and one of eternal punishment. Rather, they consider there to be a virtually infinite number of realms___ of consciousness___ after bodily death as varied in fact, as those during physical life. (p. 195)

This idea parallels some of the ideas set forth in other paths such as Hinduism and Tibetan Buddhism where each soul must experience repetitive cycles of death and rebirth in the physical world in order to attain spiritual transcendence. The idea of life after death is not however embraced in mainstream Jewish religious beliefs. Heller, (1975), writes that the deathbed scene is " structured to give the terminally ill and dying patient an outlet for expression of natural concerns and anxieties, yet within a reassuring framework which never attempts to be deluding " (p. 40).

Today we are in the midst of a momentous transformation in the scientific approach to the human mind, particularly, the relation between our emotional and physical health has attracted serious attention. There have been many books recently written which focus on the shamanistic or sacred dimensions of human life. The notion that the cosmos is an indivisible whole is hardly foreign to Jewish esoteric tradition. Hoffman, (1981), writes that " another key Kabbalistic feature relevant to the new psychology is the age-old view that each person comprises several distinct but interrelated dimensions of consciousness " (p. 210). The chief texts of the Kabbalah insist that our emotional and physical well-being are inextricably tied to one another; in other words we are a mind and body in the same organism. " The early Hasidic masters accurately pinpointed such mental states as unexpressed anger and depression as two of the major causes of bodily illness " (p. 215). In the past few years the field of behavioral medicine has grown more aware of the vital link between our mind and our body. What has appeared as strictly mythological parts of the Kabbalah may one day find acceptance among many scientific investigators.

Jewish tradition and religious practices continue to play a vital role in the day to day living of most of its cultural members, old and young alike. Myerhoff, (1979), describes the importance and meaning of the religious holidays:

> Between Rosh Hashanah and Yom Kippur are the High Holy Days, Days of Turning, Ten Days of Awe, when the Book of Life is opened, humanity appraised, then closed for the year. This is the anniversary of the creation of the world, . . filled with possibility for joy, forgiveness and renewal. Human relations with the living are repaired. The graves of the dead are visited, blessings bestowed on children. Apples, the fruit of creation and symbol of the Divine Presence, are dipped in honey, thus ushering in a sweet year It is customary to ask for and grant forgiveness of those one has injured . .With mighty blasts, the ram's horn (shofar) trumpets in the New Year Then there is a time for reflection, atonement, repentance and judgement, ending with Yom Kippur. The names of the dead are bound up with ancestors . . .These days are a sacred interlude, a suspension of ordinary time when the human soul, the community and the year are made new and may begin again. In this interlude said one of the rabbis, " A man may acquire his eternity in one hour." (p. 273)

Religious ritual and ceremony play a central role in the lives of Jewish people. Heller, (1975), writes that " to the individual of traditional faith, death is not an end but a transition fiom one state of human existence to another " (p. 38). This does not mean that the process of dying is not without anxieties which are difficult to resolve. Judaism has always been concerned with the emotional welfare of the terminally ill. ". . . Jewish tradition confronts death directly and specifically views the period of terminal illness ("Shechiv Mera") and dying ("Goses") as a time when loved ones should surround, comfort, and encourage the patient " (p. 39). The terminal patient is encouraged to face the future realistically which includes facing the idea of imminent death. A series of practices and customs has evolved relating to death, funerals, mourning, and anniversaries. According to Pollock, (1989), Judaic formal mourning has been divided into five stages:

1) The first stage marks the period of time between death and burial This is the time when despair is most intense.

2) The second stage occurs during the first three days following the burial. During this period the mourner remains at home and does not respond to any greetings.

3) The third stage is the period of Shiva, the seven days following the funeral.
This stage corresponds to the acute mourning process which eventually leads to the chronic stage of mourning.

4) The fourth stage is the period of Shleoshin, the thirty days following the burial. The mourner is encouraged to rejoin the community without having to assume full, normal social relations. Greater awareness of the loss has taken place and slowly psychic balance is restored.

5) the fifth and last stage is the twelve-month period during which life gradually returns to the preloss state.

Jewish religious procedures are very precise and eventually formed the Code of Jewish Law which deals with particular aspects of the mourning process. These laws appear to act as a guide to aid the adaptation of the individual mourner as well as the community. Pollock writes that " In this magnificently conceived, graduated process of mourning an ancient faith raises up the mourner from the abyss of despair to the undulating hills and valleys of normal daily life " (p. 259) for groups, as well as for individuals, life becomes a continual process of separation and reunion, of change and transformation, of death and rebirth. Mourning is a transitional period for the bereaved. " They enter through rites of separation and emerge from this " transition " through rites of reintegration into society (rites of the lifting of the mourning) " (p. 280). Thus there are internal and external mechanisms for the mourner, social rites for the community, and assumed rites of passage for the dead.

4.2 ALCHEMY:

The idea of a transitional period involving separation, transition, and reintegration is central to the process of alchemy. The process of turning lead into gold was symbolic for the attainment of enlightenment. Fontana, (1994), defines alchemy in this way:" At the most esoteric level, the base metal of the alchemist was symbolic of the unredeemed self, while the gold, with its incorruptible nature and capacity to shine steadily, was symbolic of the transformed spiritual self " (p. 146). The journey to inner transformation or enlightenment known to alchemists as the

Great Work___had interdependent physical and spiritual dimensions. The theory underlying alchemy derives from the view that the whole of the cosmos including mankind, is created from a non-physical *materia prima* ___that takes form as the elements earth, fire, air, and water corresponding to sensation, intuition, thinking, and emotion. These four elements or stages of the alchemical process were signified by different colors: Black (guilt, origin, latent forces) for ' prime matter '; white (minor work, first transmutation, quicksilver); red (sulpher, passion), and finally gold. Interestingly, Jung, 1964, describes in Man and Symbols, a Jewish legend that when God created Adam, he first gathered red, black, white, and yellow dust, from the four corners of the world , " and thus Adam reached from one end of the world to the other." (p. 214).

Wilson, (1985), describes the alchemical process as one " which appears to be a natural dialectical process which is operational throughout the animal, vegetable and mineral worlds " (pp. 3-4). Alchemical theory rests on the belief that change is our only certainty in life. Cirlot, (1973), quotes Evola who writes: " Our Work is the conversion and change of one being into another being, one thing into another thing, weakness into strength, bodily into spiritual nature. . . " (p. 8). Alchemy was essentially a symbolic process involving several purifying steps which resulted in the creation of the Philosopher's Stone enabling its possessor , among other things, " to turn base metals into Gold and Silver ___the metals of the Sun and Moon___and to produce a universal medicine for all disease " (Biederman, 1989, p. 6). Wilson, (1985), describes the process of alchemy as a process of dissolution and coagulation, the separation and rejoining of the various ingredients of life. She writes.

> It is representative of the repetition of everyday experiences which accumulate to reveal, eventually, the true meaning and value of life. The dissolving and coagulating aspects of the work are representative of active and passive elements of the cosmos. seen in traditional alchemical symbolism as male and female, spirit and matter, life and death, the volatile and the inert and their various interactions. All these are understood to reach resolution in death, and so " pseudo - death " is seen as desirable voluntary isolation, fasting or withdrawal from normal experience, succeeded by a " return " to apply ones " revelations " to the material life. (pp. 70-71)

Carl Jung was among the first in this century to revive the teachings of the alchemists. He interpreted their formulas metaphorically and alchemy emerged as an eloquent model of the stages and processes of spiritual evolution. Jung, because he viewed alchemy symbolically, was able to go forward and discover its psychological meaning. Jung felt that what alchemically speaking are processes of transformation, psychologically are viewed as the process of individuation. Working within a framework of Jung's psychology, Gordon, (1978), defines the process of individuation in this way:

> Individuation aims at the achievement of optimum synthesis of conscious and unconscious process and phantasies. It leads a person to experience his own individual uniqueness together with the recognition that there are forces both within and without him that transcend personal and conscious understanding. In consequence, the process of individuation encompasses the process of individualization though it moves a person beyond this essentially ego-building process and on towards the search for values and meaning and self-transcendence. (p. 149)

In her book, The Alchemy of Illness, Kat Duff, (1993), compares her own experience with illness to alchemical descriptions of spiritual development and the initiation rites of traditional peoples. For Duff the prima materia (base matter) is " . . . that which is everywhere, unavoidable, despicable, and out of control in our lives: the diseases of our " bodies and souls " (p. 80). The alchemists, according to Duff, insisted that two things must happen before a cure can be extracted from the disease:

> The problem must be kept in a closed container, and it must be reduced to its original state through a process of breakdown. . .The isolation and lack of sympathy that sick people often endure may even be necessary to secure the walls of the container, so that nothing is spilled or shared and the matter inside will reach the point of transmutation. The walled space of illness, like therapy, intensifies the brooding and incubates the egg. (p. 81)

In the closed container of the alchemist's flask the matter is broken down and returned to its original state. Duff points out that in healing we work back through every illness we have had until we eventually arrive at the root, described as such things genetic inclination, a predilection of character or ones destiny. " These origins are almost too profound and ethereal to identify,

except in the altered states of illness " (p. 84). Four of the most basic processes that facilitate this breakdown are *calcinatio* (burning by fire), *solutio* (dissolving in water), *sublimatio* (rising in the air), and *coagulatio* (falling into earth) and are so evident in illness. These stages do not occur in a fixed sequence but rather the person moves in and out of them, back and forth, lingering longer in one stage than in another according to the requirements of ones soul For Wilson, (1985), the psychological terms which correspond to these four functions are those of thinking (air), feeling (water), sensation (earth), and intuition (fire). She likens these processes to what happens in psychotherapy " where fixed, static aspects of the personality are led back to their undifferentiated condition in order that psychic transformation might take place " (p 85) Kreinheder, (1991), describes his own experiences with illness :

> Every illness is an onslaught upon us as we are. Somehow we get so alienated from the whole of life that a very extreme invasion is necessary to break in upon the hardened formation of oneself. We must be weakened and crushed so that we will finally be so loosened and liquified that the life spirit can flow into us again To be sick is to be shut off, to be isolated . With every invading symptom there comes also a symbolic content and it is the task of the soul to expand itself so it can include the invading images and symbols. This may be a struggle, but ultimately it is not a struggle but an expansive, releasing process as we grow beyond our former boundaries.   Even if it means death, death can be handled. The object of healing is not to stay alive. It is to move closer to wholeness. Healing may take place in death, death as the final healing. (pp. 37-38)

So how do the four functions of fire, water, air and earth relate to illness? For Duff, (1993), *Calcinatio* is a burning process most evident in fevers. At the same time it is also associated with the intensity of frustrated desires " Alchemical texts assert that the process of calcinatio produces salt, which manifests as bitterness, until it is further purified into wisdom " (p 85). *Solutio* is a dissolving process that melts rigidities opening us to chaos, often with a great surge of emotion. It frequently manifests as a sense of confusion or disorientation Emotions catch in our throats and tears are common in the stage of solutio, tears of frustration, relief, sorrow, or joy. *Sublimatio* is a transcendence , a journey to a higher world Following a heart attack, Carl Jung, (1989), described a feeling of floating high in space: " Far below I saw a globe of the earth, bathed in a gloriously blue light " (p. 289). These moments of sublimatio provide a

respit from the pain and loss of illness. The final alchemical operation is *coagulatio* and relates to the element of earth representing ways in which we are bound by physical existence, by the needs of our bodies and souls. Duff, (1993), describes this process:" Under the pressure and coercion of disease, we lose the spaciousness, freedom, and ease we has come to assume in health, here we encounter the fierce limits of our destinies limits we have not chosen but must endure and be shaped by " (p. 86). The solution becomes one of acknowledging and learning how to live gracefully within limitations of illness. The four functions of calcinatio, solutio, sublimatio, and coagulatio end in *mortificatio*, which is also referred to as the *nigredo* or blackening, meaning decay or death-making. The individual may experience feelings of defeat, failure, and humiliation, which are connected to the disabling aspects of illness. The result of nigredo can be despair and depression; in a sense a pseudo death takes place within the individual. The alchemists saw this as desirable and necessary to the process, which involved a withdrawal from normal experience and isolation. In alchemical terms the matter is dissolved in its own water; " the spontaneous imagery of the psyche can be seen as its " own water ", so it is these projected depths that one turns to when engaging with alchemy, whether it be in the process or in an attempt to understand that process " (Wilson, 1985, p. 71).

Both the writings of the Kabbalah and of Alchemy emphasize that the way to wholeness is through a process of deintegration and reintegration of the self. This process occurs throughout life and particularly in periods of great crisis such as facing death or serious illness. Pollock, (1989), writes that:

> A very crucial element for successful aging is the ability to mourn for prior states of the self. When one can accept aging and its changes, and mourn for the past, the result can be a liberation, a freeing of energy for current living, including planning for the future. One frequently sees this in individuals who have experienced serious physical illnesses and then have a " rebirth " with new life perspectives. (p. 384)

In psychotherapy this process can be seen where " fixed, static aspects of the personality are led back to their undifferentiated condition in order that psychic transformation might take place " (Wilson, 1985, p. 85).

It is my feeling that the alchemical process can, when supported by current theories on creativity and mourning, symbolize the experiences of the aged adult who is institutionalized. One of the primary concerns for the elder who is confronted with such issues as institutionalization, illness, personal losses and death, is to find meaning in the dying process. Missine, (1990), writes: " This meaning is created by the values, spiritual or material, in which we believe and is connected with our basic human needs, which we all try to fulfill, whether consciously or unconsciously, each in our own way " (p. 45). The need for spiritual integration for the elder, becomes a concern to know ones place in the universe and to attempt to understand the meaning of ones existence. As Wilson, (1985), points out, if one accepts the idea that alchemy is " the pattern of all other works " (in Wilson, Cirlot, 1962, p. 8), then " an alchemical model in art therapy could adequately contain other theoretical formulations for understanding the psyche " (p. 4). Because I am a ' novice ' when it comes to understanding the complex and archaic processes of alchemy, it will be utilized here merely as a symbol for the art therapy and psychological processes which reflect the experiences of a group of elders who live within the walls of an institution. The focus will be on the possibility for change and of the transforming agents which exist within the creative process. In the following chapter I will examine some of the literature which is available in relation to the art therapy process when working with an elderly population.

CHAPTER 5: ART THERAPY AND THE ELDERLY

5.1 Group Psychotherapy:

Commonly, discussions in therapy with older adults centre on such themes as losses, family and loved ones, increasing dependency, illness, and the approach of death. Here, Knight suggests that thematic analysis of therapy can be illustrated by considering three dimensions: empowerment, enjoyment and life review. Empowerment refers to a major task for older persons in our society which is to cope with the loss of power that is a consequence of moving from middle age into the postretirement lifestyle. Many losses which the elderly experience are major losses over which they have no control: death of loved ones, illness and so on. Enjoyment refers to the concern that as the person ages life becomes lacking in pleasure. Part of the underlying work of many caregivers working with an elderly population is to provide activities which increase the quality of life. There is a therapeutic tradition which has accepted life review and reminiscence as valuable to elders' understanding of their own personal life stories. (Erikson, 1986, Butler & Lewis, 1977) Failing to develop one's own personal story can often lead to feelings of hopelessness and despair. (Erikson, 1986) Each of these themes can be applied to understanding the depression and anxiety that some elderly people experience and by implication to understanding the stresses that face all older people in our society. Sadavoy & Leszcz, (1988), have focused on the phenomenon of " mourning-liberation as an adaptational process to loss, change, and developmental progression " (p. 11) They see this process as a central part of any crisis:

> This mourning-liberation process is universal, found throughout human history, and is even present in animals in simple form. Actually, when death is the trigger, religious-socio-cultural rituals and practices designed to diminish internal and external disorganization are evident, which, if successfully completed, can result in a freed life ready to " invest energies " in new pursuits and creative activities. . . . the premise . . . is that normal aging involves a mourning for past states of self and that with liberation, one

can move forward. If this mourning-liberation does not occur, pathological mourning responses occur and serious psychopathology can emerge. (p. 11)

The mourning-liberation process was developed by George Pollock and forms the theoretical basis for my work with Jewish Geriatric residents and will be described in the next chapter. In his research Pollock, (1989), found that pathological mourning commonly involves loneliness, isolation, and helplessness and manifests primarily in the symptoms of depression, major anxieties, regression and paranoid reactions. Pollock maintained that once the mourning process is facilitated then liberation naturally follows. A crucial element for successful aging is the ability to mourn for prior states of self. "When one can accept aging and its changes and mourn for the past the result can be liberation, a freeing of energy for current living, including 'planning for the future ' " (p. 384). This accomplishment brings freedom to view the world and oneself which serves as a stimulus for regeneration. Pollock's writings are closely aligned to the writings of Hannah Segal, (1952). In her article on art and the depressive position she cites Proust who emphasized that the only way to recover his lost past was through symbolic expression: ". . .art is essentially a search for symbolic expression. The creation of this inner world, I contend, is unconsciously also a recreation of a lost world " (p. 87). The idea of restoring or recreating a lost world will be explored further in chapter six.

When a major loss or catastrophic crisis occurs this process becomes more painful and at times may require professional intervention. Pollock, (1989), connects a successful mourning-liberation process of the past as playing a significant role in ability to participate in creative activities. When the elderly person is able to detach internally from ideals, goals, and individuals who no longer exist then creative energy can be accessed. " With this traditional accomplishment, freedom to view the world and oneself in it serves as a stimulus for regeneration " (p. 387). Indeed Pollock maintains that the creative product may reflect the mourning process " in theme, style, form, and content, and it may itself stand as a memorial. " He goes onto say that " . . . in many clinical situations___ a creative outcome may be manifested

in a new real relationship, the ability to feel joy, satisfaction, a sense of accomplishment, or newer sublimations that reflect a successful resolution of the mourning process " (p. 114). Successful resolution of the mourning process may not be fully completed, but assists the individual in their attempts at restitution, reparation, discharge and sublimation.

According to Rando, (1984), social support is critical throughout the entire mourning process. She writes, " It enables the bereaved person to tolerate the pain of loss and provides acceptance and assistance necessary for completion of grief work and reintegration back into the social community " (p. 82). Group psychotherapy, for Rando, is particularly helpful in this regard. Research has indicated that there are a number of curative factors inherent to group work. (Yalom, 1986) These include: developing a sense of connection with others who have similar problems; the opportunity to help others; obtaining hope; modeling behaviours after those members who have overcome their problems; and, unconditional acceptance and a sense of belonging. Group therapy can assist the person in breaking out of the role of passive victim. Groups can provide the opportunity for older adults to make use of their expertise and wisdom restoring a sense of meaning so vital to existence. As well, it provides a safe place to share emotional reactions with peers who are understanding and empathic. According to Toseland, (1990), group therapy programs appear to have many positive effects: direct effect for individuals with organic and functional mental disorders; identification of previously neglected persons for therapeutic programs; feelings of effectiveness for staff who are provided with helpful information regarding intervention; and a sense of community gained by long-term residents of institutional settings.

5.2 Art Therapy with the Elderly:

Recent developments in science and technology have greatly increased the ability of the institution to make advances in treating the physiological needs of residents in long term care facilities. It is not enough to care for the body alone; it is essential to treat the *whole* person which includes meeting the social, emotional, psychological, and spiritual needs of elderly residents entering care. Kreinheder, (1991), describes a more holistic attitude:

> For healing we must think miracle. . . When we stand apart and look at life, analyzing it, separating it into discrete pieces, we cut ourselves off from life and we damage a vital link in the chain of being. From our detached viewpoint we conclude that A causes B, and we think we understand. We think we have knowledge. But this kind of understanding is actually the beginning of chaos because it is a false knowledge that makes us feel superior to the butterfly. In our sophistication we have lost the fundamental basis of wisdom. We have lost the attitude of wonder. And we have lost an appreciation of the miracle of life. (p. 24)

Old age presents individuals with a dilemma that they may no longer be able to conduct their lives as they did in the past. At this time an individual must make new choices and approaches in order to incorporate the changes occurring within. If appropriate changes are not made and personal issues are not dealt with then depression and illness can set in. (Weiss, 1984) Along with the internal changes that the elder person faces, he or she must also contend with external pressures and stereotypes that exist regarding ' aging ' and the dying process. Robbins, (1987), describes therapy as a " a means to refight the lost battles and to complete unfinished dialogues. " He views the process of therapy as a reflecting back on relationships that have been associated " with loss, annihilation, pain, and love, and in which the polarities and paradoxes inherent in relationships are reworked so that the painful process of leave-taking can proceed " (p.149). The process of re-sifting elements associated with past events and experiences seems to be a common occurrence within the elderly population. As such it becomes important for the art therapist to create a safe environment where a process of separation, renewal and regeneration of the self can take place.

As previously mentioned, in our society dying is something to be dreaded and feared. Weiss, (1984), writes that ". . . dying is generally seen as the sad conclusion to existence, rather than as a sacred part of life " (p. 101). The social isolation in institutions can cause the dying person to regress and withdraw. " Denial by the family, the dying person, friends, or involved staff of the psycho-social dynamics of the dying process can result in guilt, passive acceptance, and refusal to experience and deal with the reality of the situation." Weiss goes onto say that " Dying with dignity is not a passive acceptance of death or a mere resignation of the fact of death, but requires an emotional sharing by the patient, family members, and involved individuals " (p. 101). The therapeutic modality of art therapy can help facilitate an understanding of the dying process and aid the resident, family, and staff in consciously dealing with the anxiety of death.

> The fear of death in our society, the denial of families, the blind treatment in institutions___ all compound the patient's regression. A dying person often suffers an emotional and spiritual death when he experiences a loss of self-esteem and identity. The patient withdraws, becoming socially and culturally isolated and noncommunicative. This culminates in the patient's mental, physical, and emotional deterioration, binding the patient's spirit and making a child out of an adult. (Weiss, 1984, p. 102)

Weiss et al, (1989), write that the institutionalized elderly often lack stimulating and creative activity. Their study suggests that art therapy for the elderly contributes to social well-being and to learning new forms of creative self-expression. In his book on expressive therapy with the elderly Weiss, (1984), writes:

> As long as man has breath, he communicates. His voice may be silent, his language may not be understood, but he is still a living soul with a story to tell. When the traumas of life are too great people may choose to withdraw into themselves or rail at the world about them. Finding a key that helps to unlock these defenses takes sensitivity and skill. (p. xv)

Weiss views old age as a final " rite of passage " where the person works through difficulties towards a new lifestyle or attitude toward life. Old age marks the time when individuals need to reshape their lives in order to find new alternatives and a deeper meaning in life. Weiss believes

that there is a need for group and individual therapeutic activities " which promote creativity, self-expression, communication, and understanding of one's life " (p. xvii).

The creative process enables a person to uncover aspects of the self that lie hidden in the unconscious. Verbal psychotherapy is often difficult for the elderly person because the very idea of therapy may hold negative connotations. Other complications such as speech difficulties, cognitive disabilities, and other organic problems make the more traditional psychotherapies unattainable. Weiss, (1984), writes " elders who are not verbal (i.e., aphasic, regressed, withdrawn, or depressed) can find satisfaction in expressing their feelings in a nonverbal but concrete manner through writing, drawing, and other creative arts modalities " (p 26) Weiss developed six major goals which he sees as being central to the acceptance of elders, both personally and by the community or institution in which they live:

1. To rediscover the personal meaning of their inner and social lives.

2. To use their available interpersonal tools to promote interaction and
   communication with others.

3. To develop a healthy sense of ego strength.

4. To stimulate their intellectual, physical, and emotional faculties which can aid
   toward the fulfilling of their potential.

5. To review their lives and their personal perspectives, and to give further
   insight into how their personal choices impact their ways of living; to come to
   terms with conflicting and negative feelings; and to see the value of their
   individual lives.

6. To feel a " wholeness in onc's being "; to create a personal outlook of
   fulfillment and meaning in life.

A difficulty arises, however, when the goals of the therapist do not necessarily reflect the goals of the institution. Edwards, (1986), writes that " in addition to whatever else might be said of them,

institutions . . . are typically characterized by various difficulties associated with the loss of liberty, social stigma, loss of autonomy, depersonalization, and low material standards." He goes on to say that " it is within this context that many art therapists must struggle to establish and maintain a credible therapeutic practice " (p. 3). Anyone who works within the institutional environment must obviously be prepared to accommodate the needs of the team as well as the demands of the institution. At times it may feel like an impossible undertaking. Schaverein, (1985), writes " for the person whose early training has been learning about these states from theoretical discussion in books or observation, the actual responsibility of meeting and making decisions 'for' and 'about' people must throw him into confusion " (p. 3). Schaverein uses strong words when she suggests that the adjustment common among staff and patients alike in institutions is " death to creativity on any level " (p. 4). In this setting art is only able to exist within certain boundaries. Art groups are allowed to run only at set times; groups are frequently interrupted by staff; and other departments often ignore or overlook scheduling. There is a new term which currently exists within institutions called the ' therapeutic community '. Many hospital departments now use this term whether or not there is a clearly defined policy supporting its use. However, it is the authors opinion that even though the ideas behind the formation of a therapeutic community may not be successfully met, the use of this term marks an attempt to change the existing structure within most large institutions. Again Schaverein draws these conclusions:

> As human beings we are constantly changing, one of the predicaments of western people is a fear of change, this fear causes us to attempt to hold on, to control our surroundings. We fear insecurity and construct systems in an attempt to provide security. These systems develop and grow eventually becoming institutions. Institutions are unwieldy and do not easily allow for change, they become rigid and can, once thus established, lead to socialized oppression. (p. 6)

The solution for the therapist struggling with this dilemma for Edwards, (1986), is to ensure the availability of personal supervision. He writes: " Through the process of supervision. . . I have, often painfully, been able to recognize the difficulties I experience in my attempts to function effectively as a therapist are not entirely of my own making. " He goes on to say that " . .

supervision has also enabled me to reaffirm my belief that positive change is possible, in myself, in the patients I see, and in my place of work " (p. 5). Common anxieties and problems facing art therapists often focus on such issues as isolation, helplessness, and a feeling of not being goodenough in some way. It can be extremely helpful to be able to share these feelings with other art therapists who can provide emotional and professional support.

In the following section I will examine some of the main developments in the use of art therapy in groups. The pioneers of art therapy began working in groups primarily in open studio settings. Waller, (1993), writes that " art therapy groups (as opposed to studio sessions) evolved in the late 1960s out of an understanding and growing awareness on the part of the tutor/therapist of the effect of their presence on the members of the group " (p. 9). Art therapists realized that unconscious themes were often reflected in the images created by group members and resulted in the development of a powerful group consciousness. Today, all art therapy training involves some group work. Mcneilly, (1984), has written eloquently on two approaches to groupwork in art therapy, the directive and non-directive. He has been extremely critical of art therapy practices which advocate the use of themes in working with groups.

> When one embarks upon direct suggestions in theme-centered art therapy, there is a tendency to uncover, possibly too rapidly, powerful feelings which may be difficult for the individual, the group and the therapist to contain and understand . . .indeed, certain individuals may find such a direct suggestion of theme intolerable and withdraw from stating in pictorial imagery what they honestly feel. (p. 7)

McNeilly views theme centered therapy as limiting the extent to which the group may strive. He suggests that this process feeds a need within the t'..erapist for control and for structure. " Within this, the therapist spins a conscious web, although he/she may see it as an aid to allow the unconscious entry to the group " (p. 7). This rarely occurs and Mcneilly sees such an approach as the therapist's need to avoid transference and countertransference issues.

Leibmann, (1986), favours a directive approach to working in groups and felt that working in a structured way can act as a stimulus to creativity or to exploring certain areas of human behaviour. She argues that many people have difficulty in starting and that a theme can give the individual a focus Other reasons given for the use of themes are: basic insecurity and a need for structure; pressure of time; helping people to relate to one another; and facilitation of conflict within the group dynamics. She makes this statement: " it is sometimes worth being fairly specific, if the aim is to share common experiences, but not so specific that there is no room for individual choice and interpretation of the theme, at whatever level is possible " (p. 11).

The non-directive approach to art therapy does not mean that themes do not emerge. McNeilly, (1984), contends that " themes on the whole are more subtle in development, and may be stronger and more dynamic as their emergence has not been through a direct demand " (p. 8). He believes that the therapist is better able to get past the surface authority struggles which facilitates freedom for group associations and allows for " Resonance " to occur. Resonance is evidenced through collective imagery in the group. In the non-directive approach, once the group has struggled with dependency issues and perhaps initial anger and resistance " . . .then self-disclosure becomes less threatening; of their own volition people relate more to the pictures and to the feelings about the imagery " (p. 9). At this point the resonance manifests itself more deeply and personal initiative becomes more evident. Therapy, for McNeilly, is a natural process which will develop given time and space. The group develops its own identity, find its own direction and ultimately treats itself. This is a central principle of the non-directive or group analytic approach. Mcneilly describes the structure of the group in this way:

> Here each group develops its own identity within a matrix which structures and contains it. Along with this, a group cohesiveness develops, and will cement the group, leading to greater and more meaningful resonances; this process is the group's treatment of itself. With the applied use of art materials the process will be illuminated, leading to understanding of the collective imagery. Group members portray individual feelings, but what tends to happen, as mentioned earlier, is that they produce similar shapes, colors, and symbols. (p. 10)

It must be stated that there have been many criticisms of McNeilly's article as the reader might imagine. In Waller's book on group interactive art therapy, she sites the response of Roy Thorton:

> Does it not occur (to McNeilly) that themes can be used with careful thought for clinically based purposes, as suggestions, quite free of obligation, in full knowledge of transference issues, not evasively, but to create intensity, and that the technique is supported by ample evidence of fruitful, wide ranging interchanges full of meaning, with good effect. (in Waller, 1993, p.p. 12-13)

In conclusion perhaps Harriet Wadeson has the wisest comments in regards to both directive and non-directive techniques. She believes that the challenge for the art therapist is to know whether an approach should be used at all and when such an approach is necessary. She writes:

> Art therapy isn't a piece of cake. An art therapist isn't there to provide projects. If she trusts the power of the imagery and the healing forces within her client, she will allow her groups to flow naturally and organically. She will trust herself to be sensitive to their emergence so that she can foster their exploration and encourage the growth potential of the art therapy group and its individual members. (in Waller, 1993, p. 13)

Waller, (1993), utilizes the techniques of interactive group psychotherapy which originates from the work of the neo-Freudians'. She writes that " group interactive therapy focuses on the actions, reactions and characteristic patterns of interaction which constrain people in their everyday lives and for which help in modifying is sought in the group " (p. 22) The fundamental concept behind this approach is that each person creates an individual inner world which continually changes and is reconstructed as a result of interaction with others. During the groupwork the person comes to realize how inner assumptions may influence the patterns of interaction that develop. This approach is dependent upon the group members learning from each other. " The concepts of responsibility, freedom and choice are central to the interactive model " (p. 23). Each member is responsible for his/her own participation, for accepting that one can influence a situation, and that one is not a passive victim. Work is done in the 'here-and-now'

and reflecting on the past is not encouraged. However, acts of disclosure connected to both the present and the past, do occur within the safety of therapy. " The preparedness of members to take risks___ i e. to put themselves in an exposed position by behaving differently from usual___ is essential to this model's effectiveness " (p 24). Processes such as projection, mirroring and projective identification are common in this kind of a group. It becomes important for the therapist to be aware of these processes as they occur within the group and to comment on them New behaviour is tried out by the member first in the group and then later on with family, friends etc and reported back to the group. The interactive group model allows for theme oriented artwork or for more spontaneous imagery to unfold. Themes are usually open-ended and free association is encouraged. Whatever model the therapist adheres to the value of creative activity cannot be overlooked. Waller, makes this comment:

> For many people, engaging in the art-making process is in itself challenging, rewardinFg and stimulates learning. Quite often greater flexibility in using materials goes hand in hand with a willingness to experiment with relationships in the group. Many of the objects and paintings produced in art therapy groups are remarkable for their originality. Even people who consider themselves 'clumsy' and 'uncreative' can, through the group process, open themselves up to the possibilities of the art materials. (p. 40)

Decisions relating to what kind of approach one will use, goals for the group etc., depend largely on the personal philosophy and orientation of the therapist. Commenting on this Robbins, 1(987), writes:

> Thus each art therapist brings to treatment his own particular style, experience, and attitudes from the past that will have an important impact on the patient's communications. . . Both therapist and patient are in treatment within any given art therapy relationship, each struggling with his particular attachments to the past and emotional responses to each other. (p. 151)

Most art therapy groups are divided into three areas: the introduction, activity, and discussion. Session time varies, but usually is 1 1/2 to 2 hours in length. Time is of particular importance when working with an elderly population, particularly those suffering form debilitating illness that affect both physical and cognitive levels of performance. The therapist needs to

remain flexible and aware of the individual capacities of each group member. In any art therapy session, the therapist must adapt the process and therapeutic modality to the person and to the situation. Weiss, (1984), maintains that " the development of trust, acceptance, and good faith between the client and therapist aids in honest and open communication " (p. 27). There is no one preordained method of conducting therapy. The therapist needs to determine which media is most appropriate; the setting; the use of individual or group sessions; the use of music; the structure of the group; and other elements relevant to the population and to the therapy session

When working with an elderly population the goals of art therapy are to facilitate creative self-expression; to promote socialization and meaningful dialogue (both verbal and non-verbal); to encourage reflections of the elders' lives and processes; to support elders in establishing a sense of community; and to facilitate feelings of self-integrity and self-esteem (Weiss, 1984) By focusing on t · ; elders strengths not weaknesses, disabilities can be transformed. The group context reinforces a sense of community, sharing and offers support from peers. Weiss, eloquently describes the art therapy group process:

> Metaphorically, the therapist must be the watchman in the forest for the traveller in the night: the traveller is the participant expressing his feelings and thoughts, coming to his sense of self. The therapist needs to guide the journeying client until the traveller finds his own light to brighten the path in the forest. (p. 44)

Part of the research for this thesis has focused on the evolution of man's need to find expression of his life experience (including death) through use of symbols and images. As previously stated, Gordon, (1978), has written extensively on the universal origin of death myths and imagery. She discovered that people throughout the world have been aware, even if only semi-consciously, that death and creation are inextricably intertwined She writes.

> Images, symbols: it is true that through these we relate and we commune with ourselves and with each other, about all that is most meaningful, but also intangible, to us. They are of the essence of the language of art, of the essence of the language of religion, folklore and dream, and of the essence of the language through which analyst and patient communicate. (p. 106)

The symbol in psychological interpretations has been connected to affect and feeling; it is frequently described as a bridge linking the strange with the familiar, unconscious to conscious, soma to psyche, the fragment to the whole and reason to passion. (Gordon, 1978) Jung believed that symbols contain a spiritual element which is an organic part of the psyche. " The spiritual element which urges us on the quest for the unknown and the unknowable is the organic part of the psyche, and it is this which is responsible for both science and religion " (in Singer, 1994, p. 392). The symbol, according to Singer, directs individuals towards " a way of becoming " and the goal is towards wholeness, " which is integration of the parts of the personality into a functioning totality " (p. 392).

The process of creation will always contain an element of mystery. Gordon, 1978, cautions us that it is important to consider the difference between the creative process and the creative product. She writes:

> Essential to and underlying the creative process is the search for meaning andmeaning, . . . evolves out of a synthesis of the process of differentiation and ordering on the one hand and the making and discovering of something new on the other. It is thus inseperable from the capacity for awe and wonder and from the courage to be genuinely available to any kind of experience, however unfamiliar, new, bewildering or unknowable it may be.
> (p. 130)

Using Gordon's four stages of the creative process the author will discuss the creative work of a group of elderly people who reside in a geriatric hospital centre. The four stages are: 1) the *prepatory* stage; 2) the stage of *incubation*; 3) the stage of *inspiration*; 4) the stage of *verification*. Engagement in the creative process depends on the ability to mobilize seemingly opposing but reciprocal qualities: " activity and passivity; consciousness and unconsciousness; masculinity and femininity; receptivity and productivity " (p. 130). It is this capacity to live with paradox and in the search for meaning, to keep oneself available to experience sudden moments of awe and illumination that enables the person to create.

CHAPTER 6: The Creative Process

As previously stated, for the purpose of this thesis it is my intent to use the alchemical process as a metaphor to demonstrate the capacity for transcendence in the art therapy pr..ess used when working with an elderly population living in an institution. Within this alchemical framework, the mourning process will be explored in depth. Because of the isolating factor that exists when an individual enters any long term care facility it is my feeling that the institution, the art therapy process (the relationship between client and therapist and the art work), and the psychic work carried out by the clients, reflect the purpose of the alchemical vessel - the vas bene clausum. (Newman, 1981, Wilson, 1985)

In alchemy the purpose of the vessel or vas was to create a closed and isolated system (isolation is referred to in the existential sense of aloneness). Newman, (1981), writes that " the purpose of the vas bene clausum was to 'protect' what is within from the intrusion and admixture of what is without, as well as to prevent it from escaping " (p. 229). In other words the function of the vas was to contain what was taking place or about to take place in the therapy - transformation - from escaping and reverting back (regressing) to its former state or condition For Newman, the vas is both the container and that which is contained, it both contains the process and is the process. In terms of psychology the vas with its ability to contain and hold the contents intended for transmutation and " likens itself to the psyche housing the conscious and unconscious contents of the personality " (p. 230). The psyche is both the vessel containing the contents as well as being that which undergoes the transformation. With its potential as a holding, enclosing container, the vas has inspired some analysts to visualize it as a symbol for psychotherapy itself. Newman maintains that the vas bene clausum relates to both the psyche and to psychotherapy. " For as we find it illustrated, there is not one vas bene clausum, but three___ each one nested inside the other " (p. 230-231). Here Newman refers to an illustration

from Jung's writings on psychology and alchemy which shows a small, innermost vessel contained in a larger one, which in turn is enclosed in a third, larger vessel. He writes:

> In some attempt to bring order to this multiple image of the *vas bene clausum* we might, psychologically, see the innermost vessel as that of the individual psyche and personality of the analysand in therapy. The second vessel would then correspond to the therapeutic setting that the analysand and analyst create between themselves. The third and outermost *vas bene clausum* may well symbolize the *vas rotundum* which analysts related to the world-soul, or cosmos, that encompasses the physical universe from outside. (p. 231)

Newman points out that it is the existence of the third outermost vessel that makes personal psychotherapy and its processes more than an individual matter. " It does this by firstly having direct and indirect consequences on the immediate environment that the analysand comes into contact with: individuality (is) the full flowering not only of the single individual but of a group, in which each adds his portion to the whole " (in Newman, 1981, Jung 10, p. 238). Newman furthers this idea when he writes that on another level it becomes:

> . . . a Cabalistic vision of another phase of creation achieved not through the efforts of any one being, not even a Messiah, but attained only when each individual personality takes part in the re-creation of the shattered (dissociated) reality God himself has brought about. (p. 231)

For the purpose of this thesis I will be using Newman's model of the Vas Bene Clausum as representative of the group (clients) psyche as the innermost vessel; the art therapist and the group process as the second vessel; and the institution and the outside environment as the third, outermost vessel.

6.1 Vas # 3: The Institution

The hospital, a 387 bed establishment situated in a residential suburb of a large city offered residential care to an elderly, Jewish population. Admission to the hospital was made via a central admission criteria created by the government. The average age of the residents was 86 years old. The residents received 24-hour care and were offered a variety of health care services as well as therapeutic programs which included: physiotherapy, occupational therapy, and more recently music, drama, and art therapy.

Many of the residents and surrounding community members viewed this facility as the " end of the road " or as a place to die. This feeling held a certain truth in that most, if not all resident's do die within the institutional walls and indeed the hospital became a final resting place before death. For many of those admitted whether voluntary or otherwise, there was a great stigma attached to being a resident in the institution. Brearley, (1977), writes that " admission to any form of residential or institutional care implies that the individual has in some way broken out, or broken down, in his previous life " (p. 51). Most residents admitted to the hospital were coming from a situation of crisis or breakdown and had already experienced a set of losses prior to entry into care. This is not to imply that they had failed in their outside life, but rather these people were all dealing with chronic and/or terminal illnesses which had created insurmountable barriers resulting in a need for 24 hour care by trained medical staff.

As previously stated admission to care and its effects on an older population will cause a number of losses which can result in distress, anxiety and a distortion of relationships. (Brearley 1977) It is important to note that the institution also impacts on the therapist working in this environment. Edwards, (1986), writes that:

> Although the problems these institutions create for workers and residents alike may appear intractable they must never-the-less be faced honestly. For unless they are

nothing will change and the already inadequate services provided by them will continue to deteriorate. (p. 3-4)

As a creative arts therapist, my working experience prior to being hired at this hospital took place in a small, psychodynamically oriented therapeutic community for children and adolescents. The change from working with children to working with the elderly was both a challenging and a somewhat daunting prospect. My initial response to beginning my new position was one of enthusiasm and excitement in the opportunity of working with a new population. My position involved taking over the work of a former art educator who worked with groups on several wards contained within the hospital. Her method of working involved the use of pre-drawn images, sometimes selected by the residents, to which colour would be added. She had worked with several groups for a period of 4 years and had left abruptly due to illness. Thus there was no closure for her, noi the residents and the staff she had worked with. As a result setting up the art therapy program was difficult and in the beginning the resistance to change was very strong. The other art therapist at the hospital worked mainly on an individual basis with residents and we agreed that I would continue to work primarily with art therapy groups. Very quickly and much to my surprise, I found myself feeling frustrated, angry, and increasingly isolated. At the same time, I was overwhelmed by the degree of deterioration and depression of the residents themselves and the reality of being in close proximity to death. Edwards, (1986), mirrors my own experience when he writes:

> I felt awful, especially as I found it difficult to reconcile my feelings with those of the caring and committed therapist I had thought myself to be. The struggle which I was engaged seemed to be one not so much concerned with applying and developing the skill of ' therapeutic attitude ' acquired during my training, and previous experience, but with the more immediate problem of my own psychological survival. (p. 4)

The frustration experienced in coping with the institutional hierarchy, scheduling difficulties, attending team meetings, writing reports and seeing a maximum number of residents combined with my own personal responses to illness and death left me feeling increasingly isolated and fragmented.

In the alchemical sense the institution as the third vas separated myself, other staff, and the residents from the outside world. I recall that the short walk from the bus to the hospital became a passage into the container which often promoted such sensations as a physical tension, a seizing up of my body (as when you hold your breath), and in the beginning, feelings of anxiety and despair fought with hope and belief in my ability to be a ' good-enough ' therapist. Machtiger, (1982), writes of the therapist's attitudes in a treatment situation, " The analyst must constantly deal with a barrage of feelings that include anxiety, frustration, rage , and omnipotence " (p. 95). The institution can either support the healing process by providing a variety of therapeutic opportunities creating what Schaverein, (1985), would call a ' therapeutic community ' or it can offer little in the way of therapy, adhering more closely to the ' medical model ' of treatment. Edwards, (1986) writes of the difficulties facing therapists who work in institutions where the ' medical model ' dominates the theory and practice of patient care:

> There is evidence to suggest that in some instances the emotional toll may prove too great, with unwillingness on the part of the institution to accept what is on offer leaving to find more favourable employment else-where, or remaining behind only to become increasingly detached from the original meaning or purpose of their work. (p. 4)

For any professional working within an institution an endless list of stress related difficulties could easily be compiled. Staff shortage, long hours, client needs, demands of the institution regarding performance and productivity, all serve to increase the anxiety of all who work within the hospital walls. At the same time there is an effect of feeling isolated, that ones' experience is unique. Edwards points out that ". . . it is essential (that) the therapist finds ways of coping with the demands placed upon him or her that are not defensive and destructive " (p. 5). According to Edwards, common anxieties experienced by therapists include feelings of separation, helplessness, and a lack of personal resources. Of primary importance is the availability of emotional support, particularly through personal supervision. For me emotional support was experienced in my relationship with the other art therapist working at the institution as well as private supervision outside of the work site. The value of supervision as a place to discuss client

work and the countertransference issues that it evokes as well as the institutional demands on the therapist cannot be overlooked.

Because art therapy can be considered as a relatively recent addition to other forms of psychotherapy, it was not surprising to find that a certain amount of confusion existed as to what art therapy was and how it could function within the institution. As such communication with many staff members, head nurses, physio and occupational staff was extremely necessary and vital to the success or failure of the art therapy program. Even with presentations, team meetings and personal communication, there were frequent scheduling difficulties and interruptions during group sessions. Schaverein, (1985), describes the limitations of the institution:

> Thus art groups are allowed to run between set times and patients have little opportunity for self-exploration without staff presence. As elsewhere in the hospital, in the art room there is no privacy, nowhere to be alone, there are no quiet or secret places and a therapist is required to be present to satisfy administration. Interruptions are common, usually by staff requiring an interview with the patient. (p. 5)

Taking over the art groups and attempting to begin the transition from pre-drawn imagery into a more spontaneous way of working was resisted both by staff and initially, by the residents. As well there was a great difficulty in establishing a closed art therapy group. I felt that before any meaningful therapeutic work could take place, the sessions should have minimal interruptions. This idea directly connects to the alchemical sealing of the vessel or vas. The prima materia is then ". . . placed in a sealed vessel or " philosopher's egg ", and heated at a constant temperature over a long period of time " (Fontana, 1994, p. 149). The process cannot take place unless the vessel is closed just as in art therapy the work of therapy should take place in a safe ' contained ' space.

Along with the problems in establishing a closed art therapy group, I had to struggle with my responses to the residents who were desperately ill and facing death. In the first year two

group members died, forcing me to question my own feelings regarding death and dying. According to Duff, (1993), therapists as well as doctors can be filled with " a sense of diminishment " when faced with the unknown and the incurable. Frustration, anger and despair may be experienced because there is no hope of a cure. Somehow, despite private feelings of despair and isolation, I had to find a way to persevere. It was here that support from others in the form of personal therapy and supervision was to prove invaluable to me, especially in those early days.

In the alchemical sense all of these feelings are indicative of the *nigredo*. The individual begins to " work in earnest and an ability to tolerate paradox must be cultivated " (Wilson, 1985, p. 88). The idea is to work with the four elements of fire-*intuition*; air-*thinking*; water-*feeling*, and earth-*sensation* until a move out of the depressive condition towards ' wholeness ' (in the Jungian sense) can be achieved. Wilson, (1985), writes that " in the course of the nigredo the subject is purified by means of repeated dissolutions, distillations, coagulations and solidifications until it becomes a pure mercurial substance " (p. 84). The alchemists refer to the *Opus* or great work which has its natural stages of evolution. Beginning with a letting go of conscious ego controls, the individual begins a descent into the *nigredo* where a number of often painful processes are experienced. This descent is often preceded by a depression (Wilson, 1985) The problem is then worked in the closed container and if the individual is able to find the strength and courage needed to stay with the process, then the result brings transformation and growth followed by a re-entry into life. The challenge for me was to find a way to create that closed container so that both myself and the residents could begin the work. Before discussing the art therapy process which did in fact evolve, I would like to briefly review some of the information from Chapter 2 to describe the resident's experience coming into the third vas: the institution.

6.2 The Resident's Experience:

The hospital staff most often deals with a patient's physical condition which is very demanding in this kind of a setting. Many resident's required 24 hour care which began with dressing and feeding some residents, getting them to physiotherapy etc., cleaning rooms, giving medication, mealtimes, and putting them to bed at night. Along side of these duties are team meetings, nurses meetings and writing progress reports. It is no wonder that most hospital staff may overlook emotional trauma and the emotional/ spiritual needs of the residents. Weiss, (1984), writes that " although such nurturing is an essential aspect of long-term health care, it is not always provided in the nurse/patient relationship ". He goes on to say that the hospital can truly aid the elder's need for nurturing through " a creative, loving relationship, which each health care worker, treatment team, and institution needs to mutually discover and examine " (p. 18). Conversely the meeting of basic physical and security needs routines, and ward rules are an intregal part of the functioning of both the nursing staff and the residents.

For the residents entering care, loss of identity, loss of control, and loss of a sense of purpose in living were main issues perhaps directly connected to being institutionalized. As well, a mourning for past selves which included the loss of loved ones, loss of home, loss of autonomy, and loss of physical well-being was underlying the often negative responses to the institution. Another difficulty for the residents was living in close proximity to the dying. Some residents were bedridden, often in physical pain; others were suffering from cognitively debilitating illnesses such as Alzheimers.

Old age has been described as a time when the individual looks back on life and reflects upon its experiences. " There is an attempt at an emotional integration of all of the aspects of one's life with the construction of meaning and acceptance of one's one and only life as something with dignity and uniqueness which could have been lived in no other way " (Rando,

1984, p. 247). This optimistic view of aging seemed impossible for those residents first entering the institution. Entering care required special adjustments, one of which involved the adaptation to being ill. Brearley, (1977), writes that " Illness or a disability may cause extreme anxiety: the sick role may be rejected and individual reactions may follow a variety of pathological patterns (denial, regression, withdrawal etc.) " (pp. 63-64). If the elders emotional needs are not met then despair and depression follow.

After conversations with many residents I came to understand that not all of the elders were at peace with their coming death. There is a myth that exists, one which leads many to believe that when you get old you are accepting of death. I found many elders who were fearful and/or in denial of death; while others viewed death as a release from their suffering. There were those who asked such questions as " What did I do to deserve this ? " or " Why me ? " What I discovered was that for most everyone death and illness was an important issue, one which all the residents needed to talk about and needed to be heard. Rando, (1984), suggests that therapeutic intervention should facilitate an elders attempts to face death in an appropriate and empathic manner.

Within the institutional container of the third vas my goals for art therapy unfolded. I needed to establish a safe, secure environment in which the elders could recover from the crisis of admission, work through the problems that preceded it and as Brearley, (1977), describes " initiate and sustain a process of holding and support which maintains a satisfying, continuing life, and in which growth and development are at least a possibility " (p. 67). It would seem appropriate at this point to turn now to a discussion of the work of art therapy and the Jewish residents that were involved in its process. They and myself constitute the idea of the middle and innermost vas and will be discussed simultaneously in the following section. However before I begin to describe the art therapy process, I would like to briefly speak about the importance of cultural identity.

6.3 The Jewish Culture:

In any situation where an art therapist is working with another culture he/she must develop an approach to therapeutic art tasks through an understanding of the spirituality and values of those with whom she is working. Many of the resident's residing in the hospital originated in Eastern Europe and Russia. Most had arrived in Montreal as young children or were first generation Canadians whose parents had to flee Europe because of the Holocaust. Some were Holocaust survivors. For the Jewish people the word *survivor* takes on a special meaning. Their decision to leave the homeland, to break with family, home, and community, ensured the future of their children. They had escaped extinction; virtually all those who stayed in Europe were killed in the Holocaust. Myerhoff, (1979), describes the consequences of their decision:

> In the drastic decision to leave their natal homes and countries, they were exchanging life in the Old World for a new life. It was a trade-off - America brought them gains and losses. They gained freedom but lost their sacred traditions by this move. They gained physical safety and security for themselves and their children but lost their families of origin and communities; they gained access to educational and economic opportunities for their progeny but ultimately this led to severe separation from the following generation, and eventually contributed to their present physical and cultural separation from their children. (pp. 105-106)

The most important single discontinuity of these elder's life was the dissolution of the family as they had known it from its roots in Eastern Europe and Russia. Myerhoff, describes the breakdown of the stable family group experienced by many elders in this way: " in one sudden leap the . . . elders went from a steady, coherent, predictable folk world, guided by a tight, consensus of family, rabbi, and community; into an entirely different world " (p. 109).

Israel is perhaps the one unifying element that continues to provide a common ground for all Jewish people. Since the Holocaust, Jewish people perhaps came to equate their survival as a people with the survival of Israel. " Israel was like the Great Tradition in that it linked Jews everywhere despite their diverse cultural backgrounds, and as such it transcended the very

particular, local manifestations of Judaism in the form of the Yiddishkeit " (Myerhoff, 1978, p. 97). The halakhah is the Jewish way of securing and perpetuating the Jewish way of life. It is the means by which the concepts and values are applied to everyday living. Rabbi Donin, (1972), quotes Segal who describes the halakhah in this way:

> We remain Jews not because we are members of a philosophical society with superior principles. . . We remain Jews because we are part of the community of Israel, which has agreed to live its life as a separate community, for all time, in obedience to God. To be sure, certain ideas flow from this premise. But our existence is defined by the fact of the covenant (with its necessary implication of Torah, and halakhah, or Law); it is not defined merely by ideas. (p. 31)

In everyday life there is an emphasis placed upon justice, upon compassion and kindness. These qualities became the distinguishing hallmark of Jewish communal life. The family is the core of Jewish society and a centre of its religious life. Donin, (1972) writes : " If the home is strong in Jewish values, stable and healthy, then all of Jewish life and all its institutions. . . will be alive and vibrant " (p. 121). An important part of the Jewish community is the synagogue. As an institution, it provides for certain functions required by faiths namely prayer, study, community affairs, and welfare activities. In addition to the daily way of life there are Holy days, festivals and appointed sacred seasons, special occasions which add colour to Jewish life. These special days constitute additional avenues by which the Jew takes cognizance of God's role in nature and history, and by which the Jew identifies with the land of Israel and Jerusalem, the Holy city. They embody the deepest yearning and values of the Jewish people. (p. 208)

The art therapist who works with any cultural group needs to be familiar with the customs, values and spiritual beliefs of that group. While expressing, exploring and clarifying personal and collective beliefs clients can begin to see how they fit into their culture which creates a sense of belonging. This idea is of primary importance for the therapist who works with the institutionalized elderly who experience not only isolation from the outside world

(community); but who also have lost, to some extent, a sense of identity on a personal and/or cultural level.

6.4 VAS # 1 & 2: The Elders, the Therapist & the Creative Process

In the morning of life the son tears himself loose from the mother, from the domestic hearth, to rise through battle to his destined height. Always he imagines his worst enemy in front of him, yet he carries the enemy within himself-- a deadly longing for the abyss, a longing to drown in his own source, to be sucked down to the realm of the Mothers. His life is a constant struggle against extinction, a violent yet fleeting deliverance from the ever-lurking night. This death is no external enemy, it is his own inner longing for the stillness and profound peace of all-knowing non existence, for all-seeing sleep in the ocean of coming-to-be and passing away. Even in his highest striving for harmony and balance, for the profundities of philosophy and the raptures of the artist, he seeks oeath, immobility, satiety, rest. . . If he is to live, he must fight and sacrifice his longing for the past in order to rise to his own heights. And having reached noonday heights, he must sacrifice his love for his own achievement, for he may not loiter. The sun, too, sacrifices it greatest strength in order to hasten onwards to the fruits of autumn, which are the seeds of rebirth. . . The neurotic who tries to wriggle out of the necessity of living wins nothing and only burdens himself with a constant foretaste of aging and dying. (in Gordon, 1979, Jung, p. 107).

The symbol has frequently been described as a bridge, linking the strange with the familiar, relating conscious to unconscious, soma to psyche, the fragment to the whole, and reason to passion. Jung believed that symbols are the " natural language of the unconscious " and they are " the best possible expression with which to describe relatively unknown and complex fact, which, though experienced as existing, is not yet fully grasped by consciousness " (Gordon, 1978, p. 107). Jung felt that the capacity to symbolize was a process that enabled the individual to create transitions from one attitude to another and so helped the person to transcend an existing stage of development or experience. But if the person was unable to activate this ' transcendent function ' then the symbolic content would remain ineffective in terms of stimulating growth and change. Gordon eloquently expresses the process of true symbolic activity when she writes:

. . . it links the past to present, the private and unique to the social and cultural, and archetypal processes to ego processes; and thus it becomes a bridge between the forces in the service of ego-making and the forces in the service of ego-transcendence And through the symbol, history___ both personal and collective ___is transformed into relevant and experienced actuality, private emotions and phantasies become sharable forms of communication, personal experience can expand into collective experience, and collective experience can condense into personal experience. (p. 125)

For Gordon, the role of the therapist becomes that of a facilitator, mediating his/her client's symbolic experience which involves the emergence of opposing psychic forces: wishes for death and fusion (non-differentiation), for identity and uniqueness (differentiation), towards the emergence of genuine creative work, life styles and personal growth.

6.5 The Group Members:

Weiss, (1984), chose to substitute the word elder for the term geriatric patient or old person and I have done the same. As with the Native Aboriginal people the word ' elder ' implies wisdom, respect and dignity. In my own experience of working with an older population of elder's I have found these qualities to be true. Weiss, in his commentary to Expressive Therapy with Elders uses this definition:

> An Elder is a person who is still growing, still a learner, still with potential and whose life continues to have within it promise for, and connection to the future. An Elder is still in pursuit of happiness, joy, and pleasure, and her or his birthright to these remains intact. Moreover, an Elder is a person who deserves respect and honour and whose work it is to synthesize wisdom from long-life experience and formulate this into a legacy for future generations.(p.xix)

Erikson, (1986), asks the question that confronts every individual who is faced with old age: " How, on the basis of a unique life cycle and a unique complex of psychosocial dynamics, does each individual struggle to reconcile earlier themes in order to bring into balance a lifelong sense of trustworthy wholeness and an opposing sense of bleak fragmentation " (p. 55) ? Within the hospital setting many elders were struggling with this question___ most on a daily basis. The elder is challenged to draw on t\.e life cycle perhaps more than any other developmental group. Erikson writes:

> Burdened by physical limitations and confronting a personal future that may seem more inescapably finite than ever before, those nearing the end of the life cycle find themselves struggling to accept the inalterability of the past and the unknowability of the

future, to acknowledge possible mistakes and omissions, and to balance consequent despair with the sense of overall integrity that is essential to carrying on. (p. 56)

In early groups there was much evidence of depression and despair among the Elders. (Figs. 1 & 2) The image seen in figure 1 was created by a woman just following her admission to the hospital. She had suffered a massive stroke which left half of her body paralyzed and also left her aphasic. In the sessions she frequently broke into tears and would become very anxious. She initially refused to draw, but came regularly to the sessions This was the only image she drew and it seemed to speak of the despair and depression she was experiencing. Following the creation of her image she began to cry. The group attempted to support her, but she refused to acknowledge the support offered. She did not attend the group again and I did not force the issue. However, during the previous sessions I discovered that she loved music and I recommended that she be referred for music therapy. Again there was very little response or change. Singer, (1972), writes: ". . . the analytic effort may at times put the analysand under a great deal of emotional strain. . . If it appears that he is not able or willing to sustain the additional burdens of increasing consciousness, he ought not to subject himself to the rigors of . . . analysis " (p. 152).

In figure 2 a different story unfolded. This woman again suffered from the debilitating effects of stroke, as well as other gastro-intestinal complications which left her in a great deal of pain. Before coming to art therapy this resident would sit out in the hallway and cry out " Help me, somebody, Help me ". She was often ignored by the already over-burdened staff who felt that they had done everything medically possible to help this woman In group she created this image which she entitled " My pain ". Miller, (1982), writes that " the visual arts are also able to express abstract qualities and feelings with great precision, and one of the most common feelings, and one of the hardest to describe, is that of physical pain " (p. 133) In subsequent sessions she continued to work on her pain and gradually she began to create
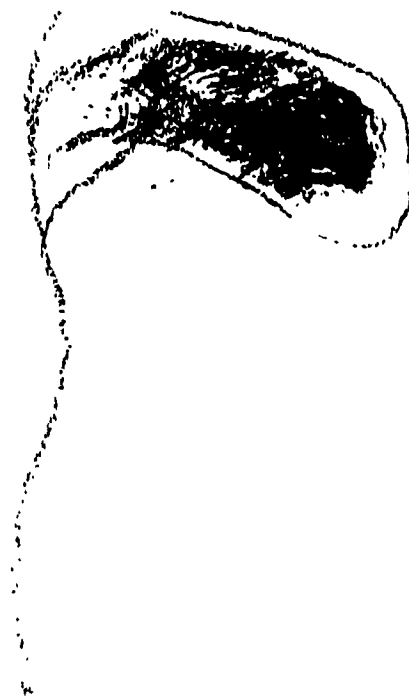
images filled with color and life. Although she remained very ill, her crying out behaviours decreased and she gained great satisfaction from the art therapy process.

For most of the group members there was a sense of an internal struggle taking place within each individual. Duff, (1993), writes about illness in this way " The struggle to counter the forces of decay is all-consuming, wearing and exhausting; . after a while death begins to look appealing___the promise of an end to the struggle, and the peace of repose" (p. 62-63). Many group members seemed locked in memories of past lives and experiences, others were thrust abruptly into the here-and-now by their pain and suffering, and still others had lost their capacity to hold on to any memory whatsoever, having only the moment to grasp onto. Some wondered how this had happened , how had they gotten here there was evidence of feeling guilty and somehow responsible for their illness and bitterness over being institutionalized. Issues of abandonment, anger over entering care and a mourning for past self was highly evident.

Elders who live in long term care facilities are looking for what Wiess, (1984), calls " surrogate relationships to substitute for the pain and loss of intimacy and caring within their life " (p. 18). This creates a dilemma because one of the difficulties of institutional life is the formation of satisfying relationships. A fear of intimacy may appear in conjunction with a person's lessening of confidence, a lack of trust in the environment, in the staff and other residents. Placement in hospital translates into the confrontation of many new and confusing elements, conflicts and personal issues which Weiss describes as: " facing the fact of one's own mortality by the recognition that in other patients are sick and dying; taking a risk in becoming intimate with someone who may die. . . and living in an environment where most relationships and activities are generally superficial " (p. 19).

Some of the recently admitted residents I worked with had retreated into their own world, becoming isolated and cut off from their environment and from those who lived within its walls.

(fig. 3) i his image was created by a woman suffering from early stage Alzheimer's disease and other physical complications. Her comment about this image was " She's lost, I' m lost " Her image powerfully expresses the isolation and loneliness that she was experiencing. This resident was considered to be a ' nice old lady ' as she required minimal care, was compliant and quiet. It was not unusual to find her sitting alone in her room. Harlan, (1990), writes that " person's in the beginning phases of Alzheimer's disease are frequently aware of the immense losses which they are experiencing . . . " (p. 100). She goes on to say that

> . . . drawing and painting can be a vehicle for communicating what words can no longer describe. In offering pleasurable activities while remaining attentive to the pain of their disease and to the ongoing struggle for autonomy, the art therapist can give these persons an engaging and meaningful opportunity for self-expression (p. 104)

This woman went on to create other images and became a part of the art therapy group As well, she was encouraged by staff to attend other activities within the hospital which enriched her life and brought her out of isolation. The need to feel autonomous, that one has some purpose in living, and the search for meaning in existence are primary concerns for the elderly Pollock, (1989), writes of Jung's observations of his older patients:

> Jung noted that about a third of his older age patients were not suffering from any clinically definable neurosis but from a feeling of the senselessness and aimlessness of their lives. . . Most importantly, Jung suggested that people in the second half of life no longer needed to educate their conscious will but needed to experience their own inner being. . . the goal was to acquire an inner stability and a new trust in themselves. (p 350)

In order to find this inner stability which Jung refers to, the group members needed to be able to become active agents in their own process or healing. The institution, with its reliance on schedules and routine often fostered dependence and passivity. The unconscious message from well meaning staff became one which implied " it is better for me to do this because you are not capable ." Weiss, (1984), makes this comment· " A person who "helps people" in an over-zealous or time-saving manner may actually be crippling a person by doing his tasks for nim " (p 21). The therapeutic attitude in the group involved helping each elder to recognize his/her

situation which included the focus on individual strengths as well as moving towards an acceptance of the limitations that illness brings; offering choices and alternatives; and providing a safe place to explore and share feelings through the image-making process of art therapy

Gordon, (1978), has written that the search for meaning is essential to the creative process. For Gordon, meaning " evolves out of a synthesis of the process of differentiation and ordering on the one hand and the making and discovering of something new on the other. This process, and in particular the incubation phase, aligns itself to the alchemical process of transformation. Wilson, (1985), makes this comment about Gordon's stages of creativity. " She links the incubation phase in art production and in psychotherapy with depression, sadness, despair and a possible living out of these themes of torture and death ___ all Nigredo experiences " (p. 164). In the following discussion I will utilize Gordon's stages of the creative process and the alchemical process to act as framework for the art work and personal experiences of a group of elders with whom I worked. In order to do this I will focus on the work of one of the group members to describe both the group and individual experience of working within the art therapy process.

6.6 The Prepatory Stage:

The group came into being after many hours of organizing and consultation with both staff and residents on the fourth floor of the institution. To assist me in the running of the group, I relied on help from volunteers, resident's companions, and if possible an art therapy intern. Time allotted for each group was two hours with the group meeting once weekly for art therapy It was comprised of ten female residents who had all expressed a willingness to enter into the image-making process; some members had previously been involved in art through other programs in the hospital. Most group members were considered cognitively ' alert ' but suffered from severe

physical limitations that such illnesses as Parkinson's disease, and Stroke bring on. As well there was some evidence of organic disorders due to brain injury and early stage Alzheimers'. Most of the members were wheelchair bound and some had hearing, speech or visual problems. All of the members could be described as experiencing emotional crises due to serious changes in their lives which included the loss of intimate relations and self-identity. The goals of art therapy were modeled after Weiss, (1984), recommendations: to foster creative expression; promote socialization and meaningful dialogue; express and deal with conflict and feelings, facilitate life review; enhance a sense of belonging and of community; and to develop feelings of mastery and self-integrity. (p. 28)

In the prepatory stage " conscious ego control and the differentiating functions predominate; knowledge and relevant skills are acquired; the problem poses itself and challenges to battle " (Gordon, 1978, p. 131). As I have mentioned the transition from exclusively pre-drawn images (fig. 4) was very difficult. This image is typical of the kind of work that members had been used to doing. While choice of image and colour can give the therapist some ideas as to what a person may be feeling or experiencing, I believed that they did not encourage a deeper exploration of each elders inner feelings and thoughts. In fact the addition of what I felt was a painful sun/moon motif indicated that this resident, could indeed create her own personal symbols. This woman repeatedly used this particular symbol in almost every drawing that she created. In this image the member was not yet ready to give up conscious ego control necessary for entering the second stage of the creative process___ incubation.

Crosson, (1976), contributes the difficulty that elders have with spontaneity to depression. " Depression is so pervasive among nursing home residents, whether or not they are stroke victims, and its effects in impeding spontaneity are so strong that an art therapist working in a nursing home must think about how to deal with it. " Crosson goes on to say that the art therapist can learn to work with the limitations that the elders experience by " developing
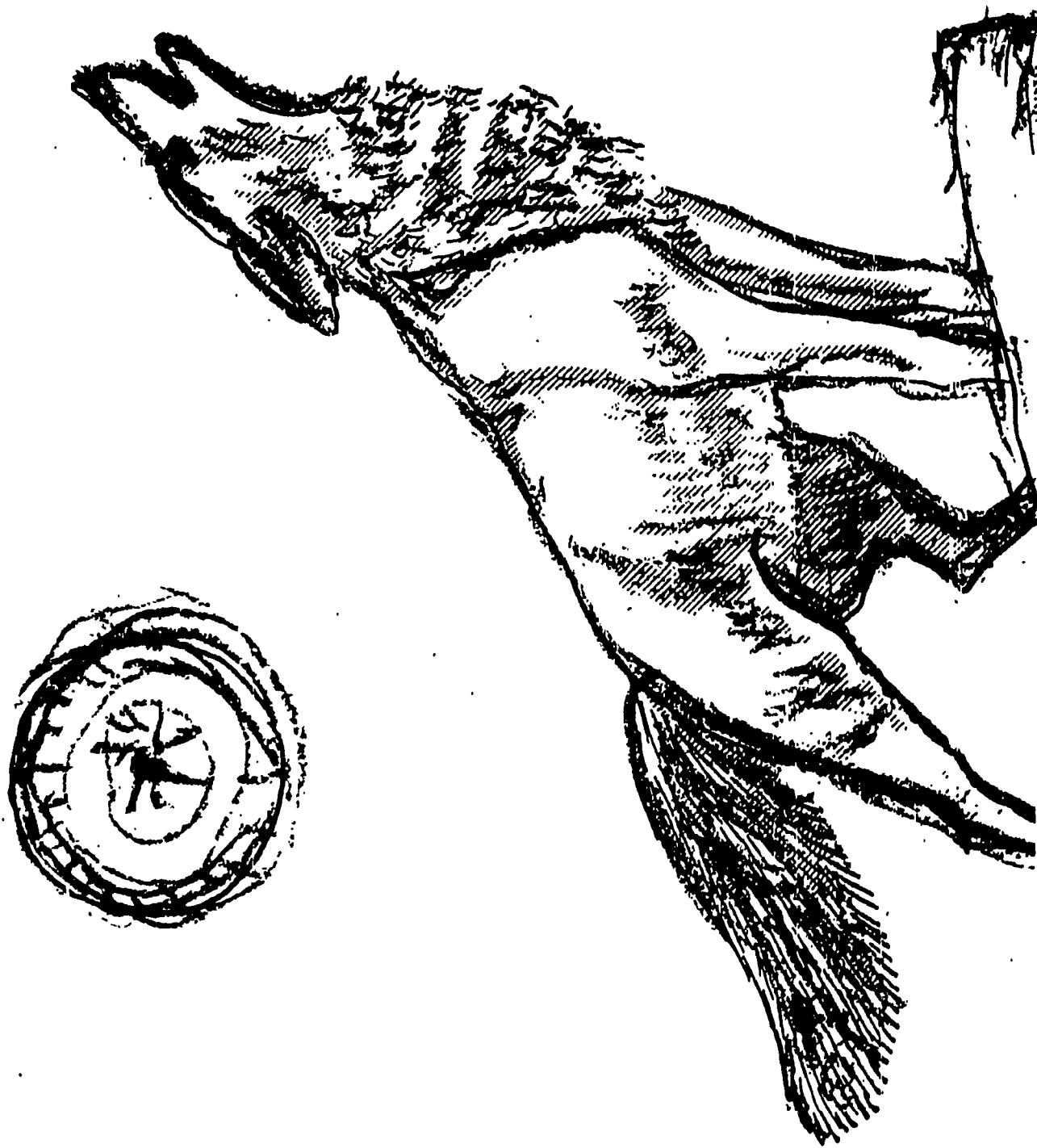
techniques for extending the limits it imposes and permitting thereby a freer expression of self than the elderly could achieve otherwise " (p. 52). One way to encourage elders to be more spontaneous is through creating an approach to the art which is simple, non-threatening or judgmental.

The residents for the most part had never used paint before and many expressed the observation that they hadn't done any kind of artwork since primary school. Aftersuggesting that we try an experiment with a new medium I began to ease them into the painting process by introducing simple techniques such as working with form, colour and texture. During the first session responses were mixed. Many residents were fearful of this new medium, not easily controlled or manipulated. Crosson, (1976), makes this comment:

> My work with geriatric patients in a nursing home has convinced me that ease and assurance of success in a ‎imple task are important in combating discouragement, frustration, and depression. For many of the patients, it is a therapeutic success if they merely pick up a crayon or chalk. (p. 52)

Most residents were reluctant to put that first mark on paper so I suggested that they all choose one colour to begin this I also demonstrated each technique to the group and suggested that they ' play ' with the materials Figure 5, made by a woman of 85 years and confined to a wheelchair, provides a good example of the work produced by this process. This woman, who I will call S., began by choosing one color, yellow, and then as her confidence grew added progressively more colors to her image. S. needed a lot of encouragement in her first attempt, but when she finished she was quite pleased with her efforts. When S. first began she made the comment that she " was not a child " and this triggered a lively discussion about art-making and being a child, memories of painting in school and the like. I pointed out to the group that many artists valued the ability to stay in touch with their child part because of the wonderful creative energy that every child possesses. I also made it clear that we were not about to create masterpieces in these first attempts at painting.

Over the next four weeks the group explored the painting process and slowly they began to gain confidence in their abilities. Figure 6 was created by S. who had become very involved in the painting process. In this session the group had begun by talking about their longing to get outside and their frustration of being unable to move aroundfreely. This led into a discussion of the past, to times when they could go for walks, tend to their gardens or spend time with their families. S. commented that her picture reminded her of the country outings she would go on with her husband. S. was very pleased with her image and many of the group members commented on how much they liked it. Praise from the group had increased her sense of accomplishment and self-esteem. At the end of the session S. expressed feelings of sadness when she said " I miss those days ". Butler, (1963), felt that life review was a natural occurrence which arises spontaneously in older individuals. He sees the life review process as " a . . . universal mental process characterized by the progressive return to consciousness of past experience, and particularly, the resurgence of unresolved conflicts " (p. 66). Butler viewed the tendency of elders to talk about the past as being a normal and a positive adaptational response to impending death. (In Zeiger, 1976) Indeed it was my experience that elders are eager to talk about the past and only need someone to listen. Zeiger, makes this comment:

> It appears the aged, often infirm, individual attaches himself to memory and begins to talk more of his past precisely because in the present objects of pleasure becomes fewer and more distant. . . However, at its most active the life-review process involves consideration of not only pleasurable memories, but, more important, *painful* memories of still unresolved conflicts __ in the effort to finally resolve them and find inner peace. (p. 47)

S's sadness at the end of the session spoke not only of her loss of autonomy but also alluded to an even greater loss of her husband who had died several years earlier. Many of the group members had lost their spouses and had little opportunity to express their feelings of loneliness. The art therapy process provided them with an opportunity to rework past memories and perhaps eventually would enable the group to enjoy the time left to them.

The importance of reminiscence or life review cannot be underestimated. Pollock, (1989), writes about the therapeutic benefit of reminiscence:

> Memory can be used to rescue people, places, and events from insignificance. These patients feel in control, have a sense of self-esteem by being able to do what is requested, achieve some relief from the cathartic expression of their feelings and concern, and have a diminished sense of isolation and loneliness; and when they can establish linkages between inside and outside and past and present, they find direct evidence that insight helps and gives relief. (p. 358).

Through the use of reminiscence, the group began to have a sense of themselves and more importantly they realized that they were not alone. The sharing of life stories and common experiences brought the group closer together creating a sense of belonging and perhaps marked the beginning of group cohesion.

As the group began to develop, members influencing each other, learning to help each other and to share common experiences, the images seemed to reflect an almost uncanny similarity. McNeilly, 1983, writes that " Resonance in art groups is evidenced in collective imagery " (p. 8). As people begin to relate to their pictures and to feelings about the imagery then resonance can begin to occur. In the beginning the appearance of the flower motif (fig. 7) alerted me to a possible change taking place within the group. However if resonance was indeed at play it was occurring on more of an unconscious level. The woman who created this image refused to talk about its meaning except to say that it was " beautiful ". Ault, (1992), in an interview from a special committee on aging quotes Florence Nightingale, (1860), who said:

> The effect on sickness of beautiful objects and especially a brilliancy of color, is hardly appreciated at all. People say the effect is only on the mind. It is no such thing. The effect is on the body too. As little as we know about the way in which we are affected by form, by color and light, we do know this, that they have an actual physical effect. Variety of form and brilliancy of color in the objects . . is an actual means of recovery. (p. 31)
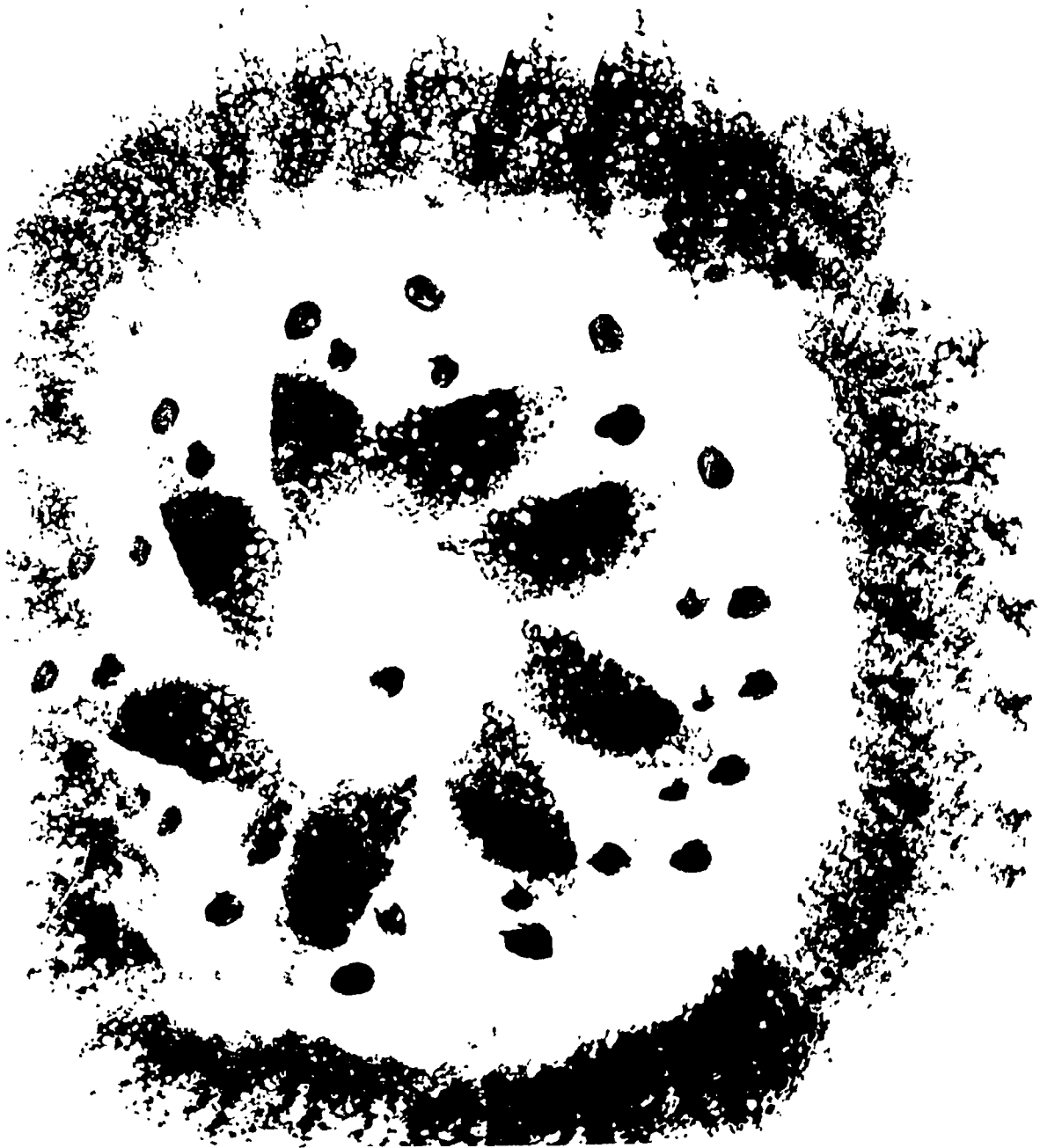
As a symbol the flower has many meanings. Fontana, (1994), writes that: " flowers are universal symbols for youth and vitality, but because of their impermanence they also connote fragility " (p. 104). Cirlot, (1971), relates the flower symbol to the transitoriness of Spring and of beauty; as well as to death. On a conscious level the group initially related the flower to beauty and to a brilliance of colour. They reminisced about their own homes, some had gardens, others associated flowers to lost loved ones. It was my feeling that the flower represented a beginning of the group mourning process described by (Pollock, 1989) , where older individuals need to mourn for prior states of self:

> The basic insight is that parts of the self that once were, or that one hoped might be, are no longer possible. With the working out of the mourning for a changed self, lost others, unfulfilled hopes and aspirations, as well as feelings about other reality losses and changes, their is an increasing ability to face reality as it is and as it can be. " Liberation " from the past and the unattainable occurs. (p. 359)

Here, by using the image of the flower, they were perhaps taking the devastation of illness with its fragmenting nature and transforming it into a thing of beauty. While this could be interpreted as a collective denial of death it could also be looked at as a beginning of mourning the loss of youth, of family, of love, and of past vitality and health. Segal, (1952), writes :

> The act of creation at depth has to do with an unconscious memory of a harmonious internal world and the experience of its destruction; that is, the depressive position. The impulse is to recover the lost world. The means to achieve it has to do with the balance of 'ugly' elements with beautiful elements in such a way as to evoke an identification with this process in the recipient.
> (p. 94)

6.7 The Group Mural

As the residents became more familiar with the art materials I suggested that we try a group drawing. During the discussion it was decided that as Hanukkah was coming we would focus the mural on the holidays. The group was very excited about making a collective image

and expressed the wish to create something for the entire ward which provided a way for everyone to celebrate

" The Feast of Lights " was named for the lighting of the Hanukkah menorah on each night of the holiday. The theme of light dominaies this holiday and the story of Hanukkah was read at the beginning of the next session. It was my hope that through the use of storytelling and a collective image would increase a sense of community within the group. Residents were encouraged to participate in the storytelling, adding their own personal experiences to the material I had found. In the seconc century B.C. Judaism was under threat of being assimilated by the Hellenists. Under Judas Maccabeus, the Jewish people successfully revolted against attempts of Antioch IV to force Hellenism upon them. Kanof, (1975), writes that: " Talmudic legend has it that when they were searching for undesecrated oil with which to light the Menorah, they found only a small quantity, enough to last for a single day; this nevertheless illuminated the refurbished sanctum for all of eight days, until new, properly sanctified oil became available " (p. 158). The lighting of the candles, one for each night, was considered to be ' Holy ' and the light must not be used for ordinary illumination. The Hanukkah menorah is a powerful Jewish symbol, relating to both religious ritual, ceremony, and to indigenous tradition. Cirlot, (1971), views the candelabra as a symbol of spiritual light and of salvation. " The number of its branches has always a cosmic or mystic significance " (p. 37). In the completed mural (fig. 8) the menorah as well as the flower were the two most prominent symbols used to express the meaning of the holidays and perhaps the groups own striving towards salvation and hope. As well as being a symbol for their identity as part of the Jewish culture, the menorah may also be looked at as a self symbol relating to the Cabbalistic Tree of Life. Biedermann, 1994, writes that

" the menorah, with its botanical features, is presumably intended to suggest a sort of World-Tree in the Babylonian manner. . . The light shines up to God, and all other lights shine towards it, in order to dissolve into it." (p. 57).
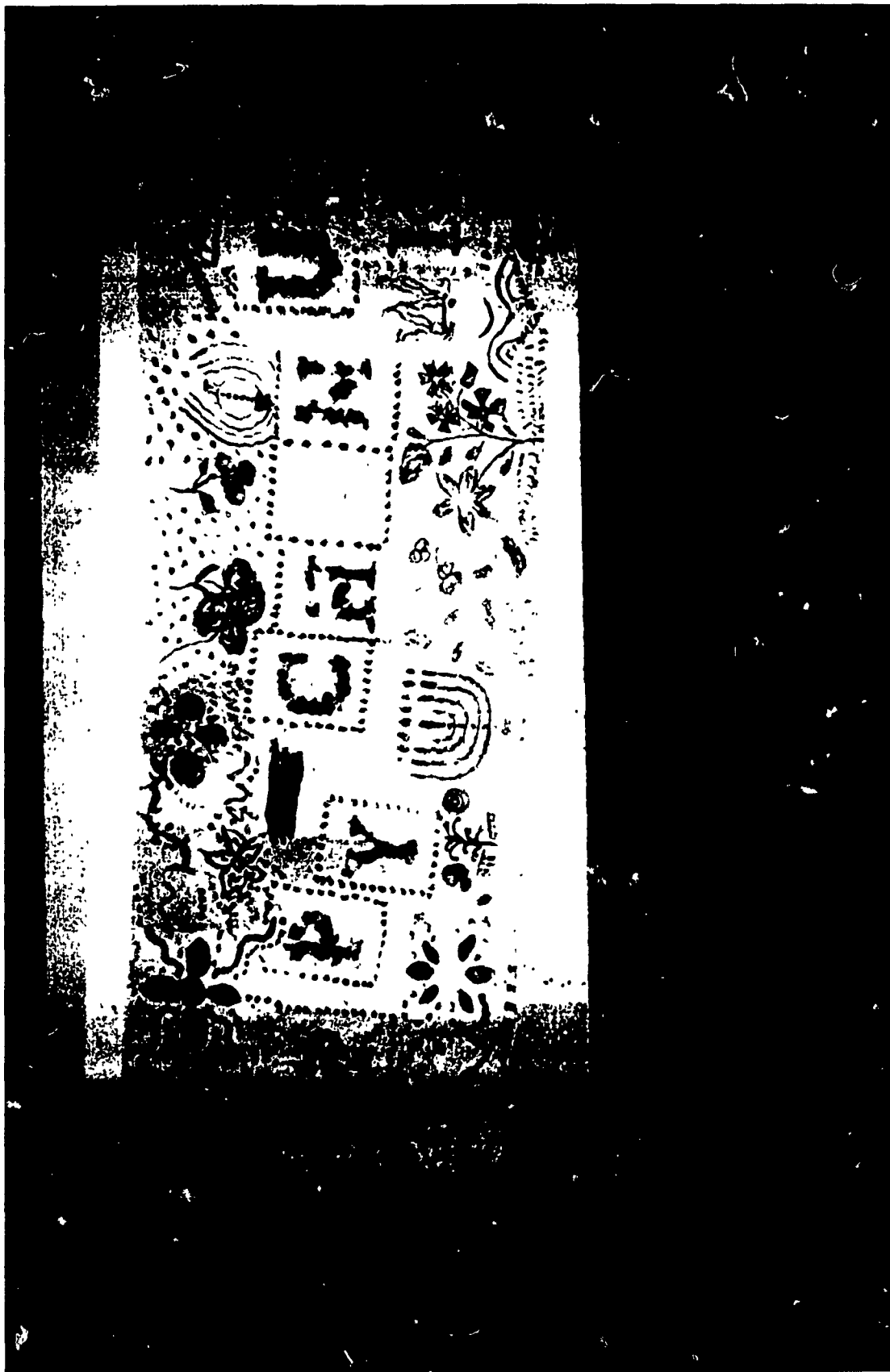
Again we see the difficult transition from pre-drawn imagery (conscious) into more spontaneous work (unconscious). The pressure to make something beautiful for the ward and to an extent for the institution created initial feelings of anxiety within the group. However, as previously stated a concern for many elders was to have a sense of belonging and a purpose in existing. Through the creation of the mural the group could give something back to the environment which not only brought them recognition but also created within each person a feeling of accomplishment. The mural making process with its collective nature reinforced both cultural and spiritual identity for each of the participants. The value of storytelling encouraged the members to reminisce about the losses they had experienced and allowed the group to find support from each other and to realize they were not alone. Weber, (1981), writes of her experience in mural making with an elderly population:

> An underlying unity among group members was present from the start, but the mural-making allowed for greater social exchange and a lessening of isolation. It fostered pride, self-esteem, and self-identity. More people contributed to the mural. . . and the experience helped all of them to see the importance and strength of their support of each other and their community. (p. 52)

Moody, (1995), writes of the value of cultural identity in this way: " While expressing, exploring, and clarifying personal beliefs, values, and experiences, clients begin to see how their view relates to their culture and how they fit into it " (p. 223). Moody explains that this is a functional way to recover identity, by seeing oneself as part of a community, it can take clients out of isolation and create a sense of belonging. For the elders, who had lost so much the mural served to bring them together and strengthened their identity as members of the Jewish community

In the process of making the mural I became more personally involved. Not only did I share my own personal stories relating to the meaning of holidays with its connection to family; I also took part in the painting process. While I was careful not to impose my own ideas or to give in to my own desire for more aesthetically pleasing imagery I did thoroughly enjoy the joining in. I felt that somehow I had moved from being an 'outsider' into being accepted as part of the group.

Newman, (1981), writes that: " Many analysts concur that the crucial moment in therapy, a genuine turning point. . . occurs when the analyst has entered into the therapy and related in a personal, unthreatening and unthreatened way " (p. 233). For me this joining-in feeling was very natural and I intuitively sensed that the time was right for me to do this. In relation to the idea of the purpose of the vas this situation refers to the second or middle vas, that contains both the therapist and the client together.

As our stories unfolded there was much laughter and the atmosphere in the room grew more relaxed. The coming holiday elicited stories about family gatherings and celebrations The strong feelings evoked by the mural making process and the sharing of stories supported the overall goal of generating communication and cohesion among the members. Many residents were looking forward to spending time with family and loved ones. The institution as well celebrated Hanukkah by preparing special dinners and gatherings for those people who were alone or not able to leave the hospital grounds.

Following the completion of the mural, there was an instinctive return to working on individual drawings and paintings. A sombre, almost depressive blanket seemed to be covering the group. I felt that while the mural project had increased the self-esteem of the group members; it reminded them of those people who were no longer there and of the reality of their present situation in the institution. Not everyone had family to celebrate with and the holiday served to remind of this. Pollock, (1989), writes that:

> Losses that occurred very long ago continue to reverberate deeply throughout life. . at every life-marking event such as their own weddings, or their children's births, bar mitzvahs, and weddings, there is for all survivors the vivid jarring encounters with those dead who should have been there. (p. 136)

Here Pollock is referring to the Jewish people who have survived many losses, of country, of home and of life itself through the terror's of the Holocaust. The group members carried their

cultural heritage inside them and the holidays were on the one hand a time to be with surviving family members and friends, and, were also a reminder of the collective loss of loved ones recently gone and of those who had died long ago. In the following section I would like to explore issues related to mourning and loss through focusing on the work of one of the group members who reflected experiences of the elder facing death.

6.8 The Individual Within The Group:

One of the group members, a 72 year old woman, who I will call R., and whose case, I felt, reflected some of the issues that the group experienced. R. had been transferred to the institution 2 years prior to our meeting. At that time she had suffered a massive stroke which left her paralyzed on the left side of her body. R. had no immediate family close by and because of the paralysis, she required full time care and so she was admitted to the institution. Before the stroke occurred R. had suffered two traumatic losses. The first came when her husband died from cancer. One year later R 's son was killed in a car accident. He was her only child and this second loss was devastating. R. did not reveal this information to me until much later on. In our early conversations the focus rested mainly on the institution, her anger at being there, dissatisfaction with the staff " Who didn't care " and on the pain and the limitations caused by her stroke.

When I first met R. I had the impression of an intelligent, sensitive and warm woman, strong-minded and inclined to be controlling. Physically, R. could be described as dynamic and colourful, a large woman, who always wore bright colours and a lot of jewelry. Her enormous weight created an impenetrable shield in that it was impossible to get too close. In retrospect she wore her mask well for it effectively kept hidden all of the pain and loss and kept alive the dead,

lost objects that she held deep inside. Here we may be seeing what Gordon, (1978), refers to as

an attraction to and a fear of death which manifests as ruthless greed. She writes:

> Greed, in this context, might then be seen as a desperate attempt to avoid the possibility
> of ever having to experience hunger; for hunger is a sign that one is, inescapably,
> separate, and subject to change and to time. Through greed a person seems to express
> hope ___however vain and doomed to failure___that he can escape all experiences of
> hunger and so feel forever in a cozy state of unconsciousness. (p. 117)

R's enormous size may also be interpreted as an attempt to stay in the world___to be seen.

Later on it became apparent that inside R. felt very small and fragile.

In group R. was a natural leader who greatly influenced the other residents. She

particularly responded to those people who were new to the group or who were less able to enter

into the artmaking process because of physical/and or cognitive difficulties and especially to

those resident's who were themselves bereaved.. In 1963, Bowlby, described four

phenomenological forms of pathological mourning:

> (1) anxiety and depression where a persistent and unconscious yearning to recover and
> reunite with the lost object is present; (2) intense anger and reproach, frequently
> unconscious, directed toward various objects including the self; (3) absorption in caring
> for others who have been bereaved; and (4) denial that the object is permanently lost,
> especially through the mechanism of splitting. (in Pollock, 1989, pp. 112-113)

R. exhibited all of these elements: I felt that she was suffering from depression, R. would remain

in her room isolated from the other residents unless she had some specific task to complete

During the time spent alone she would eat At other times she displayed a fierce independence

coming and going in and out of the hospital., going to the local mall, or attending resident's

meetings and social events. Conversely, there were occasions when she would express feelings

of exhaustion, and stated that she had trouble sleeping. Although there was no outward

expression of mourning or depression in the traditional sense I nevertheless felt that it was there

Anger was projected outward toward the staff who " didn't care " and initially towards me in the

form of criticism as to the way I ran the group. As already stated she would often care for other

resident's who were struggling to cope with their own grief. Finally it was my belief that R. remained locked in a state of denial over the loss of ner husband and son. Bowlby, (1981), writes about the prolonged absence of conscious grieving:

> Adults who show prolonged absence of conscious grieving are commonly self-sufficient people, proud of their independence and self-control, scornful of sentiment; tears they regard as a weakness. After the loss they take pride in carrying on as though nothing had happened, are busy and efficient, and may appear to be coping splendidly. . . No references to the loss are volunteered, reminders are avoided and well-wishers allowed neither to sympathize nor refer to the event. Physical symptoms may supervene: headaches, palpitations, aches and pains. Insomnia is common, dreams unpleasant. . . In some persons cheerfulness seems a little forced;. . . Bouts of tears or depression may come from what appears a clear sky. (p. 153)

In the group R. would often attempt to advise me on how I should run the sessions and if I did not comply she would let me know how displeased she was. She complained of aches and pains and would fluctuate from controlling behaviours to extreme dependence. Initially she refused to attempt to make her own images; even when other group members began to try. In her first attempts at more spontaneous imagery, anxiety and fearfulness were observed. Anger, would finally take over and she would complain that I would not allow her to work on the pre-drawn imagery. When I pointed out that she always had a choice as to the way she wanted to work she withdrew into silence. Initially, I was very frustrated and realized that there was a danger of becoming locked into a struggle for control with R. When she began to paint R's resistance to the painting process can be looked upon as an inability to enter her unconscious internal world which held the idealized lost objects. Gordon, (1978), writes:

> . . . if there is excessive resistance to separation, and if a person relies on denial as a defence against the pain caused by the death of another person. . . then the relationship to the dead person is not available to the symbolic process, through which alone a new attitude, a new relationship to the dead person can become possible. (pp. 117-118)

I felt the difficulty of R's transition to more spontaneous imagery reinforced her denial and resistance to separation and especially related to the loss of her son. Pollock, (1989), writes that

" there are, however, some instances where the mature mourning process may not be able to be fully concluded; for example, maternal mourning for the death of a child . . ." (p.110). Pollock has written extensively on the relationship between mourning and the creative process. He writes " I have observed that the creative work at times is used in the service of the mourning work itself " (p. 106). Pollock maintains that the mourning process may be reflected in theme, content, form, and style and can reflect attempts at finding resolution.

As previously stated the transition from pre-drawn imagery, for R. was very difficult and she complained loudly that she didn't want to try painting. Rubin, (1981), points out that the clients behaviour when working with the art materials can be a form of defense against unwanted transference responses. " This may be the form of copying, tracing, or stereotypic repetition " (in Agell et al., p. xxvii). It was interesting to note that despite her loud protests R. had participated in the earlier painting sessions where we explored the painting medium. Following the mural project she returned once more to a defensive resistance. Her anger towards me was very powerful and at times I had difficulty ' holding ' onto to it. In one session I finally confronted her by stating that I felt angry and I wondered if she did too? She seemed very surprised by my question and quickly denied the possibility. I wondered if she was experiencing me as the 'bad' mother-therapist who threatened to destroy her idealized inner world? Later on in the session however R. admitted that she was indeed angry at the change I had brought to the group. She commented on how difficult it was to accept change and this led into a group discussion which focused on the changes that come in life.

6.9 The Incubation Stage:

In the stage of incubation, according to Gordon, 1978, the person feels baffled and confused.

It is a stage that doubt and pain and anxiety and despair rack and torture him who would create. Should he flinch, seek refuge or attempt a short-cut, he will either return to that which has already been and so enter upon the process of repetition, stagnation, putrefaction or petrification. . . it is during this stage of incubation that a seed may take root___but if it does, it happens unseen, in the depths of the unconscious psyche, in the dark (p 131)

R's first painting (fig. 9), came during the second session following the making of the group mural .She did not like her image but she continued to struggle with it. At one point she was sweating profusely, which was not unusual, saying " I'm burning up inside ". Her comments and outward responses to her images might be indicative of the descent into the nigredo Duff, (1993), writes describes the descent: " In the closed container of the alchemist's flask, the problem is reduced, broken down, and returned to its original state of disorder. . . " (p. 83). One of the many processes that facilitate this breakdown is *calcinatio* or burning by fire. Duff describes calcinatio as the burning process most evident in fevers, " but it is also associated with the intensity of frustrated desires " (p. 84). The heavy black, containing lines were added near the end of the session. I had never seen R. use black before therefore I believed that this was significant, an indication of the nigredo. The image was one which I felt contained R's whole story which she needed to uncover. Wilson, (1985), writes of the idea that many art therapists adhere to where the whole problem presents itself in the first picture a client makes. Newman, 1981, echoes this idea when he writes about the nature of the 'opus' or great work. He writes that " the prima materia the alchemists worked on contained within itself all the necessary patterns of change, as well as an inclination or inner tendency to do so. . . " (pp. 236-237).

R's picture is completely contained, the black lines completely sealed off her image. Here we have the first or innermost vas as described by Newman representing the individual psyche. Newman, (1981), writes that " within the context of *vas* number one, the therapist is always working in an ' I - It ' relationship, because although relating and involved, he is outside, looking on___ " (p.237). My feeling when looking at this image was that I was a kind of witness to

the process which, although painful for R. to create, was not destroyed but rather was adequately contained within the middle vas of the therapeutic space.

Cirlot, (1971), writes that: " mystics have always traditionally considered the feminine aspect of the universe as a chest, a house or a wall, as well as an enclosed garden. " He goes onto say that " Finally, there is, as we have said the association of the house with the human body, especially regarding its openings " (p. 153). The Kabbalist's also considered the house to be symbolic of the human anatomy .R's house was very tiny and dwarfed by the large red flowers which appeared to be guarding it. Oster & Gould, (1987), describe the house as representing " the place wherein affection and security are sought. In this manner, a drawing of a chimney emitting smoke is often related to feelings of warmth and affection " (p. 33). R's house felt empty and looked as if it might easily fall apart, perhaps indicating the fragility of R's ego strength. The heavy, black chimney could be cold, and empty; but it's solid form suggested that it was blocked in some way. Pollock, (1989), cites Freud's writings on Narcissism " as libidinal interest and investment is withdrawn from a loved object into the ego, there is a damming-up of libido in the ego. With this increase and tension, pain is experienced " (p. 16). The yellowy-green line which divided the lower and upper sections of the house, as well as the absence of windows, may have indicated the inaccessibility of the unconscious (lower) part towards consciousness. If we accept this idea then the blocked chimney could hold the unconscious emotions contained in R's image and her inability to let them out. The chimney can be looked at also as symbol for warm intimate relations (Oster & Gould, 1987). Again this possibility is blocked or empty for R. perhaps because of the two rather dangerous looking red flowers guarding the tiny house. Ambivalence regarding emotional accessibility seemed to be indicated by the tiny zig-zag shaped walkway.

The two flowers were perhaps symbols for R's dead husband and son. I felt that all of R's emotional energy was focused on keeping these inner objects alive. During the session R's

responses to her image were those of anxicty, frustration giving way to sadness at the end. She

had very little to say about her image. Pollock, 1989, writes

> Sadness indicates object loss, real, threatened, or fantasied, but not yet a giving up
> Sadness as a transitional aftect includes nostalgia, longing, and hope for eventual
> reunion. The image of the self is felt to be in varying degrees impoverished, deprived,
> empty, weakened, or in some way deficient. (pp. 100-101)

It was my feeling there was some measure of hope in R's ability to express perhaps

' authentic ' feelings of sadness 'oi tne first time in the therapy.

At one point R. wanted to destroy her image. She had attempted to try to ' fix ' it by

adding colour to the sky and the sun Her attempt was abandoned and she stopped painting.

However, she did not destroy the painting, but was able to leave it, instead, with me. I felt that

this represented R's attempts to bring the meaning of her image into the consciousness. At this

time, she could not successfully do that, her tiny house did not contain the strength necessary for

bringing the reactivated mourning process into conscious understanding. Pollock points out that "

indeed the creative product may reflect the mourning process in theme, style, form, and content,

and it may itself stand as a memorial " (p. 114). R's decision to leave the painting with me

perhaps indicated a beginning of trust in the external mother/therapist. For now her image would

be held by me for safe keeping. Wilson, (1985), writes that:

> Both the art therapeutic and alchemical processes allow for an initial recognition that
> certain issues do exist, but safely removed from the individual until they are gradually
> seen to have a personal as well as a collective component. . .the art activity may remain
> on the level of building integrative capacities and self-esteem rather than being used to
> uncover and establish insight about unconscious impulses. (pp. 103-104)

In group discussion many members seemed drawn to R's. image and supported her

difficulties by encouraging her not to give up. Pollock makes this comment: " If the artist touches

a universal affective theme, each of our individual responses, coming from our own specific

sources, having unique meanings, could still have a commonality that is stimulated by the product itself " (p. 121). Many group members were, I believed, primarily dealing with a reactivation of their own mourning processes and it was this element which drew them to R's image.

It was possible to imagine that the other ,mages of flowers and plant-like shapes could represent the sick, damaged parts of R. which weakened her and prevented R. from carrying out the work of mourning. Fontana, (1994), writes that plants and flowers in part are symbolic for the cycle of life and suggest links to the human body. (p.104) As well, Duff, (1993), writes of the vegetative processes of illness which reflect the life processes with all its dirty, messy qualities. She writes: " I rumble, shiver and sweat, burp and fart, and drink vast quantities of liquid___all of which work to soften the rigid, eliminate the unnecessary, and reduce wholes to their original parts " (p. 70). In the alchemical sense this is the 'salt' which all the members could understand. Salt represents the bitterness of suffering that illness contains. The group, united in their struggles of dealing with illness, aging and loss may also have identified with or been represented in the clustered marks of the plants to left of the image. I believed that this painting represented R's first real attempts at completing the unfinished mourning work through the creative process. The effort and energy that it took for R. indicated both a desire to begin to work on the unconscious but , it also indicated a capacity to trust. Gordon, (1978), writes :

> Basic and underlying the various potential hindrances to the creative process is the capacity to trust. . . there must be enough trust that the world and the people inside it exist, are relatively reliable and benevolent and relatively free from excessive envy. . . But the world and its people must also be felt as sufficiently solid and sufficiently able to resist one's own lurking destructiveness or wish for domination. (p. 153)

The same sort of trust is necessary between the therapist and client and I believe determines the nature and quality of the work done in the sessions. Trust must go both ways: the client needs to feel that the therapist can hold the material which appears in the images, that he/she will not

abandon the client or impinge on him. At the same time the therapist must believe that the client has a capacity for healing and is able to carry out the work. Perhaps prior to this session neither R. or myself were able to completely trust in the process or each other. I was also aware that R had been very close to the former art educator who had run the art groups The abruptness of this woman's departure had a huge impact on R. and several other residents. I am quite certain that for R., her leaving had intensified all the feelings of loss and abandonment that she held inside.

In subsequent sessions the group and R. struggled to work through and to allow the unconscious elements to emerge. Gordon's, (1978), stage of incubation is dependent upon the capacity of the individual to ". . . suspend ego functions and controls, to risk ' not knowing ' and ' not controlling ', to allow oneself, to make oneself available to possession and to the possible experience of ' sacred awe '. . ." (p. 134). This also related to the nigredo phase of alchemy. R's next two images (figs. 10 & 11) were a wonderful example of Gordon's second stage of incubation; and of a possible movement towards change and growth.

In the second image (fig. 10) R. repeated the symbol of the house, but here it was much larger, more solid and very closed off from the surrounding shapes and movement. The red ' X ' blocked any access to the house from the outside world. The upper part of the house was filled in perhaps indicating R's conscious decision to cut herself off from me and the group members. To the left of the house was a red flower which I felt also represented R. In this image it appeared to be crushed by the house or had been knocked over. R. had perhaps attempted to crush or deny her emotional part by the sheer force of her ego The ground too, is red and seemed to be pushing towards the house. The affective elements experienced by R may have been felt to be too powerful and consuming. Perhaps she was not ready to deal with them especially as I was about to go away on vacation.

The white of the house and the heavy snowfall with its coldness and cooling powers can ue looked at here as the principle of coagulatio. Duff, (1993), defines the alchemical operation of coagulatio:

> It relates to the element of earth and represents the ways in which we are confined or bound by physical existence, by the necessities of our bodies and souls. Under the pressure and coercion of disease, we loose spaciousness, freedom and ease we had come to assume in health, here we encounter the fierce limits of our destinies, limits we have not chosen but must endure and be shaped by. (p. 86)

Here the snow was like the ice that Wilson, (1985), refers to as the solidification of a liquid by cooling. " Ice is one of the least stable of solids having a ready tendency to dissolve into water. . . " (p. 192). Wilson relates this symbol to a precarious ego position. The fact that I was free to come and go between the hospital and the outside world, that I was healthy and young, and my upcoming vacation may have served to remind R. as well as other group members of their own inability to leave the hospital because of their illness. The birds which were surrounding the house may have represented these feelings. Fontana, (1994), writes that " Flight has always represented freedom from physical restrictions of earth-bound life and the ascent of the soul to the gods, either through mystical experience or through death " (p. 86). The birds in R's picture reflected both the longing for freedom and the reality that for R. and other group members, freedom might indeed come from death. In fact during the discussion many residents talked about the loss of freedom and of the pain and discomfort of illness. They all wished to escape from the captivity of their bodies. Winter was a very difficult time for the resident's. They were very much trapped inside the hospital and often many succumbed to a worsening in their physical condition. There were more deaths during the winter than during any other time of the year.

During this session, R. again voiced her complaints regarding the painting process. Her anger was directed towards me and indirectly towards the group. R's usual warmth and caring

attitude towards the other elders was not present, instead, it was replaced by withdrawal and resentment. At times she would become quite helpless, and demanded my attention. Part of this response, I felt, was in part due to her experiencing my upcoming departure as abandonment. Pollock, (1989), describes his experience with working with patients who have experienced abandonment, loss, and vulnerability. " Another example of this type is the dying patient abandoned by his or her " loved ones " in a hospital, hospice, or nursing home " (p. 130). The discharging of feelings such as fear, rage, and despair within the safety of the therapeutic space can be seen as a necessary part of healing process. Robbins, (1981), speaks of the ability of the art to ". . . help the patient externalize and give a framework to his or her affects and images from the past " (in Agell et al., p. 7). He suggests that the patient may only require the quiet, empathic presence of the therapist in order to give concrete, symbolic form to the affects of primary process thinking. I felt that R. was not yet ready to talk about her image. When an image is first created, the individual may be in a state of fusion with the object and unable to talk about its content. Schaverein, (1987), cautions that the art therapist's timing, through the use of interpretation becomes very important " For the therapist to demand explanations too early can be to rob the client of her own process. We must have confidence in the process and wait " (p. 85).

6.10 A Movement Towards Change and Growth:

R's next painting (fig. 11) was done shortly after my return from my holiday. Upon reflection I believed that this image marked the beginning of a transition and a movement out of the nigredo The house was much more accessible and inviting, less empty, suggesting growth It also seemed that R's defenses were breaking down and

she was allowing the environment into her image. The tree seen in figure 10 was no longer bare but had the beginning of leaves which furthered the idea that some transition was taking place.

Wilson, (1985), states that the tree can be symbolic of Mercurius, which here " is boldly filled in with green___ the alchemical " green of the beginning " (p. 182) The snow not only surrounded the house but had touched it. R's image had the sensation of upward movement by the vertical use of the paper, the snow, the birds in flight and the new growth of the tree with its branches strained towards the sky. The red flower was restored again and held the qualities of the red, rubedo and perhaps symbolized a return of the lost or blocked affect. (Wilson, 1985) The blue sky, mixed with the white snow had the qualities of the solutio. Duff, (1993), writes: " *Solutio* is a dissolving process that melts walls and rigidities, opening us up to the full chaos and mystery of life, often with a great surge of emotion " (p. 85). During this session R. was very animated and filled with warmth and caring. She was attentive to both me and the group members. Wilson, (1985), refers to this as a " mirror transference " where the client sometimes mirrors the role of the therapist through gesture or expression of caring or concern. (p. 189) R's sense of humour had a wonderful effect on the group. The whole session was very lively and filled with laughter. The appearance of the snow could be evidence of the albedo, where the white no longer represents the absence of colour but in this image contained all colours. Fontana, (1994), describes the process of alchemy as written by the Chinese, as a process involving inner work and through meditation, " physical energy can be visualized as gathering and concentrating. . . in the " place of power " below the navel, where it generates immense heat and then passes " the boiling point (and) mounts upwards like flying snow . . . to the summit of the Creative " (p. 149).

In this image R's first painting (fig. 9) had transformed itself. Instead of remaining locked inside the black container of the Vas # 1, the image now was clearly connected to the Vas # 2, the therapeutic space which included the therapist and perhaps included Vas # 3, R's connection to the environment of both the group and the institution. R's image reflected the beginning of a transformation on an individual level and also reflected a similar change within the group. With the development of trust, there was a decrease in anxiety levels and a greater ability to express both graphically as well as verbally thoughts and feelings.

R. created a powerful image in the next session, which was to be one of her last individual works. (fig. 12) She arrived at the session stating that she hadn't been feeling well lately but requested to get started right away. I sensed an urgency within R. and quickly moved to get her the materials she would need. R. worked quietly and with great concentration. The image which unfolded marked a complete departure from her other paintings. For the first time there was the appearance of human figures in R's artwork. The transitional feel of the session was enhanced by the image of the couple. The tree as a symbol for the inexhaustible life-process was now in full bloom having moved from something dead (fig. 10) towards the beginning of life (fig. 11). R's ambivalent image seemed to both hold an inordinate attraction to and/or an inordinate fear of death. Another way of viewing R's image would be to see the masculine form as representative of R's. dead husband and son; who appeared to come between the life-giving mercurial tree. In order for R. to reach a place of wholeness she needed work through the loss of her dead husband and sonand here seen to be moving into the realm of consciousness. The female figure however appeared to be helpless as indicated by the absence of arms in R's painting. Also, there was a feeling of sadness which permeated both these figures who seemed almost frozen and unable to move. Wilson, (1985), writes that " when the alchemists spoke of freeing the spirit from an entrapment in matter . . . through their distillations, evaporations, etc., it was to the precise end of bringing them together again, but with added awareness and knowledge that only consciousness brings " (pp. 98-99). Whatever the precise meaning of R's painting might be she remained silent. One element that struck me were the wavy red lines contained within the body of the female figure. These I felt were connected to the salt element pertaining to R's body, the pain of illness and to the emotions which filled her. The black hair seemed almost to taking leave of both of the figures suggested a departure of libidinal energy. Cirlot, (1971), writes that " In general, hairs represent energy, and are related to the symbolism of levels. . . a head of hair . . . stands for higher forces " (p. 135). When the hair is full

it is linked to the will to succeed. Black hair is related to dark, terrestrial energy. Pollock, (1989), writes:

> In ancient Israel mourners expressed their sorrow for the death of relatives by cutting their own bodies and shearing part of their hair . . .Since blood was believed to be synonymous with life, the cutting of the body with blood flowing out represented life flowing away. However, since the Hebrews believed in death as a means of passing to another existence, this blood flow, sometimes over the dead body, established a bond with the dead and symbolically served to nourish the departed on his journey to the next world. In similar fashion, hair was a symbol of life and strength. Thus the placing of the hair from the living on the dead body or at the grave was a means of giving strength to the deceased. However, it clearly is also the separation and pain in the living. (p. 264)

By offering the hair and blood, symbolic for strength and vitality, the dead are given a source of energy (blood) and strength (hair) and in this way the mourner continues to survive. As the session drew to a close R. seemed very tired and left quickly. Following the session I stopped into to her room to make sure she was alright. She began to talk to me about her husband and son and how she wanted to die. She stated that she had never gotten over the loss which left her filled with despair. She seemed tired and defeated. She was very childlike at this moment and I felt her sadness within me. We talked about loss and death and the artwork. For R. the artwork was the only thing that " kept her going " and I wondered silently if that was enough? I kept thinking of her image and when I looked at it again later on I wondered about the placement of the female figure on the left side of the image. Tate, (1989), writes about left-side placement:

> In the field of art therapy, there is a positive correlation between symbols and events drawn on the left of the page as representing the past. The future is most often portrayed on the right side. One possible explanation for these findings is that the life-threatened artists subconsciously knew that their future was limited or that " their sun was setting. (p. 116)

It seemed clear that R. was still identified with her dead husband and son but the fact that these images were moving into her conscious awareness left the possibility that she might be able to bring her mourning to completion. But R's image may have also indicated that within the Vas # 1 she intuitively sensed that her own death was imminent.

R. continued to attend the sessions but not as regularly due to illness and fatigue. The art therapy process had a healing and transformative effect of increasing her depth of the satisfaction, leading to a greater self-identity and sense of mastery. There were still times when she would fall back into despair but we continued to work through the process of mourning and letting go. In one of our conversations she expressed feeling tired and depleted. At the same time there was an excitement in the air as we all anticipated the approach of Spring. In a 'flash of inspiration' the group made the decision that it was time for another mural which would focus on the approaching springtime with its promise of new life and energy, after the darkness of winter. It was agreed that the mural would focus on nature and all that it symbolized: life, death , and regeneration. R., too was very excited about the mural project. She suggested that again we make the mural for everyone on the ward " to give the place some life". Despite her fatigue, she seemed to be finding a newfound joy in living, and was filled with gaiety. When the mural began she joined in enthusiastically working on the painting. Pollock, (1989), writes:

> With the working out of the mourning of a changed self, lost others, unfulfilled hopes and aspirations, as well as feelings about other reality losses and changes, there is an increasing ability to face reality as it is and as it can be " Liberation " from the past and the unattainable occurs. (p. 359)

I felt that R. had begun the journey back to life and living. In group she mentioned her husband and spoke about missing him for the first time. However, she never spoke of her son. Perhaps the loss of her only child was still too painful for R. to acknowledge openly. As previously stated the loss of a child may never be fully mourned. Because her son had died unexpectedly, I believed that R's ability to mourn was further inhibited. Rando, (1984), writes :

> At least when a death has been anticipated, even though it puts tremendous emotional demands on the individuals involved, coping capacities are directed toward an expectable end. . . When this preparation is lacking, and the loss comes from out of the blue, grievers are shocked. They painfully learn that major catastrophic events can occur without warning. As a result they develop a chronic apprehension that something unpleasant may happen at any time. It is this lack of security, along with the experience of being overwhelmed and unable to grasp the situation, that accounts for the relatively severe postdeath bereavement complications that occur in cases of sudden death. (p. 52)

For R. the unexpected loss of her son which followed the loss of her husband must have completely overwhelmed her and affected her ability to cope with the trauma. Rando continues by saying that in these situations " There is less likelihood of regaining full capacity for functioning, happiness, and security." (p. 52).

I was not to know if R. would completely resolve her issues for, like her son, she died unexpectedly. R. had another massive stroke and went into a coma, where she remained for a few days and she died. The stroke occurred when I was away from the hospital. I did not see her again. The shock of her death left me numb and in retrospect I went through my own mourning over her death. I realized how profoundly she had effected me, and how much I cared for her. In many ways it was like loosing a close family member or friend. " By the very nature of their characteristics as a population, dying and bereaved individuals force our own confrontations with loss: that which is presently being dealt with by our patients or clients, that which will result after they die or terminate therapy, and that which is resurrected from our own past experience" (Rando, 1984, p. 430). I would like to stress that any therapist or caregiver who works with the dying and bereaved must have a support system in place and the need for self-awareness cannot be overemphasized. My own therapy and the support of my peers was invaluable in helping me to cope with the loss of R. and others with whom I worked. As well, the group also were deeply affected by R's death. A discussion of their response will follow in the section which focuses on the creation of a second mural. But first I would like to briefly discuss some of the changes that the group experienced during the sessions preceding the making of the mural.

6.11 Changes Within the Group:

With the capacity to trust the group began to openly discuss issues which focused on institutional concerns. I was able to begin to work with the staff to solve some of the elders needs, again strengthening the connection between Vas # 2 and Vas # 3. Concerns focused on issues relating not only emotional well-being, but on problems which related to physical pain, discomfort, and problems between residents. One example of this was a situation which occurred when two of the members were placed together and had to share a room. They did not get along and their hostility eventually created tension within the group. I had to gently make it clear that fighting was not an appropriate way to solve a problem. I talked to each of the women and the matter was also addressed by other group members. An uneasy alliance was formed and they agreed to tolerate each other. Brearley, (1977), writes that " Some boundaries must be set in groups: members need to be sure of how far they can go. . . residents will feel safer with clear boundaries and limitations " (p. 79). One of the difficulties of institutional life was the fact that sometimes people are put together, not by choice but because there are only a certain number of single rooms available, making privacy very difficult. In the team meetings I was able to present this concern and a solution which ultimately led to a change in rooms was reached. The matter was handled sensitively, with both women being consulted. Afterward they were better able to tolerate each others presence in the group.

Other issues related to the physical comfort of the residents. Another woman complained of a constant pain in her leg. After speaking to the occupational therapist, it was discovered that there was a problem with her wheelchair. One elder who was very quiet and often isolated, was encouraged to join the group to which she responded to positively. This led to the staff awareness of her potential to actively participate in other activities held within the institution. Most important, was the increased awareness of the staff regarding the emotional and spiritual well-being of the group members.

Not every member was able to respond to the art materials on the same level. There were members who were unable due to physical disabilities to make more than a few marks, but everyone participated in group in some way. For example there was one woman who could only tap with a brush in time to whatever music was playing. As the group began to develop and with the help of a volunteer, she was able to create images of sound which he thoroughly enjoyed. Her love for music indicated that she would be a good candidate for the music therapy so she was referred to the program. Weiss, (1984), writes:

> Elders who are not are not verbal (i.e., aphasic, regressed, withdrawn, or depressed) can find satisfaction in expressing their feelings and thoughts in nonverbal but concrete manner through writing, drawing, and other creative arts modalities. For elders who are verbal, creative arts therapy can be used to further uncover, explore, and clarify their feelings and thoughts. (p. 26)

As greater cohesion and harmony came into being, group conversations turned to issues of loss and those relating to death. Many of the resident's expressed the difficulty in talking about such things to family members or friends, " Who they did not want to burden " The staff as well were not available to listen, or when they did, would often respond which such words as " Now, don't talk like that, you have everything to live for. " Weiss, (1984), writes:

> The social isolation in institutions and hospitals can reinforce a tendency of the dying patient to regress and withdraw. Institutions often do not administer administer sufficiently to the psychological process of the dying patient, but focus on physical needs. . . Instead, they pacify the patient and the bereaved. Denial by the family, the dying person, friends, or involved staff of the psycho-social dynamics of the dying process can result in guilt, passive acceptance, and refusal to experience and deal with the reality of the situation (p. 101)

Denial in the attitudes of staff and family, was observed and in some of the elders in the form of a passive withdrawal, which eventually led to feelings of despair. The art therapy process fostered communication, especially with concerns about death and dying. Through the use of the image-making process the group began to express their feelings more directly and through the images. The process facilitated a sharing of those thoughts and feelings which were difficult to discuss. The use of life-review allowed them to openly mourn their many losses, especially those

who had lost close family members. In this way they could attempt to reorganize and transform

feelings of despair into those of hope and meaning in whatever life was left. Part of this process

also involved the acceptance of the limitations brought on by illness. By working with the art the

group began to realize that they could indeed accomplish something and could master new skills.

For some members this opened up a way to gain deeper insight into personal issues; for others it

meant gaining greater satisfaction and increased self-esteem. Pollock, (1989), writes:

> In the elderly where reminiscence is common, there is a particular and special
> therapeutic benefit from remembering, free association, . . .and fantasy elaboration.
> Memory can be used to rescue people, places and events from insignificance. These
> patients felt in control, have a sense of self-esteem by being able to do what is
> requested, achieve some relief from cathartic expression of their feelings and concerns,
> and have a diminished sense of isolation and loneliness; and when they can establish
> linkages between inside and outside and past and present, they find direct evidence that
> insight helps and gives relief. Therapeutic progress stimulates hope and facilitates the
> process even further. (p. 358)

With the working through of these issues there was an increasing ability for the group to   e the

reality of their situations as they were and as they could be. For some the art therapy process

opened up new possibilities, stimulated greater interest in the hospital community, gave them a

greater sense of autonomy. and the capacity to experience joy as well as sadness.

## 6.12 The Inspiration Stage: A Community Mural

> From the root the sap rises up into the artist, flows through him, flows to his eyes. He is
> the trunk of the tree. Overwhelmed and activated by the force of the current, he conveys
> his vision into his work . . . he does nothing other than gather and pass on what rises
> from the depth. He neither serves nor commands, he transmits. His position is humble.
> And the beauty at the crown is not his own; it has merely passed through him. (Paul
> Klee, in Gordon, 1978, p. 132)

Inspiration is the stage in the creative process where illumination occurs. Gordon, (1978),

writes " There is, as it were, a sudden flash of light, a sudden catching of one's breath " (p. 131).

Gordon emphasizes that as with the incubation stage the artist must be prepared to surrender ego functions and controls.

In the creation of the mural we began by using three large sheets of mural paper roughly six feet in length. The group wanted to use two symbols: the tree and the flower. Because of the size of the panels myself and my assistant drew a very simple outline of the trees on paper under the direction of the group members. Here we have a good example of Kramer's, (1986), idea of the third hand: " . . .art therapists must also command a " Third Hand " a hand that helps the creative process along without being intrusive, without distorting meaning or imposing pictorial ideas or preferences alien to the client " (p. 71). It was impossible for the members to do the outlines themselves and they needed some guiding lines to get the project under way. In order to work on the paintings we had to lie each panel flat on the table, working on one panel at a time. There was feeling of anticipation in the air and people were anxious to begin.

What happened in this session and the ones that followed was magic. I really cannot think of any other way to describe it. The artwork materialized ' out of the depths of the unconscious ' with a multitude of color and form. (figs. 13-17) Within the safety of the middle Vas the artwork could unfold. Group members worked with an intensity that I had not seen before. They worked in harmony as a united whole. Everyone participated in some way, from making single marks to those who were able to work on larger areas of the painting surface. Conversation was minimal during the sessions as all were very involved in the painting process. Over the course of the next several weeks the group worked on the mural. In some sessions we focused on memories of the past, of the loss of the ability to walk around freely, of the pain of illness and of the isolation from the external world experienced by everyone. The sessions were very meaningful and filled with personal stories. My role became one of providing the necessary nourishment through the art materials and whenever needed I helped a person in self-expression, communication andsharing. Anything else that happened during the session was
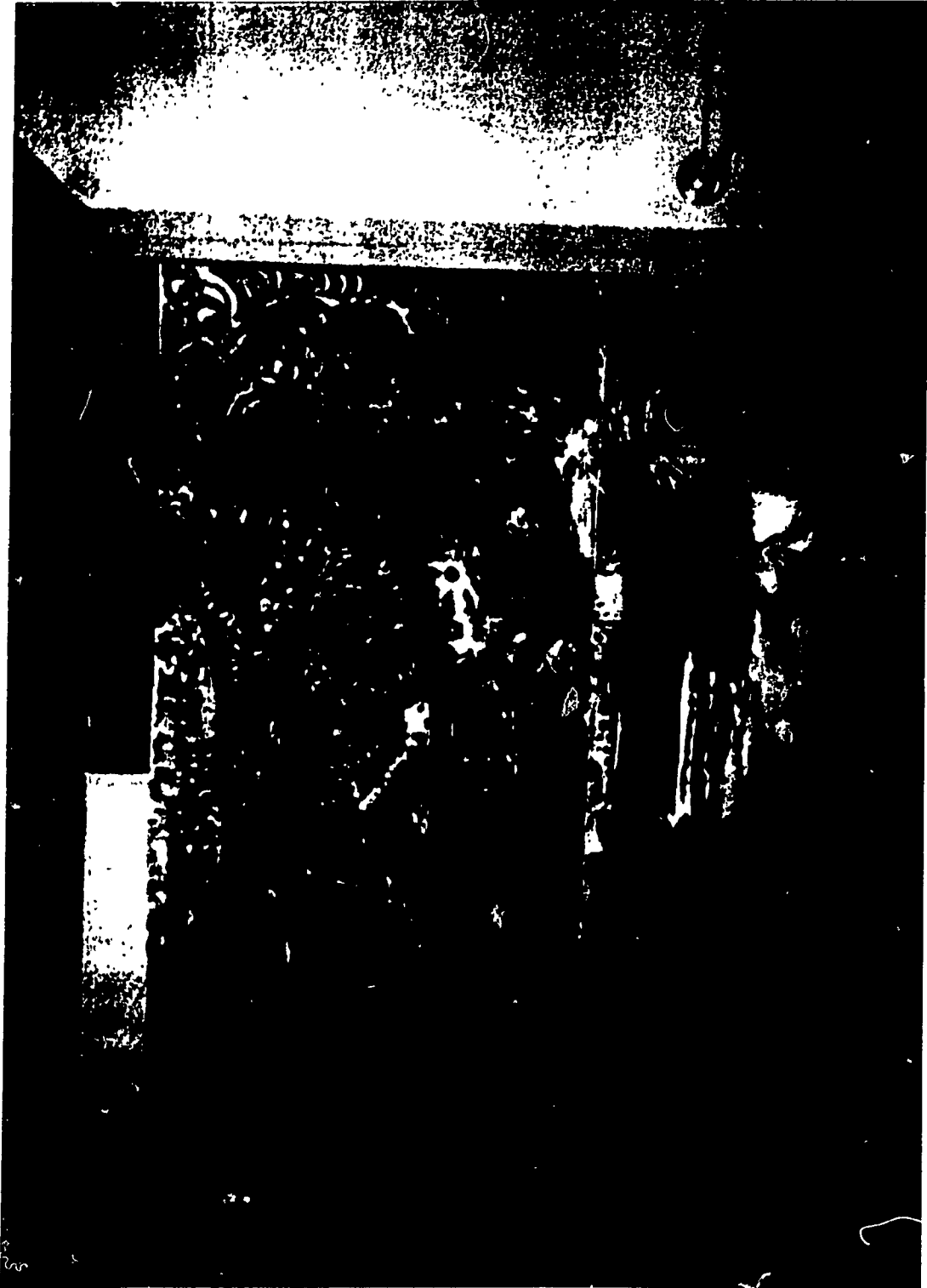
done by the elders. Through their use of colour, line, marks and form the beauty of their life-transforming experience unfolded before my eyes. Weiss, (1984), describes the experience of working with a group of elders eloquently when he writes: " The hidden reservoir of meaning and experience in each person's life was reflected in his activities. The participants expressed little in words, but their graphic expression and nonverbal communication conveyed a whole world " (p 115). The ability to make images seems to be a universal phenomenon and here was linked to the need to give form to both the outside world and to each participants inner experience. As one resident put it " lets bring the world into this room ." By letting go of the ego control the spirit or soul of the group was able to emerge. Gordon, (1978), writes.

> Through art forms man can, however, to some extent at least break the seal that locks him into his inner world. For art is the language that least distorts his image world and is, as nearly as his skill will allow, analogous to it. The privacy of the image world on the one hand, together with man's need to communicate and to validate this inner world, is probably one of the most powerful incentives that drives man to make art. (p. 146).

The image of the forest was central to the residents work. As a symbol the forest is complex, holding a duality of meaning. Cirlot, (1971), writes: " . . it is connected at all levels with the symbolism of the Great Mother. The forest is a place where vegetable life thrives and luxuriates, free from any control or cultivation. " Cirlot goes on to say that at the same time " the forest harbours all kind of dangers and demons, enemies and diseases " (p. 112). The forest as well as being symbolic for the earth, also symbolizes the unconscious. Biedermann, (1994), interprets the forest as symbolic of " all the dangers with which young people must deal if they are to survive their rites of passage and become mature, responsible adults " (p. 141) He also sees the image of the forest as the yearning for a place of refuge. Indeed in conversations, the elders associated their image to a quiet, peaceful place that they " would like to walk in." Biedermann echoes this feeling when he writes " . . . the forest can offer some seclusion from the hustle and bustle of the civilized world. Hermits do not fear the dangers of the woods· they are protected by higher powers " (p. 141). Within the forest nature carries out the business of life, death, decay into re-generation in a never-ending cycle. I felt that it was likely that this powerful

image contained the entire life/death process and experience of the elders. As well it spoke of the community spirit which had developed within the group. The trees, placed so close together, reflected their capacity for growth and reinforced the sense of community and sharing.

The tree with its roots in the ground and its branches reaching up to the sky was linked to the life forces and the continuity of creation. The Kabbalists consider the Tree of Life to be a central feature of Jewish mystical speculation. Using an elaborate system which resulted in ten primordial energies or Sefiroth they depicted these levels in various diagrams, the most favoured being the tree of life. These ten principles were separated into triads (Chapter 4), from the crown or Keter___ signifying the higher powers of wisdom and understanding down to the Malkuth or kingdom___ signifying the physical realm including humankind. Hoffman, (1981), comments on the symbolism of the tree of life: " Moreover, it refers to the *Shekinah*, the feminine counterpart of the deity, said to dwell in exile in our universe. Whenever we act with the right intention and devotion, . . .we convene this divine presence around us " (p. 55). The mural seemed to represent the connection between the physical aspects and the transcendent function which enabled the residents to overcome their limitations and strive upwards to a more spiritual place. For Jewish mystics agreed that within each individual the potential to transcend the material, physical realm was possible. The Kabbalah suggests that each of our attributes must be balanced by its opposite; the objective being to integrate all of them into a harmonious whole. Hoffman, writes: " The crucial concept, though, is that we must recognize and embrace our entire human makeup. In this way, we may better understand the workings of the cosmos as well " (p. 58).

The symbol of the tree and its use in the mural can be looked at as both a personal symbol of the collective, as well as a cultural one. Many residents associated the tree to the tree of life. Initially, the group looked at their creation in awe not quite believing that they had created this beautiful image. They made the comment that individually they could not have created such

a picture, but working as a group, in harmony, they could indeed create a work of art. The whole process of mural making depends heavily on the collective group putting aside their differences and working together. Klee wrote that " To achieve vital harmony the picture must be constructed of parts themselves incomplete brought into harmony at the last stroke " (in Segal, 1952, p 93). For the group it was the act of putting the mural together, the image-making process, that held the unconscious meaning of restoring something inside each participant. Segal, (1952), explains the process in this way, " This symbolic recreation is a psychic act. It has a bearing on the whole problem of the artist's relation to inner and outer reality " (p. 95).

Reaching into the depths of the unconscious the group was able to transform their disabilities into abilities and find unity in the human spirit. Weiss, (1984), writes that: " By viewing a person from his heart, feelings, and life, . . . I found that people would relate with a greater sense of self and an increased awareness of their strengths and abilities " (p. 179). The forest indeed offered a refuge for the residents, their families and the staff on the ward. Everyone related to it on some level and marveled at the ability of the resident artists who created it. The mural I believed represented the *prima materia* with all its potential, which through the creative process was broken down, worked on separately, and then reunited and restored on a new level. Wilson, (1985), quotes Edinger (1973), who writes of working with the prima materia until the *Philosopher's Stone* emerges:

> The Philosopher's Stone is a symbol for that reality. There is a healing power in the images that cluster around this symbol. It is a potent expression of the source and totality of independent being. Whenever it appears in psychotherapy it has a constructive and integrating effect. It is truly a pearl of great price. (p. 215)

With the creation of the mural came a decrease in the despair and depression experienced by the group members. However, I believed that this release would not have occurred without the acknowledgment of those very feelings which initially, had been denied.

As previously mentioned, near the beginning of the mural the group and myself had to deal with a major loss___ the death of R. In the session that followed R's death we discussed the loss and the reality of living in a close proximity to death. The group seemed to sense my own sadness and surrounded me with love and support. They became the caretaker/parent of the wounded therapist. Their acceptance of R's death was verbalized in many ways. Such statements as " we all know that it is just a matter of time " or " everyone dies, we are old people and we know this " expressed their own awareness of living in close proximity with death. Their acceptance did not prevent the loss from being felt. Knight, (1986), writes that: " The therapist, however, may have difficulty accepting the death of his/her clients." Knight goes on to say that " . . . the therapist may be forced to confront the issue earlier in life than normal or have personal anxieties reinforced by close contact with those nearer death " (p.145). Being able to talk about the death of R. helped me enormously.

In the group, we collectively mourned the loss of a valued group member and through their acknowledgment members were able to speak of their own experiences and feelings about death. Some members were aware of R's history and grief over the loss of her husband.. The two ' love birds ' (fig. 16), were added to the mural during this session. One resident spoke of the love of her husband and how she feared losing him, grateful for each day that they spent together. Perhaps R. was reunited with her husband in the spiritual world, represented by the two birds in the mural. Cirlot, (1971), relates the bird as symbolic of the human soul. Here the two birds were united and gazed upwards to the sky, symbolizing the group loss of loved ones and the acceptance that everything in life has its opposing element___where there is life there is also death.

6.13 The Verification Stage:

Gordon, (1978), describes the stage of verification as the time of coming-down-to-earth. " This is a period of critical testing, when the ideas received in the period of inspiration are tested, organized and given relevant and appropriate form and expression " (p. 132). In this last stage the ego functions must re-assert themselves, the work must be evaluated and any changes made. The finishing of the mural involved its own process. It was decided that following completion, the mural would be hung in the central activity room where many residents visited with family members and friends. We devoted an entire session to this task. After the mural was hung the group discussed their feelings regarding the mural, the process and the end product. We added some colour to areas that felt ' unfinished ' and then we gathered around the mural to talk. Many residents expressed surprise in the beauty of the image, not quite believing that they had created something so wonderful. The sense of accomplishment, pride and mastery was felt by all members. Some elders made associations to the past, others of their longing to be able to go outside, some spoke of love and family and the anticipation of showing their accomplishments to them. Everyone agreed that the mural brought the outside world into the room, into the hospital. One woman stated that in the making the of the mural she often forgot about her illness and the hospital, feeling a freedom in the act of creating. Segal, (1952), writes that in the unconscious of all artists:

> All creation is really a re-creation of a once loved and once whole, but now lost and ruined object, a ruined internal world and self. It is when the world within us is destroyed, when it is dead and loveless, when our loved ones are in fragments, and we ourselves in helpless despair___it is then that we must re-create our world anew, re-assemble the pieces, infuse life into dead fragments, re-create new life. (p. 199)

Through the creation of the mural, the group had overcome their feelings of despair and hopelessness by deriving energy and perhaps inspiration from the past, and thus attempted to work at mourning through creativity. The idea of immortality, of leaving something behind was

touched upon indirectly. The importance of leaving something behind was perhaps linked to more spiritual concerns of the search for meaning in life that was common for many elders who were feeling that the end of their earthly life was inevitable. One of the members made the comment that the mural would probably outlast everyone in the group. Others agreed. Segal makes this comment:

> All artists aim at immortality; their objects must not only be brought back to life, but also the life has to be eternal. And of all human activities art comes nearest to achieving immortality; a great work of art is likely to escape destruction and oblivion. (p. 207)

After the group discussion, the staff were invited in to view the mural. Their response was filled with genuine enthusiasm and they expressed surprise at the accomplishment of the group members. It was as if they were seeing the residents for the first time; not as old and sick, but, as individuals who were capable of creating something meaningful. Their response left the resident's feeling proud of their abilities, restoring a lost sense of purpose and identity. Often elderly residents feel as if they are no longer needed, that they are less than human. Pollock, (1989), has written that the goal for the elderly is to " acquire an inner stability and a new trust in themselves " (p. 350). He goes on to say that " Some individuals find their aging years rewarding, liberating, enjoyable___a time for personal growth, creativity, accomplishment and pleasure " (p. 362). By working through the mourning for a changed self, accepting limitations , unfulfilled hopes, and lost others, the group members were able to find new strengths, and found joy in the act of creating. Not everyone in the group experienced change on a deep level, some merely took pleasure in the aesthetic value of the work and enjoyed the social aspect of the group dynamics. But there were those who experienced profound insight into issues around aging and loss, who stated that by exploring their feelings they felt better able to deal with their present circumstances. Most importantly the mural helped all of the members to see the importance of their support of each other which fostered a sense of community within the institutional container.

6.14 Termination:

Over the next several weeks I began the process of termination with the residents. A return to individual work seemed natural at this time. The mural project had demanded a lot of intense energy and we were all drained and in need of a rest. Arrangements had been made for the other art therapist at the hospital to take over the group when I left. This made the termination process less difficult for most residents who were already familiar with her. In the last two sessions we reviewed the art work and the experience of art therapy. Knight, (1986), writes that " experience in clinical supervision and in consulting with other therapists shows that terminating with an elderly client is often anticipated and sometimes experienced as the most difficult part of therapy with the elderly " (p. 149). Knight maintains that often termination is more difficult for the therapist. I found his observation to be true, that saying goodbye to the group was a very emotional experience for me. On the therapist's response to termination, Knight has this to say:

> Termination often calls attention to the sense of impotence felt by many therapists in working with the elderly. Older people, and especially older clients, are frequently dealing with illness, disability, grief over the death of close loved ones, ageist prejudice, complex relationship problems . . .and being deprived of the opportunity to work. If the therapist has any question about the value or the power of therapy or about his or her own competence as a therapist, it seems working with clients facing these types of problems brings those self-doubts to the surface. The therapist working with aged clients must find a realistic view of the contribution of therapy to enabling elderly clients to more easily resolve their problems free from anxiety, depression, relationship issues, and so on. (p. 150)

The termination process with the group brought the realization that along with the group experiencing change, I had also experienced my own growth through working with these wonderful individuals. In the process of art therapy with the elders I had to confront my own fear and anxieties regarding the aging process, the meaning of life and of the inevitability of death. In a sense my own mourning process was resifted and reshaped through my work with the residents. Saying goodbye to these people was very hard and we all expressed sadness over the

impending loss. The last session was filled with emotion which included both laughter and tears___and a collective agreement that our time together had been filled with meaning.

6.15 Conclusion:

Jung and others have likened the meeting of two personalities in therapy to the contact of two chemical substances; if there is any reaction at all, both are transformed. (Jung, 1968, In Wilson, 1985, p. 134) The idea of ' alchemical ' change supports this idea. According to Newman, (1981), within the container of the middle Vas the " . . . doctor [must] step out of his role altogether and fully enter into the process on an equal footing with the patient. " Newman continues by saying that " this participation of the ' whole man ' in the therapeutic process clearly implies, then, the exposing and incorporation of the psychology of the analyst " (p. 233). Many analysts agree, and I concur, that the unique view of Jungian therapy is the emphasis placed upon the personal individuality of the therapist. Thus within the container of the middle vas both therapist and client are involved in 'experiencing'. Experiencing is a spontaneous activity and part of the creative process in which shapes emerge, are related, dissolved and re-combined. This is both the nature of the art therapy process and alchemical operations. Robbins, (1987), explains the art therapy process in this way:

> Therapy, then, becomes a means to refight lost battles and to complete unfinished dialogues. If nothing else it is a process through which one revisits relationships that have been associated with loss, annihilation, pain, and love in which the polarities and paradoxes inherent in relationships are reworked so that the painful process of leave-taking can proceed. A creative arts therapist must create an environment where this series of separations and the consequent renewal and regeneration of self can take place. (p. 149)

The strengths and weaknesses of using an alchemical model based on Newmans, (1981), idea of *Vas Bene Clausum*, depends on the existence of harmony within and between

each of the three Vas. This level of development is very rare in practice as is the making of alchemical gold. More often you will see some degree of balance rather than total integration. Particularily when one is working in an institution, where stability and efficiency are prized, introducing a new way of working can create an imbalance within the milieu. One danger with imbalanced arrangements is frustration. For example, the therapist introducing a new program can become frustrated with the apparent limited intellectual understanding or appreciation of other staff and management. Also, the resident's frustration with the institution's lack of empathy and understanding can be another problem. A second danger is fear; fear of having traditional roles and routines upset or changed.

A third and final danger exists for the therapist and the client. This pertains to the ideal of finding the alchemical gold. With any therapeutic model, goals are set but not always achieved. Success can only be measured when the therapist sets goals which are based on reality and not the ideal. Flexibility and the acceptance of the limitations of working in any institutional environment is necessary. Finally, the knowledge that not every individual will respond optimally to an alchemical model is extremely important for the therapist to keep in mind. By selecting and working with those people who are open to the possibility for change, the therapist can ensure that, through the capacity for relationship inherent in each, growth can be achieved.

Various terms have been used to describe the course of life and the aging process. Pollock, (1989), comments that " each of these catches the notion of temporality and movement, of process and change." Pollock states that the problem with many developmental theories is the implication of the idea of ascendancy and decline leading to the inevitability of death. He continues: " while raising our awareness of the inevitable ending to the life course, this theme may have done us a disservice if it has diverted our energies and concentration from what may be a more important issue: life and living " (p. 324). As previously stated the expectation that

aging is linked to sickness, disability, and deterioration is to a certain extent perpetuated by our culture, society, institutions, and by those who are directly involved ___ the elderly.

While many of us, myself included, abhor the need for institutions and hospitals, their existence for the time being is both necessary and part of the treatment of those who suffer from debilitating physical and/or emotional illness. Some elders who are institutionalized never recover from the trauma but sink into despair finding release only through death. Duff, (1993), describes the experience of being hospitalized:

> Hospitals are notoriously depersonalizing, giving out numbered ID bracelets and one-size-fits-all gowns. . . Initiates are often exposed in their nakedness, alternately ignored and ordered about, sometimes insulted and humiliated and inevitably forced to face their fears in the rigor of prolonged isolation. Those who have spent any time in a hospital can attest to undergoing many, if not all of these ordeals, and they are made all the worse by what we bring to them___our hopes and fears, attachments and resistances___the fixtures of identity and residues of a lifetime. (pp. 95-96)

While this image cannot be denied, as attitudes change and more work is done in the area of palliative and hospice care, perhaps the attitude of society and institutions will improve. Within the institution where I worked there was a real attempt to move away from the more traditional ' medical model ' of treatment, towards one which incorporated treatment of both the physical and psychological health of the individual. The success or failure of this attitude depends mainly on the co-operation of all the departments, as well as the nursing staff, doctors and even the maintenance people.

In the two years that I worked at the institution there has been some real attempts at finding ways to work together for the benefit of the residents. More importantly, through communication, meetings and experiencing the artwork done in group sessions the staff were more aware of the importance of the art therapy process and its ability to bring about change. This is not to say that our views were fully integrated. I believe that this situation must be very

rare. In this aspect the attempt to bring about transformation was not attained. Rather there was an acceptance that the art therapy program and the day to day running of the hospital routines co-exist together for the benefit of the residents, so within the container of the institution a kind of balance was achieved.

In my experience of getting to know the residents, staff and families whose lives were linked toge.her under the walls of the outer Vas, I have come to understand that the Jewish attitude towards healing and illness is one which supports the idea of a holistic approach. In fact this wisdom probably has been handed down over the ages and as previously stated has its roots in the teachings of the Kabbalah. In fact many ancient disciplines have caught the interest of the West because of their approaches to the mind and the body. Hoffman, (1981), writes that ". . the Kabbalah has for centuries been profoundly concerned with the mind-body relationship Its chief thinkers have focused at length on the cause of sickness and methods for improving overall health " (pp. 65-66). The basic belief of the Kabbalists was that our mind and body constitute a unity and they are inseparable.

> . . . they have asserted for centuries that well-being is an active condition, encompassing such mental qualities as clear thought, a sense of purpose in life, and openness to higher experience. . . they have also deemed health to include a physically vibrant an energetic body. Furthermore, the Jewish esoteric system stresses that health is a condition of dynamic equilibrium among our various inner aspects. Each part of us is fully alive and in balance with the others. (Hoffman, 1981, p. 69)

The Kabbalah's descriptions of events just before death and beyond support the modern hospice movement's attitude that every person deserves to die with dignity and in peace. The act of dying is viewed simply as a transition to further levels of being. We have much to learn form these ancient mystics whose wisdom we are only now re-discovering.

The nature of the art therapy process quite naturally lends itself to this ' holistic ' approach to healing. In particular the image making process can provide a safe place for those

elders who are cut-off or withdrawn from the world and perhaps immersed in their illness. Underneath the distortions and pain of illness is a person who has lived, loved, and experienced many losses and gains throughout their lifespan. There may be unresolved issues, ' unfinished business ' which need to be resolved and concerns of what kind of future, if any, is left to look forward to. Miller, (1984), writes that art therapy can " allow people to express their anger, acceptance, or fear of death in a way that allows this expression to be acceptable " (p. 132). Miller goes on to say that " . . . paintings can have a sequential or cumulative effect, and are therefore capable of depicting change over a period of time " (p. 133). It has been my observation that elders do indeed experience a series of stages or changes as they work through the creative process. Moving from isolation and despair they can find a measure of hope and acceptance of limitations of illness and the reality of death. This would be part of what Pollock, (1989), describes as the mourning-liberation process or Kubler-Ross's,(1970), and Rando's, (1984), theories on grief, death and dying. No matter which theory one turns to be it Freudian, Jungian, Humanistic, or others; the essential ingredient seems to be that the process of working through ones thoughts and feelings can result in some kind of change or transformation. The idea that spiritual transformation can come from ones immediate surroundings is central to alchemy. The very idea of the alchemical process___ of transforming the ordinary base matter of lead into gold supports this. Wilson, (1985), maintains that

> The work of the artist is closely related to that of the alchemist who formed an empathic bond with matter. Both project their subjective states on to an object. . . The artist, therapist, alchemist and patient in therapy can be seen as working to similar ends, since the aim for all is greater consciousness. . . The alchemical attitude allows for work on whatever level is presented: the patient engaged in art therapy may therefore work on repairing early narcissistic wounds . . . or on more current life issues. (p. 142)

In working with the group I observed this change taking place. By providing a safe place in which the residents could work essentially free from interruption, they could attempt to resolve, restore or transform their lives. This formed the second, middle Vas, which constitutes the therapeutic setting and the therapist, which gave the necessary protection from the outer Vas or the

institution and the outside world___facilitating a way for the 'work' to be carried out. In the safety of therapy, the elders could work on their own processes which constituted the innermost Vas or that of the individual psyche.

As in alchemy, art therapy can provide an elder with a bridge to the inner feelings and experiences of the individual or group. In the group the transition from pre-drawn imagery into more spontaneous work allowed the residents the opportunity to explore their own processes at their own pace and to whatever depth they wished. Jung et al., (1964), write that man has always used the creative process and his/her symbol-making propensity towards expressing the life cycle and those elements which held important psychological meaning for the creator. Part of the life cycle includes the expression about feelings related to death. Miller, (1984), supports this idea when he writes, " the metaphors that ancient man used to describe the world and his journey through it were derived from his immediate surroundings: birds, flowers, trees, and the celestial bodies seen in the sky " (p. 131). These images were often seen in my work with the elderly. They were used to express many feelings: despair, sorrow, pain, loss, anxiety of death, and finally, hope and joy in living. I believe that the forces of nature are a wonderful metaphor for the experience of life with its cycle of birth, death and re-generation as well as the vegetative processes of illness. In writing of the experience of illness I would like to quote Duff, (1993), who says:

> Carl Jung had visions of the beginning and end of all things when he hung on the edge of death after his heart attack; he described it as an " iridescent whole " in which past, present, and future were all interwoven. Initiates are often given the opportunity to glimpse, as Jung did, the drama of ongoing creation, for to witness creation and learn how all things are put together is to be created anew, to find one's place in the cosmic order and part in sustaining that harmony. It is also to heal___whether one lives or dies, stays sick or recovers___which explains why the curing ceremonies of many native people involve a retelling, or reenactment, of the creation story. As the sixteenth century alchemist Gerhard Dorn observed, in order to heal, one must learn " from what one depends and to whom one belongs and to what end one has been created. (p 100)

My work with the elderly has enriched my life and their courage in the face of illness and death has shown me that while life is indeed a process of mourning for past losses, accepting ones limitations in life, and perhaps facing debilitating illness; it can also be a process which promises continuing growth, discovery, and many transformations. Life would seem to involve a perpetual balancing of opposing forces: life and death, pain and pleasure, joy and sorrow, hope and despair. I believe the key to healing is the acceptance that all things are related to their opposites, and the goal, whether you call it transformation, spiritual revelation or self-realization, involves the reunion of opposites. In closing I would like to again turn to Kat Duff, 1993, whose work on The Alchemy of Illness has greatly inspired me. She writes:

> Magic is present in those sacred spaces where opposites touch___at dawn and at dusk when day meets night, at the edges of sleep where dreaming and waking realities mingle, and wherever ego touches archetype in the midst of defeat or the postures of prayer. Miracles of healing can occur at these intersections, although they are not necessary or inevitable, but simply demonstrations of grace. (p. 89)

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