THE USE OF THERAPEUTIC MASK AS A TOOL TO AID ELDERLY ADJUSTMENT TO LONG-TERM CARE

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ABSTRACT

THE USE OF THERAPEUTIC MASK AS A TOOL TO AID ELDERLY ADJUSTMENT TO LONG-TERM CARE

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The following theoretical research paper sets out to explore the question: “How might therapeutic mask work be used to aid elderly adjustment to long-term care?” by reviewing literature regarding elderly adjustment to long-term care, the use of creative arts therapies in long-term care, and the use of mask in therapy. Based on the themes that emerged across all three categories of the literature reviewed, the researcher ultimately found that therapeutic mask work may have the potential to aid elderly adjustment to long-term care due to the flexibility and adaptability of therapeutic mask approaches, as well as due to the potential of masks to serve as safe containers for the many unique challenges/ traumas that may be experienced by elderly individuals during their transition to long-term care. With historical roots in aiding transitions and transformations, therapeutic mask work may also have the potential to aid elderly adjustment to long-term care due to its ability to facilitate expression and exploration of self, communication and connection with others, and to provide individuals with opportunities for autonomy. Contraindications identified for the use of therapeutic mask work in the context of elderly adjustment to long-term care include: the potential of mask work to lead to further loss of sense of self, and that cultural and religious taboos surrounding mask may discourage elderly participants from engaging in therapeutic mask interventions. Further research on the topic of the use of mask to aid elderly adjustment to long-term care, in particular intervention research, is necessary to determine whether mask work would be an effective intervention.

Keywords: therapeutic mask, elderly adjustment, long-term care, nursing homes, transitions, creative arts therapy, drama therapy, art therapy

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Chapter 1. Introduction

My own interest in masks emerged in the context of my undergraduate theatre studies, during which I personally experienced mask making as having therapeutic properties while constructing a commedia dell'arte mask. Upon entering the drama therapy master's program at Concordia University, I was thrilled to learn that others within the fields of psychotherapy and creative arts therapy had also discovered the therapeutic properties of mask. However, regardless of literature which suggests the efficacy of mask work as a tool for therapy (Dunn-Snow & Joy-Smellie, 2000; Fryrear & Stephens, 1988; Janzing, 1998; Landy, 1985, 1994), I quickly came to realize that relatively few current therapists, with the exception of Silverman (2004, 2010, 2018), Stahler (2006), and Walker, Kaimal, Gonzaga, Myers-Coffman, and DeGraba (2017) are currently documenting the use of mask in the field of creative arts therapy.

During my first year of the drama therapy program, I also became aware of and interested in the use of creative arts therapies in the context of long-term care (see Sandel & Johnson, 1987; Weisberg & Wilder, 2002; Weiss, 1984). From this, in combination with my aforementioned interest in the use of mask as a tool for therapy, I began to wonder if therapeutic mask may somehow be beneficial to elderly people living in long-term care.

As I began to consider this question further, a quick venture into geriatric nursing literature revealed that much is written about elderly individuals' initial relocation/ transition into long-term care, as well as the challenges they often face in adjusting to life in long-term care following relocation (see Brownie, Horstmanshof, & Garbutt, 2014 for a systematic literature review). In fact, relocation to long-term care is consistently identified by many sources as a major life transition that poses significant cognitive, social, and emotional challenges for individuals (Heliker & Scholler-Jaquish, 2006; Melrose 2004; Porter & Clinton, 1992).

The magnitude of the difficulty of relocating and adjusting to life in long-term care is highlighted by the fact that an official syndrome called 'relocation stress syndrome' (RSS) was developed by the North American Nursing Diagnosis Association in 1992 "in recognition of the physiological and psychological stress a person suffers in transition to a long-term care facility" (Brownie et al., 2014, p. 1655). From this, it appeared worthwhile to explore if therapeutic mask may have the potential to help elderly residents adjust to life after relocation to long-term care.

Therapeutic mask work (defined below) has been used with a wide variety of populations, struggling with a wide variety of difficulties/ challenges (Dunn-Snow & Joy-

Smellie, 2000; Janzing, 1998). From this, the following research paper aims to review the topics of elderly adjustment to long-term care, creative arts therapy interventions in long-term care, and the use of mask in therapy, in order to explore the following research question:

> How might therapeutic mask work be used to help elderly people with mild to no cognitive impairment adjust to life in long-term care?

The focus on elderly people with mild to no cognitive impairment, instead of all elderly people in long-term care, emerged in response to the discovery that the vast majority of research studies about the phenomenon of elderly adjustment to long-term care are based on the experiences of those who may be categorized as cognitively intact/ able to participate in interviews and or answer questionnaires (as seen in Altintas, De Benedetto, & Gallouj, 2017; Heliker & Scholler-Jaquish, 2006; Kennedy, Sylvia, Bani-Issa, Khater, & Forber-Thompson 2005; Lee, 2010; Porter & Clinton, 1992; Yu, Yoon, & Grau, 2016).

Operational Definitions

Creative or expressive arts therapy. The terms *creative arts therapy* or *expressive arts therapy* will be used interchangeably as umbrella terms to refer to any approaches to therapy which involve the use of the arts (art, music, dance/movement, drama/psychodrama, poetry, or play) for therapeutic intervention (Brooke, 2006; Miraglia & Brooke, 2015).

Long-term care or nursing home. The terms *long-term care* and *nursing home* will be used interchangeably to refer to any type of residential care facility "designed for older people with physical or cognitive autonomy deficits… intended to provide a safe environment and continuous nursing care" (Altintas, Guerrien, Vivicorsi, Clement, & Vallerand, 2018, p. 334).

Therapeutic mask. The researcher uses the terms *therapeutic mask* or *therapeutic mask work* as umbrella terms to refer to the use of mask making and mask exploration (a term defined below) as a means for therapy.

Mask exploration. This term refers to any further exploration of a self-constructed mask including but not limited to: discussion about a self-constructed mask (Walker, Kaimal, Gonzaga, Myers-Coffman, & DeGraba, 2017); wearing a self-constructed mask and engaging in dialogue, movement, or role play (Fryrear & Stephens, 1988; Jennings & Minde, 1993; Landy 1994; Silverman, 2004; Wadeson, 1995); writing a story/ monologue based on a self-constructed mask (Stahler, 2006); or writing a letter to a self-constructed mask (Trepal-Wollenzier & Wester, 2002).

Chapter 2. Methodology

Rationale

A qualitative, theoretical approach, culminating in the form of a theoretical research paper has been selected to address the research question at hand: How might therapeutic mask work be used to help elderly people with mild to no cognitive impairment adjust to life in long-term care?

In their discussion of theoretical frameworks within qualitative research, Lunenburg and Irby (2008) suggest that the researcher may not always be able to find a specific theory and that "the comprehensive review of the literature may need serve as the theoretical framework" (p. 122). This is the case for the current study, which thoroughly reviews nursing, creative arts therapy, and therapeutic mask literature to address the research question above.

Marshall and Rossman (2016) define qualitative approaches to inquiry as "uniquely suited to uncovering the unexpected and exploring new avenues" (p. 82). Lunenburg and Irby (2008) further articulate the qualitative approach as explorative, suggesting that qualitative studies can lead to the creation of new theories, by permitting researchers to first collect data, and to then derive theories from the data collected. A qualitative approach is thus well suited to address the research question, as theories specific to the use of therapeutic mask as a tool to aid elderly adjustment to long-term care do not currently appear in creative arts therapy literature.

In *Art Therapy & Drama Therapy Research Handbook*, theoretical research is defined as a type of research that does not only identify the ideas of others, but reaches further to investigate, critically analyze, and synthesize ideas (Concordia University, 2015). This type of methodology therefore permits the investigation of factors contributing to adjustment to long-term care, critical analysis of current interventions, investigation of the use of mask in therapy, and synthetization of ideas regarding how therapeutic mask may, or may not (depending on the findings) be used to aid elderly adjustment to long-term care.

Data Collection

Data was gathered using electronic academic databases accessible through Concordia University library including Concordia's Spectrum Research Repository, SAGE, PsychINFO, Medline, PubMed Central, and EBSCOhost. Google Books and Google Scholar were also used for sources which were inaccessible via the Concordia database. Search terms for data collection included: "nursing homes or long-term care and adjustment," "nursing homes or long-term care and adjustment and interventions," "nursing homes or long-term care and

creative arts therapy and adjustment," "nursing homes or long-term care and drama therapy or art therapy and adjustment," "mask and psychotherapy," and "mask and drama therapy, art therapy, or creative/ expressive arts therapy." PDF versions of electronic resources were organized into electronic folders titled "Adjustment," "Creative Arts Therapy in Long-term Care," and "Therapeutic Mask." Books were organized into these same categories on the researcher's bookshelf. Further academic resources recommended by the researcher's professors and supervisor were also collected and organized into the categories identified above.

Procedure/ Data Analysis

In *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, Creswell (2014) suggests the following steps for data analysis and interpretation in qualitative research (p. 197-201):

1. Organize and prepare the data for analysis;
2. Read or look at all data;
3. Start coding all of the data;
4. Use coding process to generate…themes or categories;
5. Advance how the description and themes will be represented in the qualitative narrative; and
6. Make an interpretation of the findings or results.

While these suggestions were originally made by Creswell (2014) for the analysis of qualitative data such as observations, interviews, or audio and visual materials, an adaptation of this approach appeared well suited for qualitative analysis of the data (literature) gathered for the research at hand. Therefore, the researcher began with the organization of data/ preparation of data for analysis (as described in the previous "data collection" section). Literature gathered regarding elderly adjustment to long-term care, creative arts therapy in long-term care, and therapeutic mask was then read and coded using *open, axial,* and *selective coding* (Neuman, 2014) to articulate dominant themes. Themes which emerged across all the data were then organized and presented in a literature review, which aimed to bring the reader on a journey alongside the researcher in her exploration of adjustment to long-term care, creative arts therapy interventions in the context of long-term care, and the use of mask in therapy. From the synthesis of themes that emerged from the data, the researcher then analyzed the data in the discussion section and formulated informed inferences regarding why therapeutic mask may and may not be suited to use in the context of elderly adjustment to long-term care.

Reliability and Validity

As articulated by Merriam (2009), concerns surrounding validity and reliability within any type of research can be addressed "through careful attention to a study's conceptualization and the way in which the data are collected, analyzed, and interpreted," (p. 210) as well as through careful attention to the ways in which findings are presented. Strategies used to foster validity and reliability within the study at hand included: the triangulation of multiple sources of data, adequate engagement in data collection, looking for data supportive of alternative explanations, peer review/ examination, and researcher reflexivity (Merriam, 2009).

Position of the Researcher

Within qualitative research, ethical dilemmas "are likely to emerge with regard to the collection of data and the dissemination of findings" (Merriam, 2009, p. 230). For the theoretical research at hand, the process of data collection and dissemination of findings has been influenced by both researcher bias and confirmation bias.

Researcher bias in the context of qualitative research is defined by Johnson (1997) as a type of bias which can emerge "from allowing one's personal views and perspectives to affect how data are interpreted and how the research is conducted" (p. 284). Crotty (1996) suggests that bracketing can be used to reduce the impact that the researcher's assumptions may have on data collection and interpretation (as cited in Ahern, 1999). Bracketing "typically refers to an investigator's identification of vested interests, personal experience, cultural factors, assumptions, and hunches that could influence how he or she views the study's data" (Fischer, 2009, p. 583). As a drama therapy student, the researcher holds the assumptions that: (1) creative arts therapy interventions are inherently healing, (2) many different populations can and want to engage in creative arts therapy, (3) creative arts therapies are unique from other forms of therapy and, (4) that academic sources (from which this research is built) are reliable sources of information regarding aspects of human experience. As a 27-year-old, white, Canadian, cis gender, able bodied woman, the researcher recognizes that the social locators listed above contribute to researcher bias.

Another specific type of researcher bias important to acknowledge here is cultural bias. Within a discussion of the use of mask across various cultures, Chase (2017) highlights a variety of mask making and using traditions from Bali, Japan, West Africa, Native America, and many other "Eastern places" (p. 3). In terms of contextualizing mask in Western society, Chase (2017) draws attention to its use in Greek theatre and commedia dell'arte, however, suggests that mask has ultimately "not been taken up by Western society

as a lineage of mask traditions" (p. 5). With this, the researcher acknowledges her understanding of mask as influenced by her Canadian upbringing (especially her lack of engagement with mask as a tool for spiritual and religious ceremony) and that this understanding of mask, which is less rooted in tradition, will impact her interpretation, analysis, and conclusions regarding the use of mask as a potential tool to aid elderly adjustment to long-term care.

Lastly, the researcher acknowledges that confirmation bias may also play a role in the research at hand. Confirmation bias refers to the researcher's tendency to interpret and draw conclusions from new data that are "overly consistent" with their previously established hypothesis (Greenwald, Pratkanis, Leippe, & Baumgardner, 1986, p. 216). Having experienced mask as therapeutic in her own theatre and therapy encounters, as well as having previously studied therapeutic mask within the context of an independent study, the researcher acknowledges that her established understanding of mask as therapeutic will impact the data collection process. As mentioned above, actively looking for data supportive of alternative explanations will be used to help curb confirmation bias.

Chapter 3. Elderly Adjustment to Long-term Care

Defining 'Adjustment'

As authors (Lee, Yoon, & Bowers, 2015; Yu et al., 2016) have begun to recognize, a review of the literature focused on elderly adjustment to long-term care reveals that the actual definition of *adjustment* appears inconsistent across sources, as different researchers turn to varying previously published sources to construct unique definitions for this term. A good example of this is seen in the work of Altintas, Guerrien, Vivicorsi, Clement, and Vallerand (2018), who conceptualize their definition of adjustment in the context of long-term care from work by Bizzini (2004), Freeman and Roy (2005), and Roy and Andrews (1991, 2009) articulating that:

> Adjustment to a new environment involves developing new behaviours that meet the demands of the environment as well as developing new skills, including qualities such as problem solving or managing anxiety…thus, adjustment can be viewed as a dynamic process that involves the use of strategies to adaptively acclimate to the nursing home. (Altintas et al., 2018, p. 334)

The term adjustment also often appears to emerge in the broader context of *transitioning* into long-term care. For example, in her research, Brandburg (2007) suggests that when transitioning into long-term care, residents move through four stages which she labels: "initial reactions," "transitional influences," "adjustment," and "acceptance" (p. 54). Brandburg (2007) further specifies that during the adjustment stage, residents often focus on contemplating their new homes, forming new relationships, and maintaining previous relationships. In their interpretive grounded theory study within which they investigate the relocation experiences of ten nursing home residents through retrospective interviews, Sussman and Dupuis (2014) identify adjustment as one aspect of study participants' overall transitional process. According to Sussman and Dupuis (2014), adjustment was described by all study participants "as an active process that included adaptation to new rules, regulations, and routines; participating in activities; building relationships with staff; and emotionally accepting the move" (p. 455).

In their research focused on adjustment to old age, Panday and Srivastava (2017) define adjustment as:

> A process involving both mental and behavioural responses by which an individual strives to cope with inner needs, tensions, frustrations, and conflicts and to bring harmony between these inner demands and those imposed upon him by the world in

which he lives…Adjustment is the flexibility in adopting appropriate behaviour towards changing ability, role, responsibility, environment, and social network. (p. 89-90)

While this definition refers to adjustment in the context of aging in general, it sheds light on the potential complexity of elderly adjustment in the context of long-term care, as new residents may be faced not only with the challenge of adjusting to a new living environment but also with challenges of adjusting to various other changes (ability, role, responsibility, social network) associated with aging. The aforementioned literature demonstrates that there appears to be no one consistent definition of adjustment. Therefore, for the theoretical research paper at hand, the following definition of adjustment has been constructed by the researcher based on those definitions presented above:

> Adjustment in the context of long-term care refers to a complex process, involving the active development of novel cognitive and behavioural responses which serve to reduce tensions or discomforts initiated by changes (internal and external) associated with nursing home relocation, and lead to a sense of acceptance surrounding nursing home relocation.

Adjustment Process as “Unique” to Each Individual

Across the literature regarding elderly adjustment to long-term care, adjustment is often conceptualized as a process that is unique for each individual. In their research, Porter and Clinton (1992) set out to explore the lived experiences of those transitioning into long-term care. Using a qualitative, phenomenological approach, Porter and Clinton (1992) interviewed 332 nursing home residents and asked residents open ended questions regarding their experience adjusting to long-term care. Following these interviews, Porter and Clinton (1992) describe the various factors which influenced adjustment as diverse, as they were “representative of each residents’ unique life experiences” (p. 474). In their research, which presents four case studies chronicling four different elderly people’s transition to assisted living residences, Kennedy, Sylvia, Bani-Issa, Khater, and Forber-Thompson (2005) found that “older adults in assisted living are heterogeneous, especially in physical functioning, life histories, and patterns of decision making” (p. 23) and thus recommend the development of personalized approaches to helping residents adjust.

Rehfeldt, Steele, and Dixon (2001) discuss the way in which different characteristics of the individual may impact elderly transition to long-term care, suggesting that within previously conducted research, “a variety of individual characteristics have been linked to successful survival of relocation, including feelings or concerns about moving, perceptions of

health, and personality traits" (p. 31). In a similar vein, Sussman and Dupuis (2014) suggest that an individual's personal values or assumptions and functional abilities, combined with interpersonal interactions with family, as well as societal and/or organizational rules, regulations, values, and practices all intersect to influence residents' transition experiences.

Lack of Therapeutic Services

With the exception of Brownie, Horstmanshof, and Garbutt (2014) who encourage making mental health professionals available to residents following their relocation to long-term care, the recommended use of therapeutic services to aid elderly adjustment to long-term care appears to be missing from published literature regarding elderly adjustment. Many studies focus on making recommendations for interventions that nursing staff might employ to help residents adjust (Curtiss, Hayslip, & Dolan, 2007; Ellis, 2010; Heliker & Scholler-Jaquish, 2006; Kennedy et al., 2005; Sussman & Dupuis, 2014), rather than recommending that residents be referred to therapy to help them overcome adjustment challenges.

In their discussion of mental illness prevalence in long-term care facilities, Rehfeldt et al. (2001) report that overall, research addressing the relationship between relocation to long-term care and mental illness is currently lacking. Rehfeldt et al. (2001) articulate that according to the minimal, previously published research that does exist, resident mental health evaluations are rarely conducted due to a lack of mental health professionals in nursing homes. Rehfeldt et al. (2001) further suggest that "[nursing home] staff seldom have the formal training necessary to treat the psychological needs of the residents" (p. 36). From this, Rehfeldt et al. (2001) advocate for the increased employment of trained professionals such as psychologists and psychiatrists in the context of nursing homes, to ensure that residents receive proper psychological care.

Factors that Impact Adjustment to Long-Term Care and Corresponding Approaches to Aiding Adjustment

Loss of sense of self or sense of identity. Loss of sense of self or sense of identity is documented as something that is commonly experienced by those transitioning into long-term care. Brownie et al. (2014) articulate that as home is closely linked to one's identity, the homelessness experienced by older adults as they leave their previous homes and enter long-term care ultimately leads to a sense of loss of identity.

In their research, Heliker and Scholler-Jaquish (2006) examine the lived experiences of ten newly admitted nursing home residents in the process of adjusting to long-term care. Conducting phenomenological interviews with residents the week after their initial admission to long-term care, and periodically in the three months that followed, Heliker and Scholler-

Jaquish (2006) identified *becoming homeless* as a theme which commonly emerged for residents. Heliker and Scholler-Jaquish (2006) articulate how a sense of homelessness experienced by those transitioning into long-term care can significantly impact sense of self/identity:

> Home is where individuals share space with their friends and loved ones who tell them who they are. This "mirroring" of self helps individuals to understand their identities and their stories. When older individuals enter a nursing home, there is no one to mirror their very self. (p. 37)

In their research, Sussman and Dupuis (2014) discuss the way in which the common systematic pressure of having only 24-48 hours to accept an available room in long-term care can be particularly challenging to residents' sense of identity. Sussman and Dupuis (2014) suggest that the pressure to move immediately means that residents have very little time to go through their personal belongings, and therefore end up feeling as though they were forced to leave "important aspects of themselves and their histories behind" (p. 447). Given the major impact that relocation appears to have on sense of self, promotion of sense of self/ identity has thus been documented by many researchers as something which can aid adjustment (Brownie et al., 2014; Heliker & Scholler-Jaquish, 2006; Melrose, 2004; Sussman & Dupuis, 2014).

Objects as identity affirming/ aiding adjustment. In their research, Brownie et al. (2014) recommend helping residents regain their sense of identity through enriching their living environments with personal possessions. Sussman and Dupuis (2014) suggest that creating personalized spaces for residents by allowing them to return home and collect personal items that might make their nursing home rooms "more functional, comfortable, and true to their sense of self" (p. 449) can contribute to adjustment. Sussman and Dupuis (2014) highlight the experience of a nursing home resident named Betty, who after making multiple trips home to retrieve personal items articulated "I think as long as you have your things around you, you feel better" (Sussman & Dupuis, 2014, p. 449). In her research, Melrose (2004) suggests that nursing staff can promote residents' sense of identity by inviting them to craft an ongoing biography in the form of a life-story scrapbook. From this, it appears that the presence of objects which serve to support / affirm identity play an important role in helping elderly people adjust.

Storytelling as identity affirming/ aiding adjustment. In order to support and validate residents' sense of identity following nursing home admission, Heliker and Scholler-Jaquish (2006) encourage nursing home staff to facilitate opportunities for residents to share their

stories, and argue that "story sharing is an important way to help new residents integrate into the unfamiliar long-term care facility" (p. 41). In their research involving the impacts of nursing home transition on an individual's sense of identity, Riedl, Mantovan, and Them (2013) conclude that "identity forming conversations" (p. 8) in new social networks within the nursing home are essential to helping new residents reform their sense of identity, and recommend that "a narrative climate should be established in order to make identity-forming story telling possible" (p. 9).

Need for socialization. Nursing literature surrounding adjustment also consistently highlights the importance of providing new residents with opportunities to socialize with others. Brownie et al. (2014) identify maintenance of social relationships, alongside control over the decision to move and preservation of autonomy, as a key determinant of adjustment to long-term care. Brownie et al. (2014) articulate that ultimately, the ability of "residents to retain or regain meaningful social relationships is an important determinant of the extent to which aged care residents adjust to their new living environment" (p. 1663). The way in which relocating to long-term care affords new residents the chance to spend time with others and develop new social supports is also perceived by some residents as a benefit of relocation (Ellis, 2010; Lee, 1999). In her research, Lee (1999) articulates the personal account of a newly admitted nursing home resident who reported:

> I have nothing to worry about anymore, I just feel happy. I have someone to be with me and its even better than being alone at home. This is what I've been waiting for! You may not know how lonely it is when you have no one to talk to. Here… I feel safe to chat …I just feel `safe at heart' now that I am here! (Lee, 1999, p. 1121)

In Lee's (2010) cross-sectional survey of predictors of adjustment to nursing home life, emotional support from other residents was identified as the strongest predictor of nursing home adjustment. With this, it appears that adjustment to nursing homes is something which is influenced heavily by socialization with others. This is also highlighted by Porter and Clinton's (1992) research, as "when residents were asked to describe their experience of the changes associated with nursing home life, they spoke of that experience as one of interaction with others rather than as a reaction to an event" (p. 475). Altintas, De Benedetto, and Gallouj (2017) explore the role of leisure activities in the context of adaptation to nursing homes, and conclude that "when an environment facilitates relatedness, and leisure activities practice, it promotes adaptation to nursing homes" (p. 12). Altintas et al. (2017) recommend providing elderly residents the opportunity to develop secure relationships with peers, as relatedness can be understood as the first step to nursing home adaptation. In a similar vein,

Lee (2010) recommends that in nursing homes, social support "should be fostered to improve nursing home adjustment" (p. 963).

Loss of autonomy. Brownie et al. (2014) articulate that across adjustment literature, "the initial admission to an aged care facility and subsequent period of adjustment was viewed by many residents as leading to a loss of independence, autonomy, decision-making [and] control" (p. 1659). For many new residents, a lack of control may surround their transition and adjustment experience, from a lack of control regarding the circumstances which led to institutionalization, the choice of nursing home (Brownie et al., 2014; Kennedy et al., 2005), and experiences inside the nursing home, as "many aspects of…the way the institution must be managed are non-negotiable for residents" (Melrose, 2004, p. 16).

Koppitz et al. (2017) also discuss the negative impacts of loss of autonomy on adaptation to long-term care in their qualitative research study, in which 77 elderly people were interviewed regarding their unplanned admission into a nursing home. Koppitz et al. (2017) identify "being restricted" as a common theme within the interviews of study participants, as participants reported that following relocation, they "were less able to decide for themselves… [and had] restricted input as to what they could do, how, and when" (p. 522). Koppitz et al. (2017) further explain that "being restricted" reminded residents of their physical limitations and led residents to struggle to pursue new activities. From this, Koppitz et al. (2017) argue that "when older adults can less participate within the nursing home they will be less adopt to their new home" (p. 522).

In her research, Melrose (2004) looks specifically at relocation stress syndrome in the context of long-term care. Relocation stress syndrome is defined as: "physiologic and/or psychosocial disturbances as a result of transfer from one environment to another" (Manion & Rantz, 1995, p. 8). In describing what relocation stress syndrome looks like during the first year following relocation, Melrose (2004) identifies seeking a sense of control over one's new environment as a key psychological issue for new residents. From this, in her implications for practice, Melrose (2004) encourages nursing staff to offer residents the opportunity to make choices as frequently as possible. Melrose (2004) argues that providing residents the autonomy to make choices regarding where to put their belongings in their personal space, which food items they wish to eat, what name they wish to be called, and which clothes to wear is essential to helping residents adjust to long-term care.

In line with these findings, Philippe and Vallerand (2008) found that "autonomy-supportive nursing home environments were positively associated with residents' perceptions of autonomy" (p. 81) and that such environments, in turn, increased psychological

adjustment. Similarly, Brownie et al. (2014) identify preservation of autonomy as a key determinant of adjustment. In their aforementioned research study in which they examined ten nursing home resident's retrospective accounts of being relocated to long-term care, Sussman and Dupuis (2014) ultimately discovered that "when conditions at individual, interpersonal, and/or systemic layers nurtured a sense of control… residents reported positive relocation experiences" (p. 451).

Loss of autonomy as multifaceted. Worth noting here, is the way in which the loss of autonomy which emerges within the context of transitioning into long-term care may be derived not only from institutional limitations as those articulated above, but also from the changes in an individual's physical and/or cognitive abilities that are often the catalyst for nursing home admission. Curtiss, Hayslip, and Dolan (2007) articulate that:

> In some cases, the person is recovering from a serious illness or injury, which in itself calls for adjustments and/or compromises of some sort. In most instances, the person's functioning has deteriorated to the point that she can no longer care for herself independently. (p. 30)

Chapter 4: Creative Arts Therapies in Long-term Care

In order to establish some foundational context for the exploration of therapeutic mask as a tool to aid elderly adjustment to long-term care, the following section provides information regarding the use of creative arts therapy interventions in long-term care. The search for creative arts therapy interventions aimed specifically at helping elderly people adjust to long-term care reveals a gap in the literature. Therefore, the following section aims to highlight common themes presented in the literature regarding the use of creative arts therapy with elderly people in nursing homes in general.

The term *creative/expressive arts therapy* will be used as an umbrella term to refer to any approaches to therapy which involve the use of the arts (art, music, dance/movement, drama/psychodrama, poetry, play) for therapeutic intervention (Brooke, 2006; Miraglia & Brooke, 2015). As an extensive review of the use of all types of creative/expressive arts therapies within the context of long-term care falls outside of the scope of this project, this section will focus on creative/expressive arts therapies that bear substantial resemblances to therapeutic mask work. Since, as Jennings and Minde (1993) say, the use of mask in therapy is “where art therapy and drama therapy meet” (p. 187), and therapeutic mask work often also incorporates movement (see Landy, 1994; Silverman, 2004), this section reviews literature that presents examples of the use of creative/expressive arts therapy approaches which incorporate the use of art, drama, and/or movement.

Promoting Expression and Exploration of Self

In *Expressive Arts Therapy with Elders and the Disabled*, Weiss (1984) argues that engagement in expressive arts therapy allows elderly individuals “to discover and understand themselves through their creative expressions” (p. xviii), and that expressive arts therapy fosters both self-expression and self-understanding. He further articulates that in creative arts therapy, the therapist can help participants identify feelings and thoughts which lie in both conscious awareness and in the unconscious, and that this can help the individual “to affirm and acknowledge [their] sense of self” (Weiss, 1984, p. xviii).

This sentiment is also expressed by Sandel and Johnson (1987) in their book *Waiting at the Gate: Creativity and Hope in the Nursing Home.* Early within this book, while discussing the benefits of using movement and drama therapy with nursing home residents, Sandel and Jonson (1987) suggest that “by encouraging spontaneous expression through the arts media, aspects of the self that have been kept from awareness often emerge” (p. 9). Sandel and Johnson (1987) further articulate that from this, individuals may then seek to

explore and better understand those emerging aspects of self, with the help of both their therapist and therapy group members.

The idea that creative arts therapy can facilitate expression and exploration of the self with elderly people living in long-term care is also highlighted in Geller's (2013) descriptive research, which chronicles the art therapy experience of a woman by the pseudonym of Rose. By taking part in group art therapy, Rose was "able to cull out positive memories of family and integrate many of the closed-off parts of herself" (Geller, 2013, p. 206).

Facilitating Socialization, Communication, and Connection

The ability of creative arts therapies to facilitate socialization appears commonly cited in literature regarding the use of creative arts therapy in nursing homes. Weiss (1984) suggests that expressive therapy is particularly well suited for elderly people living in nursing homes, as it can reinforce a sense of community, sharing, and peer support. In the article *A Foot in the Door: Art therapy in the Nursing Home,* Ferguson and Goosman (1991) articulate this same sentiment when discussing the implementation of art therapy in a residential nursing home and day-care facility, suggesting that "group work promoted a sense of community and emphasized the enjoyment not only of doing things together, but of being able to talk about it later with other group members" (para 12). Geller (2013) describes her use of weekly group art therapy sessions in a nursing home, articulating that group members supported each other significantly and that "they encouraged each other, they laughed together, and sometimes cried together" (p. 202). Social support is also highlighted by Bookbinder's (2016) research as one of the benefits of fusible quilting within geriatrics.

Jensen (1997) sets out to explore the use of an intervention integrating music, movement, and visual art making with elderly long-term care residents with Alzheimer's disease. Jensen (1997) focuses on some of the difficulties experienced by those with Alzheimer's (loss of sense of self, loss of autonomy) which, as suggested in the nursing literature reviewed above, are shared by individuals without Alzheimer's disease during their transition and adjustment to long-term care. Ultimately, Jensen's (1997) integrative intervention permitted participants to retrieve memory, socialize with others, express emotions that they were no longer able to verbalize, as well as served to increase a sense of self.

In their aforementioned discussion of the benefits of using creative arts therapy with nursing home residents, Sandel and Johnson (1987) also articulate the way in which movement and drama therapy can contribute to the development of meaningful interpersonal relationships:

> The creative arts therapies provide a means of structured communication among people. A setting of intimacy is created through the mutual expression of aspects of their inner lives. Yet due to the concrete, nonverbal nature of the arts media, people with cognitive or language deficits can participate equally. The atmosphere of play, fun, and spontaneity contributes to the bonding among members of the group. (p. 9)

Within Sandel and Johnson's (1987) book, in his chapter entitled *The Developmental Method in Drama Therapy*, Johnson (1987) focuses on his use of developmental transformations (DvT) in the context of a long-term care facility. DvT is defined as "an embodied approach to psychotherapy that involves the therapist and client engaging in free flowing improvisation" (Butler, 2012, p. 87). Johnson (1987) suggests that the fundamental goal of DvT in the context of long-term care is to help group members "establish meaningful interpersonal relationships" (p. 50). Johnson (1987) also provides readers with an account of a DvT session with a group of six nursing home residents between the ages of 80 and 94 with moderate cognitive impairments. Within this account, Johnson (1987) highlights the way in which DvT appeared to facilitate connection between group members by suggesting that throughout the session "the interpersonal demand of the activities increased from low levels to intense contact and interaction" (p. 75).

Outside of Sandel and Johnson's (1987) work discussed above, there appears to be very little published research on the use of drama therapy in nursing homes with cognitively able residents. Various documented drama therapy interventions for elderly people living in long-term care focus on the use of drama therapy interventions for those with dementia or Alzheimer's (Jaaniste, Linnell, Ollerton, & Slewa-Younan, 2015; Kontos et al., 2016; O'Rourke, 2016).

However, in her research, Smith (2000) provides readers with an example of drama therapy being used with a group of elderly residents with mild dementia who she describes as "relatively cognitively intact" (p. 326). While the focus of her work lies in articulating how DvT served to help elderly residents' approach and explore existentialism and death anxiety, she ultimately concludes that "by entering embodied encounter in the play-space, clients [were] able to relieve their existential angst and increase their sense of intimacy with the therapist and with each other" (Smith, 2000, p. 331). With this, like Johnson (1987), Smith (2000) appears to highlight the efficacy of the drama therapy approach of DT as an approach which may help cognitively intact residents connect to one another.

In their research, Keisari and Palgi (2017) discuss their use of a novel group therapy intervention called *Life-Crossroads on Stage* with three different groups of cognitively able

older adults: one group from a day center, one group from a social club, and one group from a continuing care resident community. Keisari and Palgi's (2017) intervention, which involved the narrative therapy technique of inviting participants to share their life stories through the identification of particularly significant life events (cross-roads), followed by participants then putting aspects of these stories on stage, ultimately increased participant self-reports of self-acceptance, relationships with others, sense of meaning in life, and sense of successful aging (Keisari & Palgi, 2017).

Facilitating Autonomy

In her research which explores fusible quilting within geriatric, palliative, and cancer long-term care populations, Bookbinder (2016) discusses her "art-as-therapy" approach in which participants are given much choice throughout their art making process, and within which participants are recognized as the experts regarding their preferences. Bookbinder (2016) argues that while residents are "told when to eat, sleep, take medication, clean themselves, etc." art therapists can "provide an oasis of choice-making that fosters the return of their autonomy and dignity" (p. 86).

An example of a creative arts therapy approach which can facilitate autonomy can be found in Doric-Henry's (1997) research, which chronicles the use of pottery as an art therapy intervention with elderly nursing home residents. While Doric-Henry (1997) sets out to discover how this intervention might impact self-esteem, depression, and anxiety for nursing home residents, within her methodology section she emphasizes the way in which potters were encouraged to work independently as much as possible. In her discussion of how these pottery sessions impacted residents, Doric-Henry (1997) notes that "the potters became increasingly independent as the sessions progressed" (p. 170). With this, it appears that Doric-Henry's (1997) pottery intervention served to encourage autonomy.

Another example in which a creative arts therapy intervention facilitated autonomy, can be found in Perryman and Keller's (2009) research. Perryman and Keller (2009) made use of a creative arts therapy intervention called "floratherapy" with women in a retirement home. Floratherapy, which is defined as "the use of floral design activities incorporating fresh flowers and plants as a medium to promote therapeutic process" (p. 335) was facilitated with six women across five sessions (Perryman & Keller, 2009). While being prompted by themes each week (e.g., family of origin, garden of dreams), Perryman and Keller (2009) provided participants with the freedom to choose the flowers they wished to use, as well as to arrange these flowers in any way that they wished. The impacts of this, are highlighted within the response of 89-year-old participant Louise, who explained that "I liked [facilitator's]

leadership because you didn't tell us what to do…you just let us do it…it allowed creativity because there weren't restrictions" (Perryman & Keller, 2009, p. 339). Here, it appears that floratherapy provided Louise with a sense of autonomy, as she was permitted to do what she wanted within the context of her creations.

Interestingly, the way in which creative arts therapies work to promote the autonomy of elderly people in long-term care has also been recognized by other, non-creative arts therapists. In their book which aims to articulate the efficacy of expressive arts interventions with elders, Weisberg and Wilder (2002) provide readers with the opinion of a social worker who worked alongside them to facilitate expressive arts therapy in a nursing home, who stated that:

> We work mainly from set, prescribed activities. It seems to me that the expressive arts leader offers a range of choices. You listen and take cues from the participants. You aren't afraid to give them autonomy…to let them express themselves in their own ways. (p. 77)

Importance of Considering Physical Ability

Literature regarding the use of the creative arts therapies in nursing homes also highlights the importance of keeping the level of physical ability of residents in mind in order to select or adapt interventions to suit the abilities of those participating. In her discussion of the use of art therapy with elderly adults in various settings (community centers, senior centers, colleges, hospitals, and nursing homes) Jungels (2002) reminds readers that different individuals may exhibit differing responses to art mediums depending on a variety of factors such as preferences, attentions spans, and physical abilities. Jungles (2002) also recommends that art mediums used with elderly individuals should be analyzed according to: "skills required, safety, and developmental stages of complexity" (p. 47) and from this, mediums which build on the personal strengths of the individual should be selected. In a similar vein, in her research regarding the use of art therapy in geriatric settings, Shore (1997) argues that "understanding the highly varied physical … characteristics and needs [of residents] is essential as the basis for effective treatment" (p. 177).

Avoiding underestimation. While the literature above suggests the importance of taking various levels of "ability" into consideration when working with elderly people in long-term care, creative arts therapists also emphasize the importance of avoiding underestimating the capabilities of elderly people in long-term care. For example, in her aforementioned research study in which pottery was used as an art therapy intervention with elderly nursing home residents, Doric-Henry (1997) articulates:

> During the course of this research, several observations were made. Most significant was the necessity to not prejudge the client's ability. A number of the potters included in the study would have been eliminated if physical ability had been a criterion. With lots of patience and assistance these potters were able to create and grow. (p. 170)

In their chapter written about the use of dance movement therapy in nursing homes, Sandel and Kelleher (1987) provide readers with guidelines regarding the use of dance and movement therapy with physically disabled nursing home residents with conditions such as strokes, arthritis, or other degenerative illnesses. Sandel and Kelleher (1987) argue that these limitations "need not prevent patients from participating in movement therapy" but that therapists can enable the participation of such residents through the creation of an accepting and non-judgmental therapeutic environment, in which residents might "feel free to function within the limits of their own capabilities" (Sandel & Kelleher, 1987, p. 33).

Difficulties in Engaging the Elderly in Therapeutic Services

Literature regarding the use of creative arts therapy in the context of long-term care also highlights various difficulties practitioners may face when attempting to engage residents in creative arts therapies. For example, within the context of his article *Promoting Wisdom: The Role of Art Therapy in Geriatric Settings,* Shore (1997) suggests that elderly individuals do not typically seek out therapeutic services, which in part, may be due to "the prevalence of 'ageism' [which] inherently shapes the older person's perception that need is undesirable and shameful" (p. 1997). A similar sentiment is proposed by Weisberg and Wilder (2002) who suggest that due to ageism, or "the subtle but pervasive attitude that defines the many ways the elderly are discriminated against" (p. 14), elderly individuals will often attempt to discourage practitioners interest' in them, assume that therapists' hold serious distain toward the task of evaluating them, and share little about themselves in initial interviews due to their beliefs "that there is little, if anything to share" (p. 15).

Sandel and Keller (1987) suggest that not all of those who live in long-term care "are willing to participant in a group experience" (p. 35), particularly highlighting the way in which those who commonly have visitors and are not clinically depressed will often times be satisfied to remain in their own rooms. Weiss (1984) articulates that some residents may show resistance toward engaging in creative arts therapy due to the conceptualization that the artistic mediums used within creative arts therapy are childish. Weiss (1984) describes his approach to countering this belief:

> I have found it important to describe to participants the value of self-expression through art. In my work I emphasize to clients that the type of tool used for creative

expression implies no judgement on the individual, but rather assists each person to feel at ease in relating to and expressing feelings and thoughts. (p. 28)

Literature regarding the use of art therapy with adults in general (not specific to the context of long-term care) also suggests that older adults may perceive creative arts therapy activities as childlike. In her book *Art Therapy and Creative Coping Techniques for Older Adults,* Buchalter (2011) discusses elderly resistance toward art therapy, articulating that some elderly individuals experience feelings of anxiety regarding the way that others might react to their artwork and "say they feel like their grandchildren and [therefore] choose to withdraw instead of trying something new" (p. 15). In a similar vein, in her discussion regarding elderly resistance toward art therapy, Kerr (1991) suggests that in response to not having worked with art materials since childhood, many elderly individuals "describe feeling awkward in reacquainting themselves with certain art materials and often are reluctant to use fluid media" (p. 40). In her discussion regarding adult resistance toward creative arts therapies, Malchiodi (2011) suggests that adults may show resistance toward engaging with art materials due to the perception that art making is "child's play rather than real therapy" (p. 260). Malchiodi (2011) recommends that to counter this, creative arts therapists should articulate to adult participants that creative activities can be understood as an alternative form of expression and "optional way to work on problems" (p. 260).

Chapter 5: Mask in Therapy

Classification of Masks in Therapy: Object versus Object-in-Motion

As the following section includes information regarding many differing approaches to the use of mask in therapy, it may first be important to define the two major, more general ways in which masks are used in the context of therapy. Jennings and Minde (1993) articulate that masks may be used in one of two ways: as a piece of art or sculpture which might be displayed and contemplated, or as something which might "be worn, inhabited, and set in movement by the wearer" (p. 187). Keats (2003) labels the first approach as "the mask-as-object" approach, and the second as "the mask as an object-in-motion" approach (Keats, 2003, p. 116).

Inclusion of Historical Underpinnings and Mask as Linked to Transformation and Transitions

While it is outside of the scope of the theoretical research at hand to provide readers with an extensive review of the origins of mask in the broader context of history/ society, it is worth articulating that previous research regarding the use of mask in therapy often does so - commonly drawing attention to the power of mask as a tool for transformations and aiding transitions.

For example, Janzing (1998) begins her literature review *The Use of Mask in Psychotherapy* with a section entitled 'The Origin of the Mask.' In this section, Janzing (1998) draws readers attention to the transformative nature of mask, by articulating that within the context of ancient rituals, masks served to allow wearers to "create contact with an inaccessible world…" and "to transcend their everyday identity" (p. 151). In the next section of her review, entitled 'The Mask in Theatre' Janzing (1998) also provides readers with information regarding how mask has been used for transformations within the context of theatre, drawing readers to a quote by Landy (1985) who suggests that within Greek theatre, "the mask transformed the human head into the godhead, the particular and mundane into the universal and sublime" (Landy, 1985, p. 45).

In a similar fashion, within her research regarding the construction of masks of the self in therapy, Keats (2003) includes a section entitled 'Historical Perspectives on Mask,' describing that: "ancient peoples used masks for disguises and protection in hunting and warfare, for transformation and healing, for honoring the dead and dying, in ceremonies that marked life transitions, and in times of hardship and joy" (p. 108). In their research regarding therapeutic mask making, Dunn-Snow and Joy-Smellie (2000) devote a section to 'Masks in History,' and within this section, suggest that the transformational nature of masks has been

used especially "in life transitions and in the spiritual realm" as "birth, death, marriage, and puberty are among the transitions associated with mask traditions" (p. 128).

Mask and Expression and Exploration of "Self"

In their research, Dunn-Snow and Joy-Smellie (2000) suggest that while on a collective level, masks have been built and used across many cultures to assist people in communicating their understanding of both natural and supernatural events, "individually, masks have been created and used in art therapy to help individuals understand themselves" (p. 126). In his work, Landy (1985) defines the use of mask in therapy as a projective technique, which can serve to "separate one part of the self from another" as well as to "unmask the self through masking a part of the self that has been repressed" (p. 51). Similarly, Chase (2017) suggests when used in therapy, masks play a role in allowing individuals to work with "parts of self through the concrete representation of different feelings, thoughts, and intentions" (p. 8).

In the chapter entitled *Mask, Myth, and Metaphor* within their book *Art Therapy and Drama Therapy: Masks of the Soul*, drama therapist Sue Jennings and art therapist Ase Minde (1993) also articulate mask as a powerful tool for aiding expression and exploration of self. Jennings discusses one of her most commonly used methods of therapeutic mask-work, which involves first using plaster-of-Paris bandages on the face of participants to build a mask mould, which is then removed from the face of the participant, set to dry, and later painted (Jennings & Minde, 1993). Jennings specifies that she always encourages the mask maker to look at and hold the plaster-of-Paris mask mould once it has been removed from their face and before it is set to dry, stating that in her experience "time and again people 'recognize' aspects of the self" through what she terms "the judicious use of masks" (Jennings & Minde, 1993, p. 189). Within the same chapter, art therapist Ase Minde explains:

> When I started to use masks in art therapy, I found an immediate use in my psychodynamic work: I used masks to express aspects of the self that usually could not be expressed. When a patient said to me "I always wear a mask; I can't be myself," I asked her to draw the mask that is under the mask. Any mask is part of the self, and what a person is saying is that there is a part of them that is kept hidden. (Jennings & Minde, 1993, p. 190)

In their research, Fryrear and Stephens (1988) make use of an innovative group psychotherapy approach combining mask making and video, which aims to help participants not only express / come to recognize lesser-known aspects of "the self," but also to permit conversation between such aspects in order to support integration. The group with whom their research was conducted included eight of researcher Bill Stephens' clients, between the

ages of 27-57 years old, who at the time of the study were struggling with aspects of marriage or separation/ divorce (Fryrear & Stephens, 1988).

As part of the mask-video program, group participants were invited to build a mask, and to then put on their mask in front of a camera and read a series of statements and questions that were previously constructed by researchers (Fryrear & Stephens, 1988). Unmasked, participants were then invited to review their footage and to engage in a dialogue with the mask, by responding to the questions and statements proposed by the mask in the video (Fryrear & Stephens, 1988). Alongside helping facilitate these dialogues between individual participants and their masks, researchers also supported the entire group in discussion (Fryrear & Stephens, 1988).

Fryrear and Stephens (1988) ultimately found that "as a group, the participants became more self-accepting, more inner directed, and more able to see apparent contradictions as meaningfully related" (p. 234) following the mask-video intervention. Interestingly, Fryrear and Stephens (1988) also reported that in the post-intervention questionnaires, participants expressed feeling as though the dialogue portion of the intervention "was more therapeutic than the mask making" (p. 233).

Hinz and Ragsdell (1990) set out to use Fryrear and Stephens' (1988) aforementioned mask-video method with a group of nine young women in treatment for bulimia. Hinz and Ragsdell (1990) hypothesized that this method might be particularly helpful for those struggling with bulimia, who "rarely present their real selves in relationships" (p. 259) and instead strive to present ideal or conforming versions of themselves to others. In Hinz and Ragsdell's (1990) study, however, participants showed significant resistance toward engaging in the mask-video intervention. Only three of nine participants engaged in the process from start to finish, with other group members dropping out of the process at different stages (Hinz & Ragsdell, 1990). While the intervention appeared beneficial to those who engaged in the entire process, in their discussion regarding why such a high level of resistance was shown toward the mask-video intervention, Hinz and Ragsdell (1990) postulate that "perhaps, when faced with mask construction, the bulimic women felt threatened by the risk of total exposure of their innermost selves, which usually remains hidden" (p. 260).

In his work, Stahler (2006) describes a 12-week drama therapy treatment program used with incarcerated women recovering from addiction called *Prayerformance.* As discussed by Stahler (2006), this approach aims to help female prisoners in recovery "explore parts of themselves separate from the role of addict or prisoner that they [usually] play" (p. 6) through the use of a variety of creative arts therapy techniques such as role play, improvisation,

spontaneity training, storytelling, character development, mask work, and movement. Mask making is highlighted as an integral part of the process: in early sessions, participants are invited to create masks that are representative of "the best of who they perceive themselves to be" (Stahler, 2006, p. 7). Following the completion of their masks, participants are then invited to work in pairs and to share with their partner the "story" of their mask, which is later scripted and incorporated into a ritual performance at the end of the program (Stahler, 2006). The following monologue, written by program participant Daniella about her mask named Tigress, highlights the way in which mask enabled her to express and explore an aspect of herself in the context of the *Prayerformance* program:

> Tigress represents the strong side of me that was revealed to me in the class and on this journey. Many times when things get tough or times get hard, the Tigress part always ends up shining through me and lets me know that I am strong and I am a survivor. Then my confidence kicks in an that is when I strive to do what I need to do to achieve my goals. (Stahler, 2006, p. 8)

Expression of self via Mask as Facilitating Communication and Connection

Within literature regarding the use of mask in therapy, the way the mask allows individuals to express aspects on themselves/ their identities also appears to enable participants to better communicate and connect to others.

In *Active-duty Military Service Members' Visual Representations of PTSD and TBI in Masks*, Walker et al. (2017) investigate the use of mask making in art therapy with military service members presenting with symptoms of traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). As part of a four-week interdisciplinary intensive outpatient program, study participants (n = 370) attended group art therapy (Walker et al., 2017). During their first week of art therapy, participants were provided with blank masks and a variety of crafting materials and invited to make masks to represent "aspects of their experiences and/or identities" (Walker et al., 2017, p.3). As outlined by Walker et al. (2017), the main goal of mask making was to enable participants to externalize parts of themselves artistically, in a nonjudgmental environment. Through later analysis of clinical notes which detailed each participants description of their mask and photos of the completed masks, Walker et al. (2017) discovered that the masks ultimately served as "representations of the self," (p. 4) which included "self as an individual, self in relationships, self in communities, self representing societal and philosophical value systems, and self in/over time" (p. 4). Walker et al. (2017) also identified a wide range of complex themes represented in the masks including: physical, psychological, and moral injury; grief; struggles with transitions; divided

sense of self; and disillusionment regarding aspects of the war (Walker et al., 2017). In their conclusions, Walker et al. (2017) suggest that the externalization of inner struggles in the form of a mask afforded participants a way to easier discuss their "unseen wounds and struggles by referring to an object," (p. 9) and that mask making also served as a way for participants to communicate these struggles with others through a non-verbal means of expression.

In his work, Baptiste (1989) describes a mask technique for families experiencing conflict, which aims to help family members see around the distorted perceptions they may have of one another and therefore to enable communication. Baptiste's (1989) approach involves inviting individuals to create a mask representing each one of their family members, and to then paint and decorate these masks "as positively or as negatively as the maker perceives the person for whom the mask is designated" (p. 50). Individuals are also asked to create two self-masks: one which is painted to represent how the creator perceives themselves, and the other which is painted to represent how the creator feels they are viewed by the family member with whom they are experiencing the most conflict (Baptiste, 1989). Following the completion of these masks, family members are invited to wear/ engage with the masks in various ways (role plays / role reversals) depending on the current issues that need be approached (Baptiste, 1989). Baptiste (1989) suggests that within this technique "the humor and play with masks tend[s] to make communication [between family members] less threatening and more malleable" (p. 52).

In his discussion regarding the use of masks in drama therapy, Landy (1994) provides readers with a clinical example of how mask work was used in the context of group drama therapy to help a deaf participant communicate and therefore better connect to group members. As recounted by Landy (1994), this participant experienced feeling isolated from the group and struggled to express this feeling "until she was asked to construct a mask representing a hidden part of herself" and then given the opportunity to present this mask to the group (p. 159). Landy (1994) describes the mask constructed by this participant in detail:

> Her mask extended over the ears. She had painted eyes upon the ears, because she hears with her eyes. A painted hand and mouth surrounded the openings of the actual eyes. Another hand image covered the mouth, as she speaks with her hands. (p. 159)

From this, Landy (1994) suggests that the creation and display of the mask permitted the participant to communicate "her world and her separateness from the world of others," and that, through this, "she was able to work toward a greater sense of connection with the group" (p. 159).

In her book *The Dynamics of Art Psychotherapy,* Wadeson (1995) discusses a workshop developed by Cherie Natenburg, in which Natenburg facilitated a mask intervention with elderly people. Wadeson (1995) describes that within Natenburg's workshop, elderly participants were given large paper masks and invited to paint these masks. Wadeson (1995) emphasizes that providing participants the opportunity to paint pre-made masks offered them "an easy structured means of self-expression" (p. 166). After painting their masks, participants were divided into pairs and invited to engage in dialogue through their masks and to share with one another what they saw in their partner's face/ mask (Wadeson, 1995). Following this interaction, the masks were laid out on display, and participants were invited to engage in a group conversation about their masks (Wadeson, 1995). Reflecting on this mask workshop, Wadeson (1995) clearly articulates the way in which mask work served to facilitate expression of self and connection to others in this context:

> This exercise brought people more in touch with both themselves and with one another. As many elderly people are withdrawn and isolated, this exercise facilitated contact. The paired dialogue enabled people to speak to one other person's mask from behind a mask, thus easing the contact that may have been more difficult face to face. (p. 166)

Therapeutic Mask: An Opportunity for Decision Making

Throughout the literature published on the use of mask in therapy, various approaches involve providing participants with multiple opportunities for decision making/ opportunities to lead their own creative process. For example, Landy (1994) highlights a group drama therapy mask approach aimed at helping clients examine their family dynamics. This approach begins by inviting each client to build four separate masks: one representing self, and the other three representing members of one's immediate family (Landy, 1994). Landy (1994) articulates that in this method, the foundation of all four masks are created using plaster-of-Paris bandages on the face of the client, and the client is then invited to choose from various materials such as paint, fabric, or objects to decorate each mask. Once masks are completed and participants have engaged in a warm-up, "each person is asked to construct the house where [they] grew up, using available objects," (p. 161) and to place their masks inside their constructed houses (Landy, 1994). This method then provides participants the opportunity for further forms of embodied exploration of the created masks including: wearing the masks and engaging in movement, engaging in role play with the masks by

inviting other group members to wear the masks representing each family member, and sculpting masked group members in still-life tableaus (Landy, 1994).

Through providing participants with various materials to choose from for the decorating of their masks, as well as by using the simple instruction of inviting each person to construct their childhood homes using objects available, Landy's (1994) approach appears to provide participants various opportunities for decision making / to lead their own creative process.

Work by Trepal-Wollenzier and Wester (2002) also appears to highlight the way in which therapeutic mask work can provide opportunities for decision making / leading one's own creative process. While describing the use of a therapeutic mask intervention with a female survivor of childhood sexual abuse, Trepal-Wollenzier and Wester (2002) articulate that the client was provided a wide range of art materials including blank masks, paints, glitter, glue, buttons, markers, jigsaw puzzle pieces, tape, barbed wire, as well as "a multitude of other supplies" (p. 127) to craft a mask. In response to the fact that the client had previously expressed feeling as though she often wore a metaphorical mask, hiding her true self and emotions from others, the client was given the simple instruction to construct a mask representative of the metaphorical mask she previously mentioned (Trepal-Wollenzier & Wester, 2002). Trepal-Wollezier and Wester (2002) suggest that this simple instruction provided the client "with enough leeway to be creative in the [mask making] process" (p. 127).

In a similar vein, in their mask-video intervention, Fryrear and Stephens (1988) provided study participants with a wide array of art materials including coloured tissue paper, poster board, coloured construction paper, gold and silver coloured aluminum foil, coloured yarn, coloured feathers, marking pencils, scissors, and string. Instructions given to participants for mask making were very simple: participants were told to construct a mask, and if they asked for further instruction, they were "told to begin and 'just let the mask evolve'" (Fryrear & Stephens, 1988, p. 227). With this, Fryrear and Stephens' (1988) approach appears to have provided participants the opportunity to make choices regarding what materials they wanted to use, as well as to lead their own creative process.

Mask as a "Safe Container"

Literature regarding the use of mask in therapy also articulates the mask as an object which has a strong ability to "hold" or "contain." For example, Jennings and Minde (1993) suggest that "the mask is especially a safe container of the 'self that is dangerous' or the 'self that feels dangerous' " (p. 190). In his discussion of the various psychological functions of

masks, Keats (2003) suggests that "masks can function as a frame that holds or captures an image within it" (p. 110) and further articulates that through this framing, the mask enables focus on the content or symbol that it represents. Chase (2017) articulates the holding power of masks in therapy by suggesting that masks enable "living through deep content in a 'controlled fashion,' through the focused representation of the masks which can be put on and taken off at will" (p. 8).

The power of the mask as a safe container is also supported by the work of creative arts therapist Yehudit Silverman, who, as presented in her 2010 documentary film *The Hidden Face of Suicide*, used mask making with a group of six individuals who lost family members to suicide. In her later published arts-based research paper in which she discusses the documentary at length, Silverman (2018) appears to highlight the holding power of the masks created by participants:

> The masks, once made and put on, became a poignant, extremely emotional metaphor for the trauma of the suicide itself and the need to hide that trauma from the outside world…The mask making allowed for a tangible expression of both the immense loss from the suicide and the effect of the shame and stigma surrounding it. (p. 2)

Projection and distancing. Throughout the literature regarding the use of mask in therapy, various authors also appear to highlight projection and distancing as the core therapeutic processes underlying *how* mask can become a safe container (Fryrear & Stephens, 1988; Landy, 1985, 1994; Silverman, 2018; Trepal-Wollenzier & Wester, 2002; Walker et al., 2017). In the context of creative arts therapy, the term projection, also known as artistic projection or dramatic projection refers to the process in which an individual projects or externalizes aspects of their experience or self into an "art form or process" (Jones, 2005, p. 249). In his writing, Landy (1994) categorizes the use of photography, video, objects, dolls, puppets, masks, and make up (to name a few) as *projective techniques*. Landy (1994) also explains how dramatic projection works when using objects:

> The therapist uses the object as a means to externalize and focus feelings. The object becomes a symbol, and anchor for the unconscious. In animating an object, the client partakes in a therapeutic rite through the projection of his fears, fantasies, wishes and hopes onto a thing that is not himself. (p. 154)

The idea of the mask as a projective technique is discussed by Fryrear and Stephens (1988) within their work regarding the use of mask in group psychotherapy. Fryrear and Stephens (1988) suggest that "just as one projects one's fantasies, attitudes, and personal dynamics into

such stimuli as Rorschach ink blots and Thematic Apperception Test plates, so too does one project onto a mask" (p. 227).

As previously mentioned, in his article *The Image of the Mask: Implications for Theatre and Therapy*, Landy (1985) defines mask in therapy as a projective object which can work to "separate one part of the self from another" (p. 51). Landy (1985) also draws attention to the way in which through the process of projection, the mask "provides a measure of distance from the person" (p. 51) and the material symbolized in the mask, and thus enables individuals to see challenges that are represented in the mask more clearly. This concept of distancing, or intrapsychic distancing, is defined by Landy (2000) as the idea that "one can remove or create distance from one's own feelings, thoughts, and physical self-image" (p. 13).

Walker et al. (2017) also highlight the process of distancing as underlying therapeutic mask work, by articulating that mask making "is used with a range of populations affected by trauma since it is a medium that allows for some psychological distance for expression and externalization" (p. 2). Silverman (2018) articulates the potential of mask to distance individuals from difficult material when she suggests that a unique aspect of her mask-making workshops with suicide survivors was that it provided them an opportunity to put the complex and difficult feelings they experienced "into an object that was outside of them" (p. 2). In their discussion of the use of mask in art therapy, Trepal-Wollenzier and Wester (2002) also articulate how therapeutic mask work can establish a sense of intrapsychic distance between the client and the difficulties represented in the mask:

> Having a client create a mask and then asking them to write to, or dialogue with this mask allows for the opening of space, thus allowing oneself to be removed from the immediate situation and to be put into a reflective position. (p. 126)

Mask and Storytelling

A review of the literature published regarding the use of mask in therapy also reveals that therapeutic mask interventions are in some instances used to facilitate storytelling, and in other instances, used to enhance storytelling approaches.

For example, in Stahler's (2006) aforementioned *Prayerformance* approach, the creation of masks, representative of "the best of who [participants] perceive[d] themselves to be" (p. 7) served as the foundation for storytelling, as after creating a mask, each participant was invited to also create the story of their mask and to later share this story with others in the context of a theatrical ritual performance. As articulated by Silverman (2018), the combination of mask making and interviews that was used in her 2010 documentary *The*

Hidden Face of Suicide enabled family members who had lost loved ones to suicide to share their stories/ experiences as suicide survivors.

In their chapter *Mask, Myth, and Metaphor*, Jennings and Minde (1993) suggest that mask work can be used to enhance approaches based in storytelling, within the context of a transcript of a previous discussion they once had while planning a summer school program about masks. In this transcript, after sharing many different ideas of how mask might be used in the summer school program, Jennings and Minde (1993) ultimately agree on the idea to use miniature animals for storytelling at the beginning of the summer school program, and to later build masks based on the animals and the stories created by participants.

The idea of mask as a tool which can enhance storytelling approaches also appears to emerge in the context of Silverman's (2004) research *The Story Within – Myth and Fairy Tale in Therapy*. Silverman (2004) describes a novel drama therapy approach which involves guiding the client through "the formation and exploration of a deep relationship with a carefully chosen myth or fairy tale character as a way of working with difficult personal material" (p. 127). Therapeutic mask work (see Silverman, 2004 for the specific ways in which mask was used) is implemented into the "becoming the character" step of the myth and fairy tale method and used alongside creative text and participating in visualizations to "guide clients more deeply into the experience of the character" (Silverman, 2004, p. 131).

Use with Caution

Research published regarding the use of mask as a tool for therapy also often reminds readers to be conscientious of the potential risks involved in the use of mask in therapy, as well as why in some cases, mask should not be used for therapeutic intervention. For example, in her aforementioned literature review regarding the use of mask in psychotherapy, Janzing (1998) includes a section entitled 'Dangers and Therapeutic Contra-indications,' within which she emphasizes that because the mask is understood as a particularly powerful medium in anthropology, theatre, and therapy, which is often times surrounded by various cultural and religious taboos, "one should not use it thoughtlessly" (p. 155).

Janzing (1998) later articulates that a major contraindication of the use of mask in therapy, as highlighted by previous authors, has to do with the potential of the mask to lead those who have fragile egos into a psychotic state. To support this claim, Janzing (1998) provides readers with the following quote, taken from drama therapist Renee Emunah's (1994) book:

> Masks are theatrically and psychologically powerful, but should be used with caution with clients who are disoriented or have weak ego boundaries. These clients

may experience loss of self when wearing the mask, or, as audience, a loss of the person who had just put on the mask. (Emunah, 1994, p. 156-157)

In his writing about the use of masks as therapeutic aids in family therapy, Baptiste (1989) includes a section entitled 'Mask Usage: Caveats and Contraindications' in which he suggests that mask work is not recommended during early stages of therapy prior to the trying-out of other techniques, and that it is also not recommended for families who express explicit opposition to the idea of using masks. Baptiste (1989) also articulates that the use of mask "may be inappropriate for families with children ages 5 and younger, who may be confused about the difference between masks and reality" (p. 57).

In their research regarding the use of mask in art therapy, Dunn-Snow and Joy-Smellie (2000) speak specifically about the dangers of the "self-mask technique" in the context of therapy. As described by Dunn-Snow and Joy-Smellie (2000), the self-mask technique involves the therapist building the foundation of a mask on the face of the participant using plaster-of-Paris strips, covering the face of the participant entirely, and then waiting for the plaster mould to dry before removing it from the face of the participant. Dunn-Snow and Joy-Smellie (2000) caution that this process is one that places the individual in a very vulnerable position, and that this approach "may not be appropriate with certain individuals because of past trauma, a diagnosis, or a disability such as posttraumatic stress disorder or schizophrenia, or a medical condition that requires a completely sterile environment" (p. 127). With this, like other authors, Dunn-Snow and Joy-Smellie remind readers to be careful/ cautious when facilitating therapeutic mask work.

Chapter 6: Discussion

To briefly discuss the literature reviewed regarding elderly adjustment to long-term care, it appears that promoting sense of self, facilitating socialization, and promoting autonomy are conceptualized throughout the nursing literature as the three major approaches to aiding elderly adjustment (Altintas et al., 2017; Brownie, et al., 2014; Heliker & Scholler-Jaquish, 2006; Lee, 2010; Melrose, 2004; Philippe & Vallerand, 2008; Sussman & Dupuis, 2014). However, it is surprising to discover that the weight of the responsibility of helping elderly individuals adjust to life in long-term care appears to fall on the shoulders of nursing staff, especially if nursing home staff "seldom have the formal training necessary to treat the psychological needs of residents" (Rehfeldt, Steele, & Dixon, 2001, p. 36). The lack of recommendations for residents to be referred to therapy, and instead, the presence of recommendations of interventions that nursing staff may employ to aid adjustment (as presented in Curtiss et al., 2007; Ellis, 2010; Heliker & Scholler-Jaquish, 2006; Kennedy et al., 2005; Sussman & Dupuis, 2014) suggests a need for both more therapists, and more therapeutic interventions aimed at aiding elderly adjustment in the context of long-term care.

The conceptualization of elderly adjustment to long-term care as a very complex, multifaceted process appears to emerge from the way in which no one definition of adjustment exists across literature, from the challenges of loss of sense of self/ identity (Brownie et al., 2014; Heliker & Scholler-Jaquish, 2006, Sussman & Dupuis, 2014) and loss of sense of autonomy (Brownie et al., 2014; Curtiss et al., 2007; Kennedy et al., 2005; Koppitz et al., 2017; Melrose, 2004) which often accompany the transition into long-term care, as well as by the way in which the literature articulates that each individual may experience the process of adjustment differently (Kennedy et al., 2005; Porter & Clinton, 1992; Rehfeldt et al., 2001; Sussman & Dupuis, 2014).

This suggests the need for the formulation of therapeutic interventions which are not "one size fits all," but rather, interventions which are both flexible/ adaptable and capable of holding each individual's unique adjustment experience. It is from this, that the researcher draws the first link between elderly adjustment to long-term care and therapeutic mask. As the mask literature reviewed above depicts the way in which therapeutic mask has been adapted and used with a variety of different populations struggling with a variety of different challenges, therapeutic mask may therefore also have the potential to be adapted to suit the complex needs of those in the process of adjusting to long-term care.

Through the processes of projection and distancing (Landy 1985, 1994), the power of the mask to act as a safe container and to hold many differing aspects of both self and human

experience *in an object outside of oneself* (Chase, 2017; Jennings & Minde, 1993; Keats, 2003; Silverman, 2010, 2018; Walker et al., 2017) may also suggest that in the context of long-term care, the mask may have the potential to serve as a safe container for the many unique challenges/ traumas experienced by residents as they make their way through what is recognized as one of life's most challenging transitions. The sense of distance from difficult material or trauma that can be achieved through the projection of such material onto a mask (Landy, 1985, 1994; Silverman, 2010, 2018; Trepal-Wollenzier & Wester, 2002, Walker et al., 2017) may provide residents with a sense of safety from such difficulties, as well as ease their ability to approach difficult aspects of their adjustment experiences.

Shifting the focus briefly to the literature reviewed regarding the use of creative arts therapy interventions in long-term care, as previously mentioned, the search for creative arts therapy interventions aimed specifically at helping elderly people adjust to long-term care reveals a gap in the literature. The literature regarding the use of creative arts therapy in nursing homes in general did, however, highlight the way in which creative arts therapy interventions have been used to promote sense of self (Geller, 2013; Sandel & Johnson, 1987; Weiss, 1984), facilitate socialization (Bookbinder, 2016; Ferguson & Gossman, 1991; Geller, 2013; Jensen, 1997; Johnson, 1987; Keisari & Palgi, 2017; Sandel & Johnson, 1987; Smith 2000; Weiss, 1984) and to promote autonomy (Bookbinder, 2016; Doric-Henry, 1997; Perryman & Keller, 2009; Weisberg & Wilder, 2002). From this, since other creative arts therapy interventions, especially those which enable projection through the use of art, drama, and/or movement have been documented as promoting sense of self, socialization, and autonomy, it follows that the use of therapeutic mask, as an inherently projective intervention (Fryrear & Stephens, 1988; Landy, 1985, 1994) may also have the potential to promote these factors and thus to aid elderly adjustment.

This more general argument that therapeutic mask may have the potential to aid elderly adjustment to long-term care can be further supported when moving toward a discussion of the specific themes which emerged in the context of the therapeutic mask literature. One of the most "obvious" theoretical arguments for how therapeutic mask may serve as a tool to aid elderly adjustment to long-term care may be drawn from the findings that masks have been used historically in the context of transition ceremonies. As mask has been incorporated into rituals surrounding other major life transitions such as puberty, marriage, and death (Dunn-Snow & Joy-Smellie, 2000), mask may therefore be beneficial to use in the context of the transition into long-term care.

It is the researcher's belief that the process of "adjustment" may also be conceptualized as a "transition" of sorts, as within the adjustment process, residents appear to be challenged to transition or transform from the version of themselves that existed prior to relocation, to a new or altered version of self. From this conceptualization, those who struggle most with adjustment may be holding too tightly onto the version of themselves which existed before relocation. Given the way in which mask has been used within the context of ritual, theatre, and therapy to facilitate transformation (Dunn-Snow & Joy-Smellie, 2000; Janzing, 1998; Keats, 2003; Landy, 1985) it follows that the use of mask in the context of long-term care may be helpful in facilitating an individual's transition from "self-before relocation" toward "self-after relocation."

The next major argument for the use of therapeutic mask as a tool to aid elderly adjustment to long-term care can be drawn from the way in which therapeutic mask appears to support expression and exploration of self (Chase, 2017; Dunn-Snow & Joy-Smellie, 2000; Fryrear & Stephens, 1988; Hinz & Ragsdell, 1990; Jennings & Minde, 1993; Landy, 1985, 1994; Stahler, 2006; Wadeson, 1995; Walker et al., 2017). From this, use of mask in the context of long-term care may therefore aid adjustment by serving as a means to help residents recover and express those aspects of self that may have been lost or become hidden during residents' transition to long-term care. Furthermore, as therapeutic mask work may enable not only the expression and exploration of aspects of self but also the integration of these aspects (Fryrear & Stephens, 1988), therapeutic mask may aid elderly adjustment by promoting the integration of those aspects of self which existed prior to relocation with those new aspects of self which may have emerged in response to being relocated to long-term care.

The idea that objects may also serve as a means to help elderly residents affirm their identities, and therefore support adjustment, within the process of adjusting to long-term care (Brownie et al., 2014; Melrose, 2004; Sussman & Dupuis; 2014), and the articulation of masks in the context of therapy as objects, or objects-in-motion (Keats, 2003) also brings to mind the idea that masks might have the potential to serve as *transitional objects* for elderly individuals adjusting to long-term care. The term transitional object was originally coined by Donald Winnicott to refer to a soft toy that a child between the ages of four to twelve months old becomes attached to, and that serves to comfort the child as they navigate their way through the separation-individuation process of psychological development (as cited in McCullough, 2009). McCullough (2009) describes the evolution of the concept of the

transitional object from Winnicott's early theories to how the transitional object is understood/ defined today:

> Winnicott's theories concerned the use of transitional objects during early childhood development, but they laid the foundation for other theories that have elaborated on the significance of transitional objects in everyday life beyond infancy. As tools for psychological and emotional development and the organization of the psyche, transitional objects may serve to reaffirm who we are and how we function as individuals. (p. 19-20)

McCullough (2009) further suggest that in adolescence and adulthood, transitional objects may be chosen by an individual as a representation of self and to "aid in feelings of self-continuity and control" (p. 20). From this, a mask intervention which involves inviting participants to create a mask that is representative of some aspect (or aspects) of self, may have the potential to serve as a transitional object, especially if the individual is permitted to keep/ store the mask in their room. This tangible reminder of their identity may then serve to "aid feelings of self-continuity and control" (McCullough, 2009, p. 20) and thus support adjustment.

In a similar realm, the way in which storytelling is identified as something which can contribute to re-establishing residents sense of identity/ self and therefore contribute to adjustment (Heliker & Scholler-Jaquish, 2006; Riedl, Mantovan, & Them, 2013) and the way in which therapeutic mask work is sometimes paired with storytelling/ used to facilitate storytelling may also serve to support the idea that therapeutic mask could be used to aid adjustment. For example, for those residents who may feel initially nervous or shy to share stories about themselves or their lives with other residents within day-to-day interactions, a therapeutic mask intervention which involves first inviting individuals to build a mask representative of some aspect of self, and to then share the story of the mask may serve as an ice-breaker to sharing stories.

Another argument for the use of therapeutic mask as a tool to aid adjustment can be drawn from the findings that literature regarding the use of mask in therapy highlights the way in which mask enables connection and communication with others. In the same way that therapeutic mask enabled a deaf woman to communicate aspects of herself and therefore better connect to others in the aforementioned example provided by Landy (1994), and the use of mask enabled active-duty military service members to communicate aspects of themselves and their experiences with others (Walker et al., 2017), therapeutic mask may therefore have the potential to enable elderly residents to communicate and connect with

others in the context of long-term care and thus contribute to adjustment. This argument appears further supported by the one previously discussed documented example the researcher found of the use of mask with a group of elderly people, in which masks ultimately served to enable contact between elderly participants and “brought people more in touch with both themselves and with one another” (Wadeson, 1995, p. 166).

Finally, another argument for the potential of therapeutic mask to aid elderly adjustment to long-term care, can be drawn from the discovery that “opportunity for decision making” emerged as a theme within therapeutic mask literature (Fryrear & Stephens, 1988; Landy, 1994; Trepal-Wollenzier & Wester, 2002). For elderly residents who are experiencing a loss of autonomy in various domains (Brownie et al., 2014; Curtiss et al., 2007; Kennedy et al., 2005; Koppitz et al., 2017; Melrose, 2004) therapeutic mask work may support their autonomy by providing a variety of choices throughout the mask making process regarding what materials they wish to use as well as how they wish to use them. Also worth noting here, given that the literature regarding the use of mask in therapy depicts a variety of different ways crafted masks can be further explored, for example by discussing masks (Walker et al., 2017), by writing a letter to one’s mask (Trepal-Wollenzier & Wester, 2002), or by wearing masks and engaging in movement or role play (Landy, 1994; Silverman, 2004; Stahler, 2006), residents may also be given the opportunity to choose how they want to explore the masks they have created, further supporting autonomy and thus potentially aiding adjustment.

Special Considerations

The use of therapeutic mask as a tool to aid adjustment should not be argued, without also discussing various special considerations which may need be kept in mind based on the literature reviewed. Firstly, some of the approaches to the use of mask in therapy described above begin by employing the self-mask technique (Jennings & Minde, 1993; Landy, 1994; Stahler, 2006) which as previously articulated, involves the therapist applying plaster-of-Paris bandages on the face of the participant to build the foundation of the mask (Dunn-Snow & Joy-Smellie, 2000). As this process is conceptualized as a process that places individuals in a “vulnerable and intimate position” (Dunn-Snow & Joy-Smellie, 2000, p. 127), this technique may therefore not be appropriate to use with elderly individuals in long-term care, who may already be in a particularly vulnerable place do to the many challenges associated with adjusting to long-term care. From this, therapeutic mask work in the context of long-term care should not begin with the self-mask technique, but instead, by providing participants

with pre-formed plastic mask structures, or previously crafted paper masks to serve as the base of their masks (as seen in Baptiste 1989; Wadeson, 1995; Walker et al., 2017).

Also, while some therapeutic mask interventions above suggests that masks created in the context of therapy might be worn and shared by various participants (Baptiste, 1989; Landy, 1994) the "sharing" of masks may not be suitable in the context of long-term care, in order to adhere to the health and safety standards which may exist in these settings. With this, the researcher suggests that for any therapeutic mask approach which may be used in nursing homes, the participants be permitted to wear only the mask that they created.

As the importance of taking into consideration the level of physical ability of participants is highlighted in the literature regarding the use of creative arts therapy interventions in long-term care (Jungels, 2002; Sandel & Kelleher, 1987; Shore, 1997) it follows that any potential therapeutic mask making intervention should also take into account the level of physical ability of participants and be adapted accordingly. While previous research suggest a wide array of materials can be used for mask making and decorating such as tissue paper, poster board, construction paper, aluminum foil, yarn, feathers, marking pencils, string, paint, glitter, glue, buttons, markers, jigsaw puzzle pieces, tape, barbed wire, clay, and collage and print materials (Fryrear & Stephens, 1988; Trepal-Wollenzier & Wester, 2002; Walker et al., 2017), special attention should be paid to selecting materials to use with elderly individuals, to ensure that those materials selected build on the personal strengths of the individual. For example, it may be important to exclude those materials that may prove too challenging for individuals with severe fine motor difficulties to grasp or manipulate (e.g., small buttons, yarn, and thin writing utensils such as pencils or pencil crayons). The use of pre-formed/ pre-constructed mask structures (Baptiste 1989; Wadeson, 1995; Walker et al., 2017) may also be particularly important for those individuals who may struggle to manipulate scissors and therefore find cutting out masks from construction paper or poster board too challenging.

On the other hand, it may also be important to keep Doric-Henry's (1997) advice to "not prejudge the client's ability" (p. 170) in mind when selecting materials to be used in mask making, as well as when making decisions about which mask making approach to use. While the therapeutic mask literature above appears to suggest that mask making interventions often involve many steps, "with lots of patience and assistance," (Doric-Henry, 1997, p. 170) elderly residents may find success in mask making. It may also be important to keep in mind when selecting crafting materials, that different textures can bring participants "in touch with different feelings" (Jennings & Minde, 1993, p. 45). Unfortunately, across the

therapeutic mask literature, various sources simply list the materials used within the mask making process (Fryrear & Stephens, 1988; Trepal-Wollenzier & Wester, 2002; Walker et al., 2017) without discussing why particular materials were selected or how materials selected may have impacted the overall therapeutic process. From this, it may be important to review art therapy literature regarding the impact that different crafting materials may have on the therapeutic process (see Hinz, 2009; Lusebrink & Hinz, 2016; Moon, 2011; Seiden, 2011) before incorporating them into a therapeutic mask approach.

Also worth noting here, is that given the way in which many different cultural and religious taboos may exist around the use of masks (Janzing, 1998), it may also be important for any therapist planning to do therapeutic mask work in the context of long-term care to first inquire with participants about their own cultural understanding of masks. For participants who may understand masks as religious or spiritual, additional steps may need be taken in terms of how masks are handled, displayed, or stored.

Contraindications

Based on the literature reviewed within the categories of elderly adjustment to long-term care, creative arts therapy interventions in long-term care, and mask in therapy, there are also a few reasons why therapeutic mask may not be an appropriate intervention / may be countertherapeutic for elderly individuals struggling to adjust to long-term care. Firstly, as the initial relocation into long-term care is articulated as something which can lead to a loss of sense of self/identity (Brownie et al., 2014; Heliker & Scholler-Jaquish, 2006; Sussman & Dupuis, 2014), therapeutic mask, which is described as putting those who are disoriented or have weak ego boundaries at risk of experiencing "a loss of self when wearing the mask" (Emunah, 1994, p. 156), may therefore lead to further the loss of sense of identity/ sense of self for individuals and therefore be countertherapeutic for those elderly individuals already struggling with a loss of sense of self. Secondly, the way in which mask is surrounded by a multitude of cultural and religious taboos (Janzing, 1998) may make elderly individuals weary of engaging in mask work. Such weariness of engaging in mask work may also be furthered by the more general belief sometimes held by elderly individuals that working with creative arts therapy materials is childish (Bachalter, 2011; Kerr, 1991, Malchiodi, 2011, Weiss, 1984), which may ultimately discourage elderly individuals from participating in therapeutic mask interventions.

Chapter 7: Conclusion

Having reviewed literature spanning elderly adjustment to long-term care, creative arts therapy interventions in long-term care, and the use of mask in therapy, the researcher concludes that therapeutic mask work may have the potential to aid elderly adjustment to long-term care due to the flexibility and adaptability of therapeutic mask approaches, as well as due to the potential of masks to serve as safe containers for the many unique challenges/ traumas experienced by residents during their transition to long-term care. With historical roots in aiding life transitions and transformations, therapeutic mask work may also have the potential to aid elderly adjustment to long-term care due to its ability to facilitate expression and exploration of self, communication and connection with others, and to provide individuals with opportunities for autonomy. Contraindications identified for the use of therapeutic mask work in the context of elderly adjustment to long-term care include: the potential of mask work to lead to further loss of sense of self, and that cultural and religious taboos surrounding mask may discourage elderly participants from engaging in therapeutic mask interventions. Given the rather extensive list of "special considerations" which need be kept in mind for the use of therapeutic mask in nursing homes, the researcher concludes the use of therapeutic mask in the context of elderly adjustment to long-term care is an approach that may require significant planning in order to be successful.

Limitations

Limitations of the research at hand can also be drawn from a critical analysis of the literature reviewed. Although the nursing literature referenced provides significant context regarding the experience of those transitioning into long-term care, some aspects of this literature are problematic. For example, within the nursing literature published on elderly adjustment to long-term care, 'adjustment' has not been clearly operationalized across sources, with researchers measuring a variety of different factors from life satisfaction, positive and negative affect, and activity level in order to measure adjustment (Lee et al., 2015; Yu et al., 2016). This calls into question the validity and reliability of previously published literature on the topic of elderly adjustment to long-term care, and thus suggests that further research within which the definition of adjustment is consistently defined and assessed with consistent measures may be essential to establishing a better understanding of the phenomenon of adjustment to long-term care.

Worth noting here as well, is the way in which some of the nursing studies referenced within the theoretical research exploration at hand (Heliker & Scholler-Jaquish, 2006; Kennedy et al., 2005; Sussman & Dupuis, 2014) draw conclusions from relatively small

sample sizes, making it difficult to generalize the results of these studies to others within this population. However, the conceptualization of the experience of adjustment as unique (Kennedy et al., 2005; Porter & Clinton, 1992; Rehfeldt et al., 2001; Sussman & Dupuis, 2014) raises questions regarding whether more "generalizable" studies are even possible.

As with the nursing literature, much of the creative arts therapy literature regarding the use of creative arts therapy in nursing homes also relies on small sample sizes (Bookbinder, 2016; Doric-Henry, 1997; Geller, 2013; Jensen, 1997; Keisari & Palgi, 2017; Perryman & Keller, 2009), again, making it difficult to generalize the results of these studies to the larger population. Turning to the literature regarding the use of mask in therapy, the use of mask appears to differ significantly depending on the therapeutic modality (creative arts therapies, group psychotherapy, individual psychotherapy) as well as depending on the population it is being used with. Without the documentation of consistently used, standardized approaches to therapeutic mask, it is impossible to establish the reliability and validity of therapeutic mask. Finally, the search for literature regarding the use of creative arts therapy in nursing homes and the use of mask in therapy revealed that a relatively small amount of current research is published in these areas. These difficulties, in each category of literature reviewed, inevitably impact the overall legitimization of any conclusions drawn by the researcher regarding the use of mask as a potential tool to aid elderly adjustment to long-term care.

Recommendations

For any others who may be interested in exploring therapeutic mask work as a tool to aid elderly adjustment to long-term care, the researcher recommends that they begin by first becoming very familiar with nursing literature regarding elderly adjustment to long-term care, as a thorough understanding of the complex phenomenon of adjustment is essential in order to identify the suitability of any therapeutic intervention in this context. While the researcher has provided preliminary support for the argument that the use of therapeutic mask may in fact serve to aid elderly adjustment to long-term care, the replication of the study at hand may be important to identify any further arguments or counterarguments for the use of mask as a tool to aid adjustment. In light of the researcher finding more support for the use of mask in long-term care than contraindications for its use, it is also recommended that intervention research be done, in which a clear intervention is crafted and articulates the specific steps that a therapist might use when facilitating mask work to aid elderly adjustment to long-term care, *before* therapeutic mask is attempted with elderly individuals.

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